

Cultural Sensitivity and Early Intervention in Nova Scotia

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Abstract

The family-centred philosophy governs the provision of early intervention services for families of children with special needs in Canada and the United States, and has significantly changed over the past 50 years. Professionals now collaborate with families and individualize their approaches in an effort to effectively meet families' unique and varied needs. It is believed that by utilizing such approaches, children and families will experience the greatest success (Trivette & Dunst, 2005).

Cultural sensitivity is an extremely important component of family-centred care. Culture significantly impacts individuals' views and attitudes toward disability, help-seeking and childrearing behaviours, and communication styles, all of which have significant implications for family-professional partnerships (García Coll & Magnuson, 2000; Harry, 1992; Turnbull & Turnbull, 1990). In order to best meet the needs of culturally diverse families, early childhood practitioners must know how to respectfully interact with them, and incorporate their unique beliefs, practices, and values into service plans. Although cultural sensitivity has been identified as a crucial component of family-centred practice, few studies address how professionals actually implement these practices.

This research utilized a blend of quantitative and qualitative research designs to explore the degree of diversity associated with early intervention programs across the province of Nova Scotia, and the perceptions held by early interventionists regarding family-centred care, cultural diversity, and cultural sensitivity. The Executive Directors (N=11) of early intervention programs in Nova Scotia completed the Cultural Diversity in Early Intervention Survey. Questions in this instrument concerned the number of

culturally diverse families currently involved with centres, the services they had access to, and the challenges associated with meeting diverse families' needs. Early intervention professionals (N=10) employed in two urban programs were interviewed. Participants were asked to discuss their early intervention experiences, and interpretations of family-centred care and cultural sensitivity. They were also asked to describe the ways in which culturally sensitive services were provided, their comfort levels with doing so, and to highlight any associated areas of challenge.

Results demonstrated that for the most part, participants had excellent conceptual understandings of early intervention and family-centred care. Their descriptions of cultural sensitivity were less well defined. This is likely due to the fact that no participants had received training specific to cultural sensitivity, and were unsupported by necessary resources, such as translators. Professionals noted differing languages, and their lack of culture-specific knowledge and culturally sensitive supports as major barriers that were encountered in providing services for culturally diverse families. Professionals must be supported with appropriate training and resources in order to provide high quality services for all families, including those who are culturally diverse.

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Chapter 1

Introduction

Background

The nature of family-professional relationships has changed significantly since the days when service provision was professionally-dominated in the 1950s and early 60s (Turnbull & Turnbull, 1990). Due to the emergence of various theoretical perspectives, legislation, and supporting empirical evidence, professionals have been forced to relinquish their positions as the unquestioned experts, and acknowledge the important place of the family and the valuable insights they bring to intervention. Families of young children with special needs are now involved in all aspects of intervention as professionals strive to collaborate with them in family-centred ways.

The main tenets of family-centred practice include focusing on the entire family unit, as opposed to solely on the child; addressing families' needs, goals, and priorities; developing individualized intervention plans; and respecting families' unique strengths and capabilities. Through open and respectful communications, professionals aim to empower families, improve family functioning, and minimize stress (Trivette & Dunst, 2005). Family-centred professionals attempt to acknowledge and incorporate those aspects that families identify as most important into service plans in order to best address their needs.

Employing family-centred practices with those who are culturally diverse can present unique challenges for early interventionists. Culture significantly influences an individual's identity. As a result, professionals may be unsure of how to address and incorporate unfamiliar practices, values, and beliefs into an early intervention program (García Coll & Magnuson, 2000). Changing demographics, recommended family-based

practices, and empirical evidence all serve as indicators of the need for professionals to work in culturally sensitive ways (Barnwell & Day, 1996; Chan, 1990; Harry, 1992; Trivette & Dunst, 2005).

Personal Reflection

During my first year in the Child & Youth Study Master's program, I enrolled in a student internship course that resulted in a placement at a local early intervention centre. As my undergraduate degree was not in Child & Youth Study, I knew little about what went on within the walls of these programs beyond what I had read about. My involvement in this setting was a valuable one in many ways. I was able to participate in the programs they offered and see how the concepts I had read about, such as family-centred care, were implemented into practice on a day-to-day basis. It was this experience that drew me to further explore this area in my thesis research.

In the initial stages of the project, when I was beginning to explore the existing research, I noticed a significant gap surrounding the topic of cultural sensitivity. The importance of "being culturally sensitive" was often noted, but the details of such practices were rarely described. What does it mean to be culturally sensitive? How do professionals provide these services for culturally diverse families? Are they supported to do so? These questions arose over and over, and are what ultimately led to the initiation of this undertaking.

Statement of Research Problem

Research studying the issue of *cultural sensitivity* has for the most part, made suggestions as to how professionals can act in this manner. For example, Chan (1990) and Lynch (1992b) suggest professionals become aware of their own biases, seek culture-

specific information, and attain skills that facilitate successful cross-cultural interactions. What remains largely unavailable, are studies that examine the extent to which practices such as those mentioned by Chan and Lynch are being utilized, and the associated results for families. The few examples that exist demonstrate that families can benefit from having their needs more accurately addressed (Bruder, Anderson, Schutz, & Caldera, 1991; Chan, 1990). However, research also indicates that for many culturally diverse families, this is not occurring. Due to the fact that services are not being effectively individualized to meet their needs, culturally diverse families tend to experience less positive results as compared to families of white children (Bailey, Scarborough, Hebbeler, Spiker, & Mallik, 2004).

This issue needs to be addressed further, and from a Canadian perspective. Nova Scotia has the highest percentage of individuals with disabilities in Canada, and many who identify with an ethnicity other than Canadian (Human Resources and Social Development Canada, 2008; Statistics Canada, 2006b). This indicates that cultural sensitivity in early intervention is an especially pertinent topic in this province.

Rationale and Significance

This study attempted to add to the existing body of research regarding the place of cultural sensitivity within family-centred practice in a number of ways. Professionals discussed their early intervention experiences, and their interpretations of family-centred care, cultural diversity, and cultural sensitivity. They also discussed their expectations and satisfaction levels with early intervention, and were given the opportunity to reflect on their practices. This will help early interventionists to become informed of others'

practices, which may serve to provide them with new and positive strategies for working with culturally diverse families in sensitive ways.

This study also intended to gain an understanding of the degree to which culturally diverse families are accessing available early intervention services. This was accomplished through a variety of measures, and helped to paint a clearer picture of this issue as it stands in the Nova Scotian context. These results serve as indicators of whether outreach efforts to culturally diverse families need to be developed or improved upon.

Finally, this research intended to examine professionals' use of culturally sensitive practices, and their comfort levels with doing so as perceived by early interventionists. This helped to determine what kinds of resources are needed to improve current practices.

Research Questions

- 1) What are participants' perceptions regarding their actual early intervention experiences?
- 2) What are participants' perceptions of the concept of family-centred practice?
- 3) What are participants' perceptions of the concept of cultural sensitivity?
- 4) What culturally sensitive practices do participants feel are being implemented in their early intervention programs?
- 5) What are participants' perceptions regarding the resources available to help early interventionists provide services in culturally sensitive ways?
- 6) What are participants' perceptions regarding the barriers associated with cultural diversity and early intervention?

- 7) Ideally, what supports and resources would participants like to see in place to assist culturally diverse families?

Definitions

Early Intervention:

multidisciplinary services provided for children from birth to 5 years of age to promote child health and well-being, enhance emerging competencies, minimize developmental delays, remediate existing or emerging disabilities, prevent functional deterioration, and promote adaptive parenting and overall family functioning. These goals are accomplished by providing individualized developmental, educational, and therapeutic services for children in conjunction with mutually planned support for their families (Shonkoff & Meisels, 2000, pp. xvii-xviii)

Early interventionist:

Trained to work with young children in partnership with their parents, and a variety of community-based professionals. Under this partnership, an early interventionist prepares a developmental assessment and helps to design and implement a program to address the child's individual developmental needs. The early interventionist is knowledgeable in typical and atypical infant/early childhood development, the importance of play, family systems theory, and community based resources and programming (Nova Scotia Department of Community Services, 2004, p. 1)

Family:

a group of people, related by blood or circumstance, who rely upon one another for security, sustenance, support, socialization, and stimulation (Gargiulo & Kilgo, 2005, p. 60)

Cultural Sensitivity:

refer[s] to the ability of service providers to respond optimally to all children and families, understanding both the richness and limitations of the sociocultural contexts in which children and families, as well as practitioners themselves, may be operating (Barrerra & Kramer, 1997, p. 217)

Chapter 2

Literature Review

Early childhood intervention programs assist families of children with developmental delays to access the services and supports necessary for them to reach their unique goals. The many existing definitions of early intervention differ with respect to the emphasis they place on various components, such as family involvement and eligibility. For example, Hanson (1992) defines early intervention as “the imposition or availability of a set of services provided in the early years of a child’s life. The goal of intervention is change and the assumption is made that change is both possible and valued” (p. 9). This definition neglects to explain the services provided, professionals involved, who is eligible, or to mention the family’s role.

Other definitions mention the family; however, they do not discuss the nature of their involvement, which ideally should be collaborative. For example, the definition put forth by Nova Scotia’s Department of Community Services (2004) states that early intervention is:

the provision of specialized services to families with children between birth and school age (5years) [*sic*] who are either at risk for or have a diagnosis of developmental delay. Services emphasize the continued development of functional skills through planned interaction to minimize the effects of the child’s condition. (p. 1)

This definition is an improvement on the first in that it is more detailed. The goals of intervention and the children involved are more clearly explained, which together convey a child-centred representation of what early intervention is about.

This description, however, gives the impression that services for children with special needs are imposed on families. No mention is made of services for families or of the partnership that should exist between professionals and families of children with special needs.

Shonkoff and Meisels' (2000) definition is significantly more complete. They define early intervention as consisting of:

multidisciplinary services provided for children from birth to 5 years of age to promote child health and well-being, enhance emerging competencies, minimize developmental delays, remediate existing or emerging disabilities, prevent functional deterioration, and promote adaptive parenting and overall family functioning. These goals are accomplished by providing individualized developmental, educational, and therapeutic services for children in conjunction with mutually planned support for their families. (pp. xvii-xviii)

This definition effectively portrays the comprehensive nature of early intervention as it not only references the multitude of available services and the overarching goals, but also discusses how these will be achieved and places sufficient emphasis on the importance of family-professional collaboration (Wehman, 1998).

Theoretical Foundations

Various theoretical perspectives of the 20th century have greatly influenced the depth of professionals' understanding of child development and have contributed to current practices in early intervention (Odom & Wolery, 2003). Behaviourists such as John Watson and Burrhus Frederic Skinner focused on environmental factors to explain how children's behaviours are established and maintained (Meisels & Shonkoff, 2000;

Wolery, 2000). Responses were viewed solely in terms of the events that surrounded them, and interventionists strived to replace children's maladaptive behaviours with ones that were more functional and appropriate. Successful behaviour replacement served as evidence that learning had occurred. Early interventionists still utilize behaviourist techniques in intervention development and assessment, signifying the present-day relevance of the contributions of these theorists (Strain et al., 1992).

Albert Bandura's cognitive-behavioural perspective acknowledged both environmental and social factors as influencing behaviour. This theory emphasized the importance of models in children's learning. He believed that segregating children with disabilities deprived them from typically developing peer models and therefore impaired their social development (Deiner, 2005). This perspective contributed greatly to the acceptance of inclusion as a beneficial approach to educating children with disabilities.

The developmental theories of Jean Piaget and Lev Vygotsky highlighted children's learning processes. Piaget proposed that children progressed in a linear fashion through discrete cognitive stages, and as such were unable to grasp concepts that were outside of their current level of understanding. Vygotsky suggested that learning took place when, with assistance, children could complete a task that was slightly above their current ability level. Vygotsky believed that segregation impeded the cognitive development of children with special needs by limiting their social environments, experiences and interactions, and was thus also a supporter of inclusion (Gargiulo & Kilgo, 2005). These theories have contributed to current practice as the importance of providing children with learning opportunities in natural environments that are new and challenging, yet achievable, are well understood (Deiner, 2005).

Other theorists, such as John Bowlby, Urie Bronfenbrenner, and Ann and H. Rutherford Turnbull have deepened our understanding of the nature of children's relationships with their surroundings. Bowlby's (1969) attachment theory has facilitated professionals' understanding of the implications of early relationships. The importance of encouraging the early development of healthy relationships between child and caregiver is now clearly understood and accepted by interventionists (Emde & Robinson, 2000; Mackenzie-Keating & Kysela, 1997).

Likewise, Bronfenbrenner's (1979) ecological theory demonstrated the interconnectedness between a child and the larger social system of which he or she is apart. He proposed that four social systems (microsystem, mesosystem, exosystem, and macrosystem) interacted to positively or negatively affect a family. The microsystem consists of a child's immediate environments, for example, the home and child-care centre. The mesosystem is made up of the interactions that occur between various microsystems, such as between mother and professional. The settings that directly influence the child's development, such as a community group, comprise the exosystem. Finally, the macrosystem represents ideological and institutional beliefs held in society, such as attitudes toward children with special needs (Blasco, 2001; Gargiulo & Kilgo, 2005). Bronfenbrenner believed that professionals' understanding of *how* these systems interacted was crucial to their viewing children as "situated within a family rather than as isolated experimental subjects" (Meisels & Shonkoff, 2000, p. 12).

Turnbull and Turnbull (1990) proposed the family systems theory, which also views the family as an interactional system. This model consists of the following components: family characteristics, family interactions, family functions, and the family

life cycle. Family characteristics include descriptives of the family, such as their cultural background, health status, financial situation, and ages. Daily relations that occur between family members, such as between mother and child, mother and father, siblings, or with those outside of the family, compose family interactions. Family functions are those activities done to meet family needs, such as to fulfill emotional and physical requirements. The changes that families encounter, such as having a family member diagnosed with a disability, comprise the family life cycle. The interacting components of this model clearly demonstrate how the occurrence of such a significant event would affect each element and member (Hornby, 1991; Turnbull & Turnbull, 1990). “A family systems philosophy suggests that an understanding of [the four components] can serve as the basis of meaningfully individualizing parent-professional relationships for the benefit of all concerned – the child, parents, other family members, and professionals” (Turnbull & Turnbull, 1990, p. 19).

The latter two theories are especially significant to the contemporary approach to early intervention. They contributed to professionals’ appreciation of the inseparability of child and family, and their understanding of the importance of including family in the intervention process.

Historical Evolution

As well as mentioning the theoretical contributions to early intervention, it is also important to examine the important historical events that have helped to pave the way for early intervention’s emergence as a recognized discipline. The relationships between parents of children with special needs and the professionals with whom they work have undergone significant changes over the past half-century. It should be noted that Canada

lacks a uniform national policy regarding early intervention services for young children with, or at-risk for, developmental delays. We have to a large extent followed the lead of our southern neighbour, and as such, pioneering American legislation will be discussed.

During the first half of the 20th century, parents of children with disabilities were advised to isolate and institutionalize their children. In addition, parents were often regarded as the source of their children's problems (Odom & Wolery, 2003; Turnbull & Turnbull, 1990). As parents began to organize locally in the 1930s and nationally in the 40s and 50s, awareness of the needs of children with disabilities increased (Turnbull & Turnbull, 1990). Society members' subsequent sense of obligation to provide services for these individuals grew, and services became available. In the 1950s and early 60s, services were *professionally-centred* in nature; early interventionists were the "knowledgeable experts" and dominated interactions by determining priorities and goals without family input (Dunst, Johanson, Trivette, & Hamby, 1991; Turnbull & Turnbull, 1990). It was believed that maternal incompetence often caused children's disabilities and professionals, therefore, saw their expert contributions as necessary. Turnbull, Turbiville, and Turnbull (2000) characterize these as "power-over relationships," as professionals held ultimate decision-making power over parents.

The 1960s ushered in a time of civil rights reform. In 1965, the Elementary and Secondary Education Act Amendments (P.L. 89-313) passed in the United States. This legislation is significant as it was the first federal grant program specifically for children with disabilities. It mandated that states could use federal funds for the education of children with disabilities aged birth to five years (Bowe, 2007). Project Head Start, a compensatory education program for young children from disadvantaged communities in

the United States, also began in 1965. Although not originally intended for young children with special needs, later legislation mandated that programs set aside 10% of their enrollment specifically for these children (Howard, Williams, & Lepper, 2005). This program was unique in that parent participation was required, an extremely innovative practice for the time. Parents were involved in decision-making, volunteering, and activity planning (Gargiulo & Kilgo, 2005).

The end of this decade brought changes in professionals' views regarding the role of families in caring for and educating their children with special needs. Parents were now viewed as an integral component of a child's intervention program. In the *family-allied* approaches of this era, professionals taught parents, or more specifically mothers, to implement interventions for children in their homes (Dunst, Johanson, Trivette, & Hamby, 1991; Turnbull & Turnbull, 1990). Like the *professionally-centred* methods of earlier decades, these approaches are also characterized as "power-over." Professionals demonstrated their beliefs in the parent-deficit model by telling parents what was best for their children, ignoring family input, and by assuming that intervention was a family's first and only priority (Blasco, 2001; Turnbull, Turbiville, & Turnbull, 2000).

The 1970s were characterized by "normalization," the belief that individuals with disabilities should take part in the same activities as those without (Howard, Williams, & Lepper, 2005). The passing of the Education for All Handicapped Children Act (P.L. 94-142) in the United States in 1975 was a symbol of the normalization movement. This act mandated a free and appropriate public education for all children with special needs and gave parents the right to participate in the development of their child's Individualized Education Plan (IEP) (United States Office of Special Education Programs, n.d.;

Wehman, 1998). Although children younger than five years were not covered under this act, it signified a change in attitude and an increase in parental involvement. Legislation covering children with special needs younger than five would not come for more than a decade.

In 1986, the vital role of the family in raising a young child with special needs was finally acknowledged with the passing of the Education of the Handicapped Act Amendments (P.L. 99-457). Title I provisions under Part H (now known as Part C) of this act referred to children with disabilities aged birth to two years, and mandated the use of the Individualized Family Service Plan (IFSP). The IFSP must contain the child's present level of functioning, the type of service coordination desired by the family, the family's needs, resources, goals, and concerns, and a plan for future transitions (Bowe, 2007). Title II (Part B), required that all children aged three to five years with special needs receive a free and appropriate public education in the least restrictive environment (LRE) (Gargiulo & Kilgo, 2005). Parental involvement in their child's intervention was now formalized. This law represented a shift in federal policy focus from the child to the family unit (Taylor & Baglin, 2000).

In 1990, the Education of the Handicapped Act Amendments was renamed the Individuals with Disabilities Education Act (IDEA) (P.L. 101-476). Part H was now known as Part C, and the language used in the law was changed to be person-first; "the term *handicapped children* was replaced by *children with disabilities*" (Bowe, 2007, p. 112). This reflected a more sensitive outlook toward these individuals.

As a result of these groundbreaking acts, early interventionists were progressively adopting *family-focused* approaches. Professionals and families now worked as teams

and collaborated to identify family outcomes; however, families were still thought to need expert advice. Presently, relationships between families and interventionists are *family-centred* (Dunst, Johanson, Trivette, & Hamby, 1991). The two groups share power in these “power-with partnerships,” and professionals acknowledge the important place families hold in their children’s lives (Turnbull, Turbiville, & Turnbull, 2000).

Both empirical research and theoretical proposals have greatly contributed to the power shift that has taken place in parent-professional relationships over the past 50 years. Interventionists now have a greater understanding of the child’s place within a family and the effect of a child’s disability on the family, and are better able to meet families’ needs as a result (Mahoney & Bella, 1998; Wehman, 1998).

The level of parental involvement in Head Start programs, as previously discussed, was ahead of its time. Results of recent research studies have demonstrated the positive intervention effects that were realized as a result of these practices, indicating the merit of meaningfully involving parents in children’s intervention programs, and encouraging professionals to follow suit (Gargiulo & Kilgo, 2005; Mahoney & Bella, 1998). Ecological theory and family systems theory also contributed to the emergence of family-centred practice. Both acknowledged the inextricable link between a child and family, and emphasized that to achieve intervention success, family involvement was necessary. It is important for interventionists to consider these theories, and to acknowledge the research that shows family involvement to be a crucial component of intervention success. It is because of these realizations that the family-centred approach dominates current service provision models.

Family-Centred Practice

Family-centred professionals recognize the importance of family and emphasize family strengths. Professionals acknowledge that as one's family is present throughout life, members hold valuable expertise regarding a child's strengths and needs, which can then be shared with interventionists (Beckman, 2002). Parents can also provide examples of the kinds of situations through which their child best learns, which is very useful for intervention planning (Bruder, 2000; Keilty & Galvin, 2006). As a result of what we know regarding the interconnectedness of the family system (e.g. ecological theory and family systems theory), family-centred interventions address the entire unit, and are considered to be a most effective approach (Dishion & Stormshak, 2007). It is for these reasons that in theory, professionals have conceded ultimate decision-making power to families in choosing the nature and types of services with which they will be involved (Beckman, 2002). Trivette and Dunst's (2005) definition clearly portrays the family-centred ideology:

A philosophy or way of thinking that leads to a set of practices in which families or parents are considered central and the most important decision maker in a child's life. More specifically it recognizes that the family is the constant in a child's life and that service systems and personnel must support, respect, encourage, and enhance the strengths and competence of the family. (p. 119)

The family-centred approach is referred to as an "assets-based model" in which professionals and families work together to determine and build on the family's unique strengths. This is in stark contrast to a deficits-based model, which emphasizes the family's needs and limitations (Raver, 2005). Dunst and Trivette (1996) refer to the

belief that building on strengths as opposed to fixing weaknesses leads to increased competence as *empowerment ideology*. They state that as people become empowered, they are more likely to seek other competency-enhancing opportunities and to experience positive outcomes, thereby improving their own and others' perceptions of themselves (Bailey et al., 2006; Dunst & Trivette, 1996). The ultimate goals of the family-centred philosophy include providing families with the necessary tools to enhance their child's development, to increase their confidence and independence, and to minimize family stress (Raver, 2005; Trivette & Dunst, 2005).

Professionals achieve these goals by providing supports and resources, both formal and informal, to children and families in flexible and individualized ways (Trivette & Dunst, 2005). Formal supports and resources are professional services, such as speech-therapy and counseling. Those that fall within the informal category are not professionally related; examples include contact with other families, information about community programs, and emotional support. Social support also serves as an extremely important informal support for families of children with special needs (Raver, 2005; Turnbull et al., 2007).

A crucial element in promoting successful professional-family partnerships is the use of respectful and positive communications. Professionals should involve all family members in planning, and honor and respect their decisions (Turnbull et al., 2007). According to Dunst and Trivette (1996), effective family-centred professionals demonstrate both *relational* and *participatory* aspects in their communications with families. *Relational* communications are those that express empathy, compassion, warmth, and care, and that suggest confidence in a family's capabilities. Professionals

who include families in all aspects of the intervention process use *participatory* communication.

The Division of Early Childhood (DEC) has recommended seventeen family-based practices that fall within four categories: shared responsibility and collaboration; strengthened family functioning; individualized and flexible practices; and strengths- and assets-based practices (Trivette & Dunst, 2005). Practices that fall within the first category are those that encourage both parties to share relevant information, so mutually agreed upon decisions may be reached, and goals can be set. Strengthened family functioning refers to the practices, supports, and resources (formal and informal) that increase parental confidence and competence, and that improve overall family functioning. Professionals who use individualized and flexible practices ensure that interventions are developed based on a family and child's unique strengths and needs, and are sure to take family priorities into consideration. Finally, the use of a strengths- and assets-based model, as previously discussed, involves not only the identification of strengths, but also the incorporation of them into plans, so that interventions are realistic given a family's circumstances.

McWilliam, Tocci, and Harbin (1998) discuss family-centred practices as identified by both professionals and parents. Family-centred professionals are family-oriented. These individuals regarded the family's well-being to be as important as the child's developmental progress. They were also positive, and exhibited nonjudgmental, optimistic and enthusiastic attitudes. Sensitivity was also seen as a desirable trait. Sensitive professionals put themselves in parents' shoes, and made concerted efforts to understand why families made the decisions they did. Family-centred professionals were

also responsive and friendly. They utilized individualized and flexible approaches, and their relationships with parents were reciprocal and honest. The final two characteristics related to their knowledge. Family-centred professionals were educated about child development and disabilities, and were aware of the community and cultural climate in which they worked. They also tried to collaborate with other professionals and agencies so that they could provide families with accurate information regarding available resources in the area.

Shortcomings in Family-Centred Practice

Although professionals strive to involve and empower families, they are presently falling short of fully achieving this goal. It appears that a gap exists between research and actual practice. One problem is that professionals seem to demonstrate a conceptual understanding of the family-centred philosophy, but struggle with its implementation. Turnbull et al. (2007) state that professionals understand the how, but not the what of early intervention. They know that in theory they should collaborate with all family members and work from a strengths-perspective to enhance family functioning; yet, are unsure of what specific supports and services increase the likelihood of achieving this goal. Turnbull et al. found that recommendations from national organizations and consortia placed greater emphasis on the how, and provided no suggestions as to what strategies could be used to achieve desired family outcomes. In their examination of four journals relating to early childhood special education, Taylor and Baglin (2000) also found that little emphasis was placed on specific approaches. Given this lack of guidance, it will be difficult for professionals to alter their current practice to become more family-centred.

Research has also demonstrated that programs for young children with special needs may be more child-centred and family-allied than family-centred. Turnbull et al. (2007) examined empirical data from the implementation of the Individuals with Disabilities Education Act (IDEA) focusing on family-related supports and services, the National Early Intervention Longitudinal Study (NEILS) on parent opinions of child- and family-related supports and services, and research on family satisfaction with services in one state. They found that over the past six years services have become increasingly child-centred, indicating a reverse in family-professional relationship trends. They also noted that federal statutes place more significance on the individual with a disability, as opposed to on the family unit. Other research has corroborated these results (Mahoney & Bella, 1998; Melanson, 2007). Mahoney and Bella (1998) found that parents perceived professional services to be related more to child development than to family concerns. Of crucial importance in this study, is the finding that developmental gains made by children during intervention occurred at the same rate as they did prior to its initiation. Also of interest, is that these interventions did not result in reduced maternal stress, enhanced family functioning, or improved mother-child interactions, all of which are desirable outcomes associated with intervention. The results demonstrate that approaches that do not effectively involve the family are narrow in their perspective and have limited impact.

Research also indicates that professionals are not effectively implementing the recommended family-based practices that lead to positive results for children and families. These include collaborating with parents, giving parents ultimate decision-making power, and operating in individualized and flexible ways (McWilliam, Snyder,

Harbin, Porter, & Munn, 2000; Trivette & Dunst, 2005). Despite the evidence that identifies collaboration as an important component in promoting positive family-professional relationships, few professionals have a collaborative relationship with families. For example, of the 93 articles examined by Taylor and Baglin (2000), only three addressed collaboration. Likewise, Wehman and Gilkerson (1999) found that families perceived this lack of collaboration to be a relative weakness in their early intervention experiences as well. They wanted to be involved in their child's services and included in discussions regarding their child's needs.

A key belief of the family-centred philosophy is that parents are the constant in their child's life, and therefore should hold ultimate decision-making power when working with professionals to determine the nature of their child's service plan (Beckman, 2002). Results from research studies indicate, however, that this philosophy is rarely practiced. McBride, Brotherson, Janning, Whiddon, and Demmitt (1993) observed that the majority of parents in their study acted as informants and observers, and simply approved or disagreed with options chosen by professionals; they had no input in determining the services that would most effectively meet their needs. This is reminiscent of the professional-as-expert approach. Surprisingly, families were satisfied with this role, as they felt that they had much to learn from professionals. They also reported experiencing positive outcomes, such as increased confidence and improved family functioning. This approach is more family-allied than family-centred, and is not uncommon according to the research. In Dunst's (2002) examination of relevant literature, he found that although early intervention programs espoused family-centred philosophies, they were more family-focused and family-allied in practice. Despite the

fact that beneficial results have been associated with family-focused approaches, this model does not acknowledge the important place of the family, or utilize the wealth of knowledge they have about their child.

As all children with disabilities and their families are unique, early interventionists are encouraged to utilize individual and flexible approaches (Trivette & Dunst, 2005). Results from Wehman and Gilkerson's (1999) study indicated that this may not be happening. Parents perceived inflexible scheduling to be the number one barrier to achieving desired levels of family-centred program practices. Parents who were employed found it very difficult to attend week-day appointments, or to reschedule as professionals did not work on weekends or in the evenings. The term "family-centred" implies that the family's needs are put first. It is therefore important for professionals to be able to adjust their practices to fit with family schedules and priorities.

Despite the results noted above, families are more inclined to rate intervention services as family-centred than professionals (Jeffers, 1996; McWilliam et al., 2000). An explanation for this finding could be that because parents are so grateful to be receiving services and lack a true understanding of what family-centred service provision entails, they refrain from questioning practices, and remain unaware that they can take a more active role in their child's intervention. Interventionists must explain to families what exactly is involved in family-centred practice, what their rights are, and encourage their involvement (Melanson, 2007; McBride et al., 1993). It may also be useful for professionals to establish parent-to-parent contacts (Shannon, 2004). Experienced parents can share their knowledge of the services they found to be most useful with those

unfamiliar to early intervention. This will help new families navigate the service system and establish social support networks.

The present disconnect between family-centred theory and family-centred practice must be addressed. Training is needed so professionals can develop a comfort level with this approach. Changes in early intervention have occurred at a relatively rapid rate. There is a need for professional development seminars to ensure early interventionists have the skills and knowledge required to fully embrace family-centred practices. This will ensure that family involvement is maximized and their needs are successfully met.

Cultural Sensitivity

Another central component of family-centred practice that has not yet been discussed is *cultural sensitivity*. Current knowledge regarding the inseparability of individual and environment points to the importance of acknowledging cultural influences when working with families in early intervention settings. Culture impacts individuals' views and attitudes toward disability, help-seeking and childrearing behaviours, and communication style, all of which have significant implications for family-professional partnerships (García Coll & Magnuson, 2000; Harry, 1992; Turnbull & Turnbull, 1990). Culturally sensitive practices are an important aspect of provision of family-centred services, and as such, interventionists must become competent in their use.

According to Barrerra and Kramer (1997), cultural sensitivity “refer[s] to the ability of service providers to respond optimally to all children and families, understanding both the richness and limitations of the sociocultural contexts in which children and families, as well as practitioners themselves, may be operating” (p. 217).

There are a number of points that support professionals' use of the aforementioned practices, including changing demographics, family-centred legislation, and empirical evidence. North America's changing demographics is cited in much of the relevant literature as a rationale for cultural sensitivity (Barnwell & Day, 1996; Chan, 1990; Harry, 1992). As population characteristics change, it is inevitable that interventionists will increasingly encounter families who have values, beliefs, and practices that differ from their own, and will face challenges in learning how to be family-centred within these new contexts. Professionals therefore require relevant knowledge and skills in order to effectively communicate with culturally diverse families, and to appropriately address and incorporate cultural influences into families' service plans.

Legislation also encourages the use of culturally sensitive practices. Passage of the Education of the Handicapped Act Amendments of 1986 (P.L. 99-457) acknowledged that child and family were inextricably connected, and required practitioners to honour and include family needs, resources, and concerns in their Individualized Family Service Plans (IFSP) (Bowe, 2007). According to Hanson (1992), to do so effectively, professionals must be aware of a "family's cultural, ethnic, and linguistic heritage" (p. 9). The Division of Early Childhood (DEC) also recommends including cultural considerations within family-based practice. They suggest using individualized and flexible practices and working collaboratively with all families (Trivette & Dunst, 2005). Family-centred professionals must respect and be "responsive to the cultural, ethnic, racial, language, and socioeconomic characteristics and preferences of families . . . and incorporate family beliefs and values into decisions, intervention plans, and resources and support mobilization" (Trivette & Dunst, 2005, p. 117). The inclusion of culturally

sensitive elements into laws and recommended practices helps professionals to understand all aspects involved in family-centred practice.

The rationale for using family-centred practices is that they serve to optimize intervention results for children with disabilities and their families. The justification for being culturally sensitive is the same. When parents' and professionals' ideas of what is best differ due to cultural beliefs, this represents a source of risk for the child, as it is unlikely that the family's needs will be appropriately addressed (García Coll & Magnuson, 2000). When professionals interact with families in culturally sensitive ways, the relationship is more likely to be open, honest, and reciprocal (Bowe, 2007; Roberts, Rule, & Innocenti, 1998).

Although few empirical studies examining professionals' use of culturally sensitive practices exist, those that do demonstrate positive results. Chan (1990) discusses projects aimed at empowering Asian, African-American, and Latino parents of children with disabilities, and at facilitating their participation in meetings with professionals. The projects extensively incorporated parents' native languages in sessions and handouts, and almost all staff members were bilingual. Over the sessions, Chan observed an increase in parental participation, and found that parents became more involved in their children's interventions. Parents also experienced improvements in personal coping, and in parenting and advocacy skills.

Bruder, Anderson, Schutz, and Caldera (1991) discuss their culturally sensitive model of home-based early intervention intended for Puerto Rican families in Connecticut. Their model consists of five components. The first, *family orientation*, ensured family involvement in IFSP development, and the inclusion of family-specific

goals. *Cultural sensitivity*, the second component, involved incorporating cultural roles and norms specific to Puerto Rican families into the service plan. For example, spiritualists and folk healers were often included, and services and handouts were provided in families' preferred languages. The third element, *transdisciplinary team process*, involved collaborating with a variety of professionals. *Interagency coordination* occurred as the bilingual interventionist acted as a service manager, thus allowing the family to communicate with and understand the other professionals' perspectives. The final component, *transition*, referred to the development of a systematic transition plan to be included within the family's IFSP. After one year of program involvement, families demonstrated a significantly lower number of identified needs. Their IFSPs also differed after one year in that they held fewer support and informational goals, and more child intervention goals, indicating that their former needs had successfully been met. Bruder et al. and Chan demonstrate that professionals can effectively involve families of culturally diverse backgrounds in early intervention, resulting in improvements for the entire family.

The general principles of cultural sensitivity include recognizing and respecting families as distinct, and avoiding assuming what a family's values, beliefs, and behaviours may be based on cultural affiliations (Bowe, 2007). Chan (1990) proposed that professionals develop self-awareness, seek information specific to each culture, and gain the skills necessary for engaging in successful interactions. Lynch (1992b) also discusses these elements, as she considers them to be crucial in developing cultural sensitivity, or "cross-cultural competence" as she refers to it.

First, like many researchers (Blasco, 2001; Bowe, 2007; Gargiulo & Kilgo, 2005), Lynch (1992b) discusses self-awareness. This concept suggests that in order to understand another's culture, one must first understand his or her own, and learn to separate one from the other. This is the only way to grasp its influence on all aspects of life, and to understand that what is assumed to be universal by one group may be perceived as uncommon or unusual by another (Lynch, 1992b). We must also acknowledge our tendency to view others' practices as superstitious, and recognize that our values, beliefs, and behaviours represent only one perspective (Lynch, 1992a; Turnbull & Turnbull, 1990).

Lynch (1992b) next suggests that professionals gain culture-specific knowledge, and provides methods to assist in doing so. She states that individuals can learn about cultures different from their own by reading about them, interacting with diverse people, and by becoming involved through participating in daily activities and learning new languages. This knowledge will help professionals to understand the behaviours encountered in cross-cultural interactions, and will enable them to respond appropriately and sensitively.

Finally, one must have the skills necessary for professionals and families from different cultural backgrounds to successfully interact. This involves both verbal and nonverbal aspects of communication. Individual cultures place varying emphases on these two forms of communication, and it is therefore important for early interventionists to be aware of and observe how each is used in a family's communications, so they may match their own style of interaction to this (Lynch, 1992b).

Lynch (1992b) also discusses desirable characteristics for culturally sensitive individuals to possess. They must have a respect for individuals from other cultures, should continually and sincerely attempt to understand others' points of view, must be open to learning, and have a sense of humour. Culturally sensitive individuals should also be flexible and tolerant of ambiguity, and approach others with a genuine desire to learn. These practices and attributes are valuable for any professional to possess, especially for those who work with families of children with special needs. The more accurately professionals can understand family needs, the better they will address them. The implications of culturally sensitive behaviour extend far beyond simply developing successful communications, to ultimately strengthening family competence and improving child-related outcomes.

Despite the availability of literature that discusses important elements of cultural sensitivity, and the steps that one can take to act in this manner, empirical evidence demonstrates that we have not yet fully achieved this goal, and that professionals have difficulty with the practical aspects of this concept. The National Early Intervention Longitudinal Study (NEILS) followed over 3,000 children and their families in the United States through their early intervention experiences, and paints a clear picture of these issues (Scarborough et al., 2004; United States Office of Special Education Programs, 2003). It was found that race was significantly related to families' reports of less positive outcomes. Families of African-American children were 2.13 times as likely to report less positive experiences as families of white children, and families of children from all other ethnic groups combined were 2.11 times as likely to be in the less positive group (Bailey, Scarborough, Hebbeler, Spiker, & Mallik, 2004). As these findings

indicate, for the most part, professionals are not using culturally sensitive practices, and as a result, the needs of diverse families are not being effectively met. Research is needed to examine the extent to which families are receiving culturally sensitive services, and to discover how and where much-needed changes can occur.

Cultural Diversity in Nova Scotia and Early Intervention

Specific figures regarding the number of culturally diverse children and families receiving intervention in Nova Scotia are unavailable (Hanvey, 2002). However, data indicates that Nova Scotia has the highest percentage of individuals with disabilities in Canada, at 20% of its population. It is also known that as of 2001, over 13% of children between the ages of birth and four years in this province have disabilities (Disabled Persons Commission, 2004; Human Resources and Social Development Canada, 2008). In terms of the cultural diversity, only 5% of the population of Nova Scotia are immigrants and just over 7% speak a language other than English, although over 50% identify with an ethnic origin other than Canadian (Statistics Canada, 2001; 2006a; 2006b). These numbers indicate that a wide variety of families are likely involved with the province's early intervention programs. As such, practitioners need the requisite skills to be able to respectfully and successfully interact with families with diverse backgrounds.

The Early Childhood Interventionists Association of Nova Scotia (ECIANS) (n.d.) is an organization that extends its support to current and former early interventionists by promoting professionalism, and by mentoring, supporting, and advocating on their behalf. Specific statements in their code of ethics identify the importance of acknowledging and respecting children and families' cultural diversity.

For example, family-centred practice is emphasized and related to “respect for diversity including, but not restricted to, culture, race, religion, social factors, and ability/disability” (ECIANS, n.d., Code of Ethics section, ¶ 1). They also pledge to “respect the uniqueness of each family, acknowledging different family compositions, and the significance of culture, customs, language, beliefs and the community context in which it resides” (ECIANS, n.d., Code of Ethics section, ¶ 6). This demonstrates that, at least in theory, early interventionists in Nova Scotia commit to viewing families’ differences as unique strengths.

Very few studies have examined early intervention in Nova Scotia, and those that have largely ignored the importance of cultural components. Although a theoretical commitment to cultural sensitivity may be present (as demonstrated above), research conducted by Melanson (2007) indicates that in reality little attention is being paid to its significance. Her research examined the intervention experiences and perceptions of Nova Scotian families and professionals. She assessed the extent to which services were provided in family-centred ways, family involvement and satisfaction with the IFSP process, and the degree to which families’ quality of life issues were considered. Culture was referred to only once throughout participant interviews. A professional participant when discussing the family-centredness of programs, suggested that a respect for families’ cultures was an important aspect of family-centred care; no families made reference to this. Although this study did not specifically examine cultural sensitivity as exhibited by professionals in Nova Scotia, it is interesting that reference to this concept was made on only one occasion, as it is such a critical component of family-centred care. It is possible, however, that this may be a result of the environment in which the research

took place, as it was conducted in three rural areas in the province. Perhaps a greater degree of cultural diversity exists in cities, causing early interventionists in urban programs to place greater importance on its place within family-centred care.

As so little is currently known, there is an immense need for further research to determine not only the demographics associated with this province's early intervention population, but also the perceptions held by early intervention practitioners. Such information should provide insight into professionals' perceptions of current beliefs and practices when working with culturally diverse families. An open dialogue can then occur with participants discussing areas of agreement and issues of concern.

Chapter 3

Method

Framework

The bulk of this project fits within a qualitative approach to research in which investigators seek to understand how and why participants have come to hold certain perspectives. According to Bogdan and Biklen (1992), qualitative research “demands that the world be approached with the assumption that nothing is trivial, that everything has the potential of being a clue that might unlock a more comprehensive understanding of what is being studied” (pp. 30-31). As such, researchers may engage in prolonged contact with participants in order to gain a true understanding of the nature of their subjective worlds.

According to Langenbach, Vaughn, and Aagaard (1994), qualitative research originates from the phenomenological perspective. This model suggests that one’s experience of reality is socially constructed. It is therefore likely that two individuals will have differing interpretations of the same phenomenon. Investigators seek to answer their research questions by communicating with different individuals involved in the relevant context. By familiarizing oneself with the varying perspectives held by those involved, it is possible to gain a better understanding of how participants “interpret some piece of the world” (Bogdan & Biklen, 1992, p. 96).

The constructivist perspective is an approach that has evolved from the phenomenological approach, and was utilized in this study. The investigator attempted to discover early interventionists’ unique perspectives regarding cultural sensitivity in early intervention by conducting open-ended, semi-structured interviews, a technique

frequently used in qualitative research designs (Tesch, 1994). The goal was not to find one universal answer set, as it may be in studies that subscribe to the quantitative method, but instead to capture and compare participants' different interpretations (Patton, 2002). This type of interview is most appropriate for this design as it encourages an open conversation between researcher and participant in which participants can freely discuss their views. This style of interaction allows the investigator to gain deeper insight into the phenomena in question as a result (Bogdan & Biklen, 1992). The goal of this research is to construct from participants' statements an interpretation of culturally sensitive practice that is more "informed and sophisticated than any of the predecessor constructions" (Guba & Lincoln, 1994, p. 111).

Another goal of this research was to determine the degree of cultural diversity associated with early intervention programs across the province. The nature of this inquiry better lent itself to a quantitative approach, and as such, surveys were sent to programs around the province. This served to supplement and contextualize the data obtained from interviews. According to Grant and Fine (1992), this is appropriate within the larger qualitative domain, as employing survey measures may serve to provoke "unanticipated but valuable insights" (p. 419). This also served to deepen the understandings gained from interviews, and allowed the investigator to observe how the issue of cultural diversity and early intervention existed on a larger scale.

Participants

This study had two participant groups. The first consisted of 11 Executive Directors of early intervention programs in Nova Scotia, who completed a short survey. The second group consisted of ten early interventionists who were involved with one of

two urban early intervention programs in Nova Scotia at the time of the study. It was also intended that culturally diverse families involved with early intervention in Nova Scotia would participate; however, as only one family made contact with their early intervention program to indicate that they would like to participate, this aspect of the study was dropped.

Measures

Cultural Diversity in Early Intervention Survey

Three measures were utilized in this study. A survey was sent to the Executive Directors of 16 out of the 18 early intervention programs in Nova Scotia. The survey was short and aimed to gain information on the culturally diverse backgrounds of the families currently involved with early intervention programs in Nova Scotia (Appendix A). Directors were asked to provide brief responses to questions concerning the number of culturally diverse families that attend their centres, and to discuss challenges associated with this. The purpose of this survey was to help the researcher gain an understanding of the extent to which culturally diverse families of children with special needs are accessing the province's early intervention services.

Demographic Questionnaire

The second measure was a short demographic questionnaire that was completed by all early interventionists who were later interviewed. Each participant answered questions relating to gender, age, ethnicity, and level of education (Appendix B). Professionals were also asked about their education and the number of years they had been involved with early intervention. This information was used to contextualize the interview data.

Interview Schedule

Interview questions were prepared based on a review of the relevant literature and discussions with professionals currently working in the field. Open-ended, non-directive questions were utilized, which allowed the researcher to achieve the most important goal of discovering “the interviewee’s own framework of meanings” (Britten, 2006, p. 14). The interview questions encouraged early interventionists to discuss their perceptions regarding their expectations and experiences with early intervention and culturally sensitive practices. Participants were also asked about access to necessary resources, and about barriers associated with cultural diversity and early intervention (Appendix C).

Procedure

Once approval was obtained from the Thesis Committee and the Mount Saint Vincent University Research Ethics Board, the Executive Directors of 18 early intervention programs in the province were contacted via telephone. Contact was established with 16. During these conversations, the purpose of the study was outlined, and Directors’ participation in completing the Cultural Diversity in Early Intervention Survey was requested. Directors were then sent an email containing the survey, and a more detailed explanation of the nature of the research (Appendix D). Contact information of the researcher was also provided in the event that later questions arose. The purpose of the survey was to allow the researcher to assess the degree of cultural diversity associated with early intervention programs in Nova Scotia.

The Executive Directors of two early intervention programs in the Halifax Regional Municipality, and one in Colchester County were then contacted via telephone so permission to conduct the next phase of the study at their centres could be granted.

Contact was established with two programs in the Halifax Regional Municipality. The researcher explained the purposes and goals of the research project, and answered any of Directors' questions. These conversations also allowed the researcher to obtain an estimate of the number of early interventionists and culturally diverse families that the Executive Directors were willing to pass on the research information to. Follow-up letters outlining the research aims, procedures, participant rights, and researcher responsibilities were then sent to the Directors of the participating programs (Appendix E).

The Directors were also provided with packages to distribute to early interventionists and culturally diverse families. Each package contained: 1) a letter explaining the research purposes and the nature of participant involvement (Appendix F); 2) a demographic questionnaire (Appendix B); 3) a consent form (Appendix G); and 4) a stamped and addressed return envelope. The contact information of the researcher was also included, so that those who wished to participate could either return the signed consent form or communicate with the researcher via email or telephone. Directors were asked to distribute these packages to early interventionists within their programs, and to attach address labels to packages that were to be mailed to families. In total, eighteen early interventionist and twenty family packages were distributed between two centres; however, only early interventionists contacted the researcher.

Once early interventionists' consent forms were returned, a mutually agreed upon time and place was established for the interview to take place. At this initial meeting, participants' rights were reviewed, and the researcher explained how all information collected would be reported as group data, and that no identifying information would be

included in the final thesis, or in subsequent talks or publications. They were also informed that if quotes were used, they would be to emphasize important findings, and would be anonymous. Participants were notified that their interviews would be recorded, and of university procedures governing how interview tapes, transcripts, and field notes are to be stored and disposed of. The researcher then explained that participants could withdraw from the study at any time or decline to answer any questions without penalty. If they had not already done so, participants then signed informed consent forms and filled out demographic questionnaires.

The researcher then began the interviews. While the interview was being audio recorded, the researcher attempted to facilitate an open, comfortable and non-judgmental conversation, so as to encourage participants to divulge their true perceptions. The researcher's role was to support and encourage participants in their responses, and to refrain from offering opinions. This was believed to help maintain the trustworthiness of the method, as participants were unaware of any biases held by the researcher (Seidman, 2006). Questions were non-threatening, and began with statements such as "in your opinion" and "can you share with me." The researcher also utilized non-directive prompting such as "tell me more" when participant responses needed further clarification. In the event that a participant became uncomfortable with a question, no direct prompts were used, and the researcher did not push for further elaboration. As Bogdan and Biklen (1992) suggest, the interview was modeled as if it was a conversation, as opposed to a formal question-and-answer session. After the interview questions were completed, participants were encouraged to share any other insights concerning the discussed issues.

Participants were then thanked for their involvement, and informed that after the transcripts were typed, they would have the opportunity to review them if they so wished.

Data Analysis

The survey data were first analyzed using a quantitative approach. For most items, the mean, percentages, and in some cases the range were determined. Items that demanded descriptive responses were compared and contrasted qualitatively, and those cited most frequently were noted. Any findings that were unusual or that went against those supported by the consensus were also illuminated.

Both an a priori framework and a modified grounded theory approach were utilized to analyze the interview data. As questions were developed based on a review of relevant literature, they served as an initial frame for the interviews; however, other important information that arose from questions and discussions was also included. Data was analyzed using a modified grounded theory approach as the identification of themes and codes occurred inductively as they emerged from the data (Weston et al., 2001).

As previously discussed, the interviews were first transcribed verbatim and the opportunity for member checking was presented to participants, both of which serve to ensure the trustworthiness of the method (Mays & Pope, 2006; Weston et al., 2001). Once these processes took place, the transcripts were reviewed so initial codes could be identified. Any words, phrases, or explanations that appeared to be salient were co-coded by both the researcher and her supervisor, as the use of a second rater helps to eliminate bias and adds to the validity of the results. Initial codes were then compared and collapsed, so that second level codes could be developed, and data could be clustered accordingly. Third level codes and overarching themes were then identified, and

categories were formed (Bogdan & Biklen, 1992). This categorization process remained flexible so as to ensure that the important themes could be captured and subsequently communicated. The researcher also took field notes during the interviews, so important observations of participants' body language and use of expressive gestures would be available to provide context to statements.

Ethical Considerations

1) Informed Consent

Participants were required to sign an informed consent form before the interviews commenced (Appendix G). These forms included a description of the study purposes, procedures, and goals, the nature of participant involvement, and the necessary time commitment. Participants were also informed of their rights to decline to answer any questions or to withdraw from the study at any time without penalty. They were also informed that their data would remain confidential, results would be presented in the form of group data only, and no identifying information would accompany quotations. Participants were made aware of university guidelines regarding storage and disposal of tapes, transcripts, and field notes, and were given an opportunity to ask questions of the researcher.

2) Confidentiality

Every effort was made to protect the confidentiality of participants' statements. Although interviews were taped, the researcher did not identify the participants by name on the recordings. Tapes and transcripts were coded using a number system so as to ensure that participant anonymity was maintained. In the event that names, such as of co-workers were mentioned during the interviews, they were omitted from the transcripts,

and therefore from quotations that were used. Participants were also informed during the review of the informed consent form that their data would be presented in group format only, and that quotations would not be accompanied by names. The demographic questionnaires that participants filled out will also remain anonymous, and were used only as a means of placing data within a general context. Individuals' statements were not linked with their own demographic information.

3) Voluntary Participation

Those who wished to participate in this research study did so on a voluntary basis only. The researcher informed participants of their rights to decline to answer any questions that they were uncomfortable with and to leave the study at any time without penalty. Those who participated were not asked directly by the researcher, but were instead recruited through a third party (early intervention program Executive Directors). Those who wished to participate in the research study contacted the researcher via email or telephone. Contact was not established between the researcher and participants through any other means.

4) Issues of Harm

The participants took part in this study on a volunteer basis, and only disclosed the amount of information with which they were comfortable. Although the researcher occasionally implemented the use of non-directive prompts, such as "tell me more" in the case of needed clarification, participants were made aware of their right to decline to answer should they feel uncomfortable. In the event that cases such as this arose, participants would not have been encouraged or pressured to elaborate on their statements. If it became apparent to the researcher that a participant was experiencing

distress due to participation in an interview, he or she would have been offered the contact information of a local support service. The researcher had this information prepared before the interviews took place. As a result, the possibility that participants realized harm due to their participation in this study is likely very low.

Limitations

1. The fact that participants involved with this study came from only two early intervention programs may present a limitation to this study. It is possible that interventionists in another centre may have worked with families who represented a more diverse range of backgrounds, or who represented different cultures. As such, individuals employed in such environments may have presented different perspectives and strategies.
2. As all participants were from a narrow geographical area, the results obtained are unlikely to be generalizable to individuals outside of the area researched. It is important to note however, that generalizability is not a chief concern in qualitative research, and that the findings from this study still hold great value for the field of early intervention.
3. The findings present a uni-dimensional view as only early interventionists were interviewed. Having the perceptions of families would have facilitated a more complete understanding of the issue of cultural sensitivity, and brought forth valuable implications and suggestions for improvements to practice.
4. The use of audiotapes could also represent a limitation, as it is possible that participants were uncomfortable with such methods and altered their statements as a result. It must be noted however, that all participants were informed of this

procedure before their interview commenced, their participation was voluntary, and respondents were free to ask that the recorder be turned off at any time during the interview. As this is the case, it is unlikely that participants' descriptions of their perceptions were significantly altered. Efforts were also made to ensure that participants felt relaxed and comfortable in the interview environment, and the interview was modeled to resemble a conversation. It is expected that after gaining comfort in the situation, participants took little notice of the recording device.

5. A final potential limitation is associated with the nature of conducting face-to-face interviews. A hazard of this approach is the presence of response effects, in which respondents provide answers to interview questions that they believe will please the researcher. The likelihood of this occurring was decreased by the fact that all interview questions were neutrally presented, and by the researcher explaining that the purpose of the study was to learn about their practices, not to assess them. Participants were also offered the opportunity to read their transcripts and make changes if necessary, to ensure that their perceptions were accurately communicated and captured.

Chapter 4

Results

Introduction

This chapter contains a summary of the quantitative and qualitative analyses of the obtained data. The quantitative analysis includes means, percentages, and in some cases, the range. The qualitative analysis was obtained from coding interview transcripts and through identifying emergent themes.

Participants in Cultural Diversity in Early Intervention Survey

Eleven of sixteen early intervention Executive Directors responded to the Cultural Diversity in Early Intervention Survey. The results from this survey are displayed in Table I (see below).

Of the eleven early intervention programs that responded, the mean number of families served by the centres was 54, with a range between 7 and 230 families. Most centres fell within the range of 7 and 60, with the exception of two larger centres that served 130 and 230 families. Eighty-two percent of the centres indicated that they served families with culturally diverse backgrounds. Centres had a mean number of 6 culturally diverse families on their caseloads, with a range between 0 and 27. The majority of centres currently had between 1 and 5 culturally diverse families on their caseloads, with the exception of the two larger centres that had 20 and 27. The most frequently mentioned cultures and ethnicities included First Nations/Aboriginal and African-Canadian. A number of other cultures mentioned included European, Asian, Arabic, East Indian, and Acadian. Sixty-four percent of programs indicated that they were involved with families for whom English was a second language, serving a mean of 4 such

Table I

Summary of Responses to Survey Items

<u>Statement</u>		
Mean number and range of families served by early intervention programs	$\bar{x} = 54.27$	Range = 7 – 230
Percentage of centres with culturally diverse families on early intervention program caseload		81.82%
Mean number and range of culturally diverse families on early intervention program caseload	$\bar{x} = 5.73$	Range = 0 – 27
Percentage of centres with families for whom English was a second language		63.64%
Mean number and range of families for whom English was a second language	$\bar{x} = 3.86$	Range = 1 – 10
Percentage of centres indicating translator services are needed to work with some families		18.18%
Percentage of centres with access to translator services		27.27%
Percentage of centres indicating that culturally diverse families present unique challenges		54.55%
Percentage of centres with families who were recent immigrants to Canada		36.36%
Percentage of centres indicating awareness of supports and services for culturally diverse families		36.36%
Percentage of centres that have accessed supports and services for culturally diverse families		9.10%
Percentage of centres that do outreach for culturally diverse families		9.10%

families, with a range between 1 and 10. The majority of centres served between 1 and 5 families for whom English was a second language, and a larger centre indicated that they served 10. Eighteen percent of centres indicated that translators were needed to work with their families, and twenty-seven percent indicated that they had access to these services. It is important to note however, that only one centre requiring these services actually had access to them. Another centre noted that although they could access them, it was done with difficulty.

Fifty-five percent of centres indicated that having families from culturally diverse backgrounds had presented unique challenges to the early interventionists in their programs. Most frequently noted was the challenge associated with being unaware of families' differences and unique expectations. Language was the next most frequently cited response, with centres indicating that it was difficult when they could not offer services in families' languages of choice. Other Executive Directors noted the challenges associated with different cultures' perspectives on disability, finding support networks for culturally diverse and isolated families, lack of access to culturally-relevant materials and resources, and a fear of inadvertently offending culturally diverse families due to their own lack of knowledge.

Thirty-six percent of centres had families who were recent (less than five years) immigrants to Canada. Thirty-six percent of centres also indicated that they were aware of supports and services for culturally diverse families of children with special needs in their area. Supports and services mentioned included the Metropolitan Immigrant Settlement Association (MISA), culture- or religion-specific services, such as the Islamic Association of Nova Scotia, and various local support agencies. Another centre noted

that although nothing was currently set up in their area, a committee designed to support the county's multicultural community was in development. Nine percent of programs indicated that they had accessed supports or services for culturally diverse families. Nine percent of centres indicated that they did outreach specifically aimed at culturally diverse families of children with special needs. Their efforts included accessing diverse child-care options and accessing MISA. They also mentioned working with doctors and the IWK Health Centre to access translators. Other comments were offered by three early intervention program Executive Directors. One mentioned that although their centre did not have many culturally diverse families, it was still an issue that needed to be considered. Another stated that they had "minimal experience with persons of different cultures but are happy to learn more and be responsive to the unique needs of all families as the opportunities exist [*sic*]." One Executive Director elaborated on the resources for culturally diverse families and children that they had within their centre, including resources and materials in their library in various languages, toys, such as culturally diverse dolls, and books for children that demonstrated a range of ethnicities.

Participants in Interview

Ten participating early interventionists from two urban early intervention programs in Nova Scotia comprised the second group of participants. Of these participants, eight were from the same agency. All were female, ranged in age from 26 to over 45 years, and held university degrees. Six early interventionists had completed their Bachelor's degrees in a variety of areas. Most commonly cited were Psychology and Child Studies, although other areas included Women's Studies, Family Studies, and Anthropology. Three interventionists held Master's degrees, and one was in the process

of completing hers. Their Master's degrees were in the areas of Child and Youth Study, Speech-Language Pathology, and Education. The participants had been employed as early interventionists for an average of 11.6 years, with a range from 2 to 22 years. Five early interventionists specified their ethnicities, with four identifying themselves as Caucasian, and one identifying herself as having a Western European heritage. Ninety percent of participants had recently attended a professional development session, none of which related to cultural diversity or sensitivity. The most commonly cited topics included maintaining morale in the midst of change, teamwork, and family-centred practice.

Responses to Interview Questions

Question 1: How did early interventionists describe their profession?

When early interventionists were asked to describe their profession, two main themes emerged: supporting families and programming for individual needs. When participants spoke about their role in supporting families, they referred to going into families' homes on visits, helping families to adjust to having a child with special needs, navigating the system of services, and defining individual goals. Interventionists also spoke about forming intimate relationships with children and families. One early interventionist described her profession: "there would be a lot of building a relationship with a family in order to go forward to help them define what it is they want to do to promote their child's development."

Programming for individual needs is also a significant element of early intervention. When referring to this aspect of their profession, early interventionists spoke about the importance of considering individual children's unique needs, diagnoses,

and ages in order to match them with appropriate services and resources. They also spoke about the way in which services were delivered, such as through employing specific teaching strategies and modeling.

My role is basically to do home visits, family support with those families, do developmental programming with those children, help the parents to work on activities . . . model activities that they can do at other times with their child.

Also within this theme was interventionists' work with other professionals. Children with special needs are often involved with many professional services, such as speech-language pathology, occupational therapy, physiotherapy, and neurology. As this is the case, interventionists must frequently coordinate, collaborate and network. Their jobs also involve working with other child-care settings, such as preschools.

[W]hat we do is we have a more intimate relationship with a smaller number of kids and families and it allows us to be able to coordinate all of the services that a particular child might be in receipt of or in need of . . . and help families to access resources and consult with child-care settings that the children might be going into or interested in, and around including kids with special needs and communicating with other professionals.

One early interventionist also discussed how she conceptualized her role as that of an educator. She worked with families in order to help lay a positive foundation for their child's development that would continue to assist both the child and family across their lifespan together.

[I]n terms of that caseload, I guess it's the same sort of thing, taking a long view. I know that I'm at the base level, but I'm taking a lifespan view of what this child's lifespan may . . . mean and what this family's lifespan with this child, so I know that I'm . . . building at ground level and the things that I can help them to achieve I guess you might say are the things that they're going to be able to continue building long after I'm out of their lives . . . I take that sort of philosophical view of it . . . I'm there to help them to increase their resiliency, to help them to become more resourceful in order to meet the challenges that they are going to have now and for the lifespan of their family member with special needs.

It is clear from interventionists' statements that they see their jobs as being multidimensional. Professionals acknowledged the multitude of components involved in supporting families, and the importance of tailoring services to meet individuals' needs.

Question 2: How did participants get involved in early intervention?

When interventionists were asked to describe how they got involved with early intervention, their responses demonstrated two themes. The first concerned professionals' past personal and professional experiences, and the second related to their beliefs. When participants discussed the former, one aspect that was often mentioned was their relevant educational experiences. Many had taken courses that covered early intervention and developmental disabilities, and two interventionists spoke about how research they had conducted in the area of home-visiting had piqued their interests. One individual stated that after researching home-based programs in her area, she thought,

“well wouldn’t that be an interesting job . . . to actually not have families have to bring their little ones out to this program, but able to support them in their homes.” This demonstrates a fundamental aspect of early intervention. Professionals go to where the child and family are most comfortable, the home, in order to best support them.

Five of ten early interventionists noted that they got involved with or heard about early intervention by word-of-mouth. One discussed how she learned about early intervention from a classmate with special needs who had gone through an early intervention program in the province. Another described how she overheard two professionals discussing a job opening at a meeting she attended:

I happened to be in a meeting, and I heard somebody on the other side of the table talking about the [early intervention centre] . . . I just happened to hear these two people talking about this job opportunity, and tell me about it, because otherwise I would never have known.

Individuals also discussed how elements of their personal and professional experiences influenced their career paths. Two discussed children whom they knew growing up, and two individuals discussed how having their own children with special needs led to more personal interests in early intervention. Many had worked with children in other settings, such as in community centres or daycares, and had collaborated with early interventionists in these roles.

Often when I needed something for the families I wasn’t able to access it, and I noticed that the early interventionist that was attached to the child that came into visit often was able to access where I was hitting a wall,

and so I just decided to move over into a position where I would have less walls to pull down for the children.

Another important theme that emerged was interventionists' personal belief systems and attitudes about special needs. Four participants mentioned always having an interest in children with special needs, and as a result sought professions that allowed them to work with and help these individuals and their families.

I interfaced with a lady who ran the home visiting program, and that really piqued my interest, a couple of reasons, one is because of the age group and starting so early with little ones, and the other piece was the support needs for the parents and being able to work with the family directly at home So that was another thing that piqued my interest, to learn more about that, and also to shift my career from being in a segregated setting for very physically involved little folks to a more community-based type of programming model.

It was clear from interventionists' statements that they held deep-seeded interests in children with special needs, often beginning when they were children themselves. It is these interests that caused participants to seek various educational and professional opportunities that would allow them to learn about and help individuals with special needs.

Question 3: What did participants indicate their expectations of early intervention were before being employed as early interventionists, and were these expectations met? Did professionals think that families' early intervention expectations were met?

One main theme emerged from participants' discussions of their early intervention expectations: supporting families. Interventionists stated that they expected to work with children and families in their homes in order to encourage the child's development and to help families reach a greater potential. They also expected to play a strong role in supporting the families with whom they would work. For example, one individual stated that she expected the job would involve "being in families' home[s] where they're comfortable and more making friendships . . . so that the family trusts you and feels comfortable with you and . . . just the family connection." This concept also included participants' expectations of working from a family perspective, helping parents to understand their child's condition, and giving parents ideas as to the kinds of developmentally-appropriate activities they could do in the home with their child.

One early interventionist also discussed her expectation that the job would present a variety of learning opportunities. This is evident from her statement:

So that's what I anticipated was learning a lot too from everybody that worked here because I knew other people in the . . . program where I am have been there for 10 and 12 and 20-some years, so just couldn't wait to start learning more from them and taking advantage of the educational opportunities here, the workshops and all that training that can go on.

Another professional mentioned that she was unsure as to what early interventionists did, and as a result had very few expectations prior to being employed in the profession. She also mentioned that certain aspects of the job surprised her, such as the amount of paperwork that had to be completed each day. Others had a more developed understanding due to their previous involvement with early intervention professionals and programs, or through their relevant educational and research experiences. Many mentioned their expectation that it would be a job that they would enjoy.

When asked if their expectations had been met, nine out of ten participants answered yes, and four of these stated that their expectations had been exceeded. In response to this question, one interventionist stated:

Yes, yes, and definitely exceeded, like with all the families we get to work with and the different abilities and ranges and ages and being able to work at the IWK, you know it's just different, you see it in a different way and you feel like you get to understand how it works and you know all that stuff. Yes definitely exceeded my expectations I think with what we get to do.

Another professional spoke about how being an early interventionist allowed her to incorporate the relevant knowledge she had gained from working in different, but related jobs:

I feel like . . . I can start pulling together all these streams that I have . . . and I can bring all of those things together and, I guess you might even call it, I don't want to sound like I'm bragging, but a bit, but a wisdom that

I can bring to the role at this point that I might not have been able, well I definitely would not have been able to do as a younger professional, so yah, I think that definitely I've done that and more. But my expectations have been more than met.

Another professional stated that her expectations were ongoing, and that there was always room for improvement.

When professionals were asked whether they thought families' early intervention expectations were met, their responses fell into three categories. They discussed parents' uncertainty as to what early intervention encompassed, and their interpretations that parents' expectations were fully or at least partially met. Six of the ten interviewed professionals discussed how this question was a difficult one to definitively answer. As early intervention is still a relatively unknown field, many families lack any expectations as to what they and their child will take from their involvement with such a service. This is exemplified in the following interventionist's statement:

I'm going to say no because I think families when they first come in are not sure what we're about. They really aren't . . . They're on edge, and that's understandable, because they don't know who we are and what we are, all they know is they've either been referred by somebody, or they referred themselves because they know it's going to be good for the family, but they're not sure what that service is. So it takes them a while to understand [who] we are and what we do, and once we [*sic*] do, it's great.

The family-centred philosophy that governs how family-professional relationships take place within early intervention environments holds that families are the most knowledgeable about their children with special needs, and as a result encourage families to take a lead role in directing service. Professionals also noted parents' discomfort with being placed in this expert role. As they are more used to clinical, child-centred models where the expert professional tells them what to do, they are unsure as to how they can take a more dominant role as is desired in early intervention.

In relation to this concept, a number of professionals discussed their own role in helping families to understand the nature of early intervention.

I think we need to be very clear though when we're discussing what early intervention services look like when we meet with families we need to be very clear when we're meeting with families about what we can offer and how we can match our services to meet their family and child's need. The other thing is . . . that we need to be sensitive to where families are at in terms of adjusting to having a child with special needs and how much information they're getting at that point . . . but I would say most of the feedback from parents is very positive.

Another discussed helping families to see where they fit within their child's service plan:

I think it's partly helping [the family] to understand that we're part of the service, but that they are a huge part of the service . . . in part helping families to understand that they are the experts when it comes to their child.

When interventionists thought that families' expectations were met, they discussed their satisfaction as a process that developed over time. One interventionist stated:

I've also had a couple of families come back when their children have been grade 4, grade 5 and you know they all say we didn't realize what was going on when we were in it because everything was too raw, but now looking back at it, yah we really get it now I'm not always sure we know if the family's expectations have been met at the time of end of service, but I'm convinced that certain people will certainly have a really positive experience.

Interventionists also mentioned the positive results families achieved, such as gaining confidence and the ability to advocate for themselves and their children. It is important to note, however, that even when interventionists believed that families' expectations were fulfilled, they mentioned their own role in facilitating this. Skills that were identified as important for interventionists to demonstrate included providing hope, interpretation and analysis, appropriate and individualized strategies, and maintaining open communication and rapport. Another participant mentioned how important it was to have a good match between the family and their early interventionist.

Interventionists also discussed how families' expectations were met "for the most part." This interpretation often centred around parents' desire for greater intensity and frequency of service, or their frustration with the delay that occurred between intake and service initiation. This is clear from the following interventionist's statement:

I think families are frustrated when they realize that they would probably like more of this, again, I would say that's not only just kids with autism, but in general. They would like to have someone visit once a week or something like that, and we just don't have the parameters to do that, or the resources.

One early interventionist mentioned that she believed this to be the case especially for families who saw value in the service. If they saw positive changes occurring in their family and attributed them to their involvement with early intervention, they often desired increased participation. This individual went on to mention that by partnering with parents and having them truly involved in service delivery, "that level of intensity can still be there."

Before being employed in early intervention, participants noted their expectations of being involved in a great deal of in-home family support. They also indicated that these expectations were accurate. When asked if they thought families' early intervention expectations were met, they noted how difficult it was to answer this question. This is due in part to the fact that few families know what early intervention is before becoming involved, and as a result, expect little. In many cases interventionists noted their own role in whether or not families needs were met. They identified that they must explain the nature of service provision and the ways in which families could participate. It was noted that if these points were made clear early in the relationship, expectations for the most part would be met.

Question 4: How did early interventionists describe the concept of family-centred practice?

When participants were asked to describe what the concept of family-centred practice meant to them, their adherence to an overarching philosophy became immediately apparent. As part of this family-centred philosophy, interventionists held to a belief system that placed families at the centre, respected their knowledge, and saw them as strong resources. This is clear from the following statements:

I think it's viewing, having a philosophy that the family are the authorities, that they know their child better than anyone else does now or ever will know their child. I think it's keeping in mind all the emotions that go along with having any child, but on top of that a child with special needs . . . and all the emotions that have gone with the process and the journey that that family has been on and just having respect for that and recognizing it.

[I]t's a belief system, it truly is a belief system in how you interact with families. So if you truly believe that parents are strong resources and we work from a strengths-based model, then they will become active participants.

Early interventionists implemented this philosophy by employing practices that fell into three categories: partnering with families, individualizing service delivery, and providing needed supports and services. When discussing the importance of partnering, participants mentioned their “whole family” approach, which meant including “whoever

that family believes is part of their family.” They also noted the importance of having the partnership be a truly equal one. When this was achieved, each party’s expertise could be taken advantage of, resulting in a more positive relationship.

One of the things that we have to be careful of when we’re looking at family-centred practice is that we try to put families in the driver seat so they can direct the service and give us information, but we also need to bring our expertise to the table, so it is again a partnership, it’s not directed by us, it’s not directed totally by the parent. It’s that coming together in conversation surrounding what can we find to best support your family and child. But I think the biggest piece is to have the active participation with the families, that it’s not something that we’re going in and directing.

Interventionists also spoke about their efforts to appropriately individualize service delivery as another way in which they could effectively meet families’ needs. Within this theme, the concepts of listening and supporting frequently arose. Participants emphasized listening to families’ unique goals and the ways in which they hoped to reach them. Once strengths, needs, and goals had been identified, interventionists tried to support families by providing relevant information, and by working with families to develop service plans that made sense based on their individual circumstances. Professionals also noted their efforts to take each family’s unique dynamic into account when considering what information to provide and services to suggest.

When participants discussed providing families with needed supports and services, they discussed both how they provided them and the outcomes they hoped families would achieve by being linked with such services. Interventionists spoke about

providing families with tools that they could use not only during their involvement with early intervention, but across their lifespan. They also referred to collaborating with families and engaging in ongoing communication. One interventionist also mentioned updating families' Individualized Family Service Plans (IFSP) to reflect changing needs and priorities.

Interestingly, although most participants stated that they encouraged families to direct service, one spoke about how service plans should reflect both the family's and interventionist's desires for the child with special needs:

we have ongoing conversations . . . you pull information from him and he can pull it from me, and we come up with a plan that keeps us both happy and . . . I've always held to families know their children far better than I will ever know them, and they have a far better insight as to what works for their child . . . you need to have an openness, but also you need to stick to some of what your beliefs are as well.

In terms of the outcomes interventionists hoped families would achieve, they mentioned becoming educated, being able to advocate for their children, adjusting to having a child with special needs, and being confident to direct service and provide pertinent information.

Overall, a great deal of overlap exists among the identified categories; however, all reflect interventionists' adherence to a philosophy that places the child and family's needs at the forefront, and a desire to provide effective and individualized services in order to help them achieve positive outcomes.

Question 5: How did early interventionists say they provided services in family-centred ways?

When participants were asked to describe how they provided services in family-centred ways, three main themes emerged; they discussed their family-focused, communicative, and responsive approaches. Family-focused approaches involved including all family members, such as grandparents and siblings in the early intervention process. Interventionists facilitated their involvement by bringing group activities in which siblings could be included, and encouraging parents to participate in the floor-play component of sessions. Participants also spoke about interacting with extended family members.

Interventionists also communicated their awareness of families' unique issues, cultures, and priorities. They spoke about the importance of acknowledging and being respectful of families' varied backgrounds and circumstances, and how this affected the ways in which information was offered. Family-focused professionals put families in the role of expert as a way to ensure that their needs were met. Others noted that following families' priorities often meant putting their own aside:

[I]t's always keeping in mind what the parent's focus [is], what are their priorities, and perhaps it's not my priority not to say that either goal is wrong, but you know everyone may come at it from a slightly different angle, but what matters is what the family is wanting.

Professionals held this view in an acknowledgment of the primacy of the family. They noted how their own involvement was a relatively short-term one, and as a result, realized

the importance of “empowering the family to be a strong unit” across their lifespan together.

Aspects within the first theme are aptly communicated through the following statement:

[A]lways trying to make sure that I’m doing what’s best for them, that I’m not kind of taking the lead and going off on my own path . . . you want to make sure that you’re staying family-centred, like what’s best for them, what their priorities are and stuff, maybe building that in, making sure to keep that in mind. Even family-centred, like talking with other family members . . . I’ve talked on the phone to aunts and siblings and grandparents . . . so just making sure you’re addressing all the needs of the entire family.

Interventionists came to have an understanding of such personal information by employing positive communication strategies. They asked questions, shared information, and listened. Questions concerning families’ needs, priorities, and preferences for receiving information were crucial ones for professionals to ask, as they directed them in offering information and services that were both appropriate and useful. One participant mentioned the importance of listening to families, and of not having all the answers. Adopting such an attitude nurtured the family-professional partnership and ensured that families were comfortable. The use of sensitive language was also seen as important: “using language and questions that invite families to participate and provide information and give us some direction, so . . . they very much can help give us what’s important for them at that particular time.”

The third theme that emerged related to early interventionists' responsiveness and respect for families' privacy, priorities, and circumstances. Participants put the first principle into practice by not discussing a family with another professional unless they were present, or had permission to do so. They also had an open door policy, in which families could access their files at any time. Professionals' respect for families' unique priorities and circumstances was reflected not only through the positive ways they spoke about families, but through their willingness to be available and flexible to families' sometimes unconventional schedules. One early interventionist spoke about conducting "home visits" in a child's preschool, as he was enrolled in a full-day program, and it was important that his routine not be disrupted. Another mentioned how due to one mother's work schedule, she would conduct the play component of the visit in the family's home in the late afternoon, and would then meet with the mother over her lunch hour to conduct the more reflective and goal setting portion of the visit.

Interventionists' responsiveness also became apparent when they discussed working with families to develop the IFSP. They spoke about families' changing needs and the resulting fluid nature of the document. One participant noted that all family-professional discussions came to be incorporated within it. When discussing the IFSP, one interventionist said:

It can't just stagnate, families' needs change, children's needs change, what a family may decide is really important for them at one point, two months later may have changed, so making sure we revisit that in a series of conversations, it's not a document that sits on the shelf and doesn't get accessed it is an ongoing conversation.

In response to family-identified goals, professionals offered relevant information in a timely fashion, and facilitated family understanding of the ways in which such supports and services could help them.

Professionals implemented their family-centred philosophy in a number of positive ways: they acknowledged families' different backgrounds and circumstances; listened to and allowed family priorities to dictate service, even when they strayed from what professionals saw as important; and were responsive in their scheduling and IFSP development.

Question 6: How did early interventionists describe the concept of cultural sensitivity and how did they incorporate this into practice? How many culturally diverse families did participants currently have on their caseloads?

Three themes emerged from participants' descriptions of cultural sensitivity. The first, cultural knowledge, involved family-professional information sharing. Interventionists asked questions about families' diverse cultures in order to educate themselves about different beliefs, practices, and values. One participant said that she had learned "not [to be] afraid to ask questions so that . . . I can make sure that I am being sensitive if I can be." Another reiterated this, and explained how asking questions communicated a desire to learn:

[I]f you're unsure of the reason for a request, ask about it, and find out why and learn about . . . the paradigm that they come from . . . make sure that they understand that I'm open to learning.

Interventionists also noted how barriers, such as differing languages or a family's reluctance to share such private information, could thwart the information sharing process, and pose problems for rapport building. In these situations, professionals had to develop the relationship in ways that were perhaps different from those employed with families with whom culture was shared.

The next theme, culturally attuned, incorporated professionals' sensitivity, respectfulness, and conscious efforts not to "indirectly or directly offend" families due to their own lack of knowledge. Professionals were sensitive in a number of important ways. One such example was their cognizance of families' unique characteristics, including their education levels, upbringings, and world-views. Upon learning this information, professionals tried to suggest strategies that were in accordance with families' beliefs. This is exemplified in the following statement:

[S]ome strategies I might have for working with some kids with autism, different cultures might not really agree with them or . . . wouldn't normally do things that way, so it's not . . . that easy for them. You can't just suggest it, try it, and think that they're going to pick it up just like that because maybe they're not like that with their kids or . . . it's not typical for the dad or the mom to do certain things in certain cultures, so you're careful, you want to make sure things work for that family . . . because these strategies are not across the board, they don't work for everybody, and they don't necessarily work with every family's needs.

They also acknowledged how being in a new or different culture may present various difficulties for families in addition to having a child with special needs. Professionals tried to remain sensitive to these families by ensuring that they felt listened to.

One professional also noted the importance of first understanding one's own cultural background in becoming culturally sensitive toward others.

The final theme that emerged from participants' discussions of cultural sensitivity was accepting diversity. This theme involved an awareness of cultural tenets, including childrearing and disciplining practices, beliefs and faiths, and views on disability. A number of participants, however, also warned against making assumptions about members of a particular culture based on this knowledge.

[I]t's getting to know the family and what they believe their culture practices, because what we read in books may be not the same as they would practice, because it's similar to here when we talk about Canada, some things are done regional, and even though it's Canada-wide, it's done a little differently in different regions, but that's the same thing in different countries. So I find that's the best way, is [getting] them to explain to me about their culture to make me more culture sensitive to them.

Two interventionists also made noteworthy points regarding the definition of diversity. Although racial and ethnic diversity immediately come to mind for many, it must be acknowledged that many kinds of diversity exist. This concept was clearly articulated by one interventionist:

I've been working here for 10 years and I haven't really worked with a whole lot of, like the first thing that comes to mind is immigrant families . . . I haven't worked with a lot of those families . . . but then I started thinking well but I've worked with a lot of families that are culturally different from me . . . I've worked with families where one parent was deaf . . . where parents maybe had intellectual impairment . . . with families that are headed by same sex couples . . . adoptive families, foster families, there's all kinds of different types of families that . . . their cultures would be different from mine . . . it's all kind of culture.

Another saw cultural diversity as incorporating families' socioeconomic circumstances, and the "whole range of family."

When participants were asked to describe how they incorporated the culturally sensitive elements previously noted into their practice, three themes emerged: professionals' sensitivity, acceptance of diversity, and communication. Professionals acted sensitively toward families by following their leads, and by respecting their requests, priorities, and beliefs. One professional recounted a situation in which a family of a child with Down Syndrome lived with their extended family, but had not informed them of their child's diagnosis. This was a very "tricky" situation for the interventionist, and she responded to its unique demands by "trying to be really sensitive to the way Mom was looking at the whole situation." Others spoke about trying to integrate culturally relevant activities into home visits. For example, one early interventionist developed an art activity about Chinese New Year for a family whose children had been adopted from China.

Participants also discussed how challenging it could be when they were unsure of families' beliefs, or when communication proved difficult. Professionals noted their own lack of knowledge as a barrier in these situations:

[Y]ou'll do your best to ensure that you don't overstep those boundaries . . .
. . . but I find it's that lack of knowledge sometimes . . . you're not sure, okay
is our conversation not flowing right now because you're not sure what to
say to me, you don't want to share that, you know what I'm suggesting
just goes against what you believe in, but yet you're maybe not going to
tell me that, are we just not understanding one another? For me that's so
often the question.

When they spoke about accepting diversity, many participants spoke about learning culture-specific knowledge, and their desire for this. One early interventionist told a story about going into a family's home and beginning the visit by sitting on the floor in order to put herself on the child's level. This was unacceptable to the parents, and as a result, the interventionist had to alter her typical practices. She spoke about the coming together that occurred when the parents explained why that was undesirable in their culture, and she explained the impetus behind her own actions.

Four interventionists noted how important it was to refrain from making culture-based assumptions about families' beliefs or child-related goals. Instead, professionals made sure to engage families in conversation, so they were given the opportunity to communicate such information themselves. The mindset behind this approach is made clear in the following statement:

[I]t's important to respond to that, and to know that different people have different ways of interaction, and being comfortable with that, and not imputing any of my own Western feminist types of ideas onto the relationship. That's their culture, that's how they do it.

This leads to the third theme that emerged from participants' statements: communication. Within this, the sub-themes of openness and sharing surfaced as very significant ones. Interventionists believed that part of being culturally sensitive was sharing something of themselves with families. They had open discussions, where each shared information about their backgrounds and practices. Other examples that demonstrate the sub-themes include participants' efforts to engage families in conversation about the differences between their countries of origin and Canada, challenges they faced, and typical childrearing practices. A number of professionals also spoke about taking part in families' cultural traditions. For example, five mentioned eating diverse foods, and noted the importance of being open to such opportunities when they were presented. Many believed that families did this to show their appreciation; however, it also communicated interventionists' openness to diversity and willingness to learn. One interventionist told a story about a family dressing her in a sari, and taking part in a traditional Indian brunch with them. It was clear that this was a very special and valued experience for the participant, and also signifies the high level of mutual trust that existed within this family-professional partnership.

Many also learned words in the family's first language, and incorporated them into home visits. In reference to the sharing that took place between families and

interventionists, one professional discussed families' willingness to share about their child, but reluctance to share about themselves:

I think where it sometimes becomes problematic is . . . that distinction between being willing to kind of share, talk about their whole family, because it's almost like they feel you're . . . here for our child, because if it wasn't for our child we wouldn't even be receiving this service, and for some families it can be a tough sell to say look . . . we don't need to just focus on your child, it's okay to focus on you, it's okay for you to have needs as a mom or a dad, or a brother or a sister, or grandmother or grandfather, and . . . that becomes a stumbling block too with families with different practices and different beliefs.

Professionals further communicated their cultural sensitivity by asking questions, admitting when they were unsure, and by listening.

I think the main thing that I try to do is kind of listen in all kinds of ways, you know, just listen to what they're saying, but also observe their home environment and sort of try to get a picture of how things work and what's important to them.

When interventionists were asked how many culturally diverse families they currently had on their caseloads, the average was sixteen percent, with a range between five and thirty percent. Every person interviewed was currently working with at least one family whom they considered to be culturally diverse. This points to the necessity for professionals to become comfortable with employing the sensitive practices they described.

Question 7: How prepared did early interventionists say they felt to work with culturally diverse families? Had they had adequate training to prepare them, and were they aware of any professional development opportunities related to cultural sensitivity?

When participants were asked how prepared they felt to work with culturally diverse families, only two felt that they were. One interventionist, who had been involved in early intervention and related fields for many years, felt that her educational and various work experiences had effectively prepared her to do so. Another participant, despite feeling unprepared overall, noted how a university course “about that cultural attunement process” had helped to prepare her. Other early interventionists described how they had not received training specific to cultural awareness or sensitivity, but could rely on the same sensitive approaches that they used with all families:

[W]orking with a culturally diverse family is really not any different than working with any other family because . . . the way I would approach any family no matter what their background, is . . . going in there, respecting them, and trying to find out what . . . they understand about why I’m there.

Four professionals said that they felt unprepared to work with culturally diverse families. These feelings were related to a lack of training and of culture-specific knowledge. The following statement demonstrates these feelings:

Oh not as prepared as I’d like to, I think we need a lot more training I think that’s a real need, is to make sure that we offer resources and training in sensitivity and pieces to folks, because we’re a pretty homogenous group here in Nova Scotia, we don’t have a lot of diversity

really, and so it's important for us as service providers to be trained and [to] become more aware.

Participants also desired more information about the views and beliefs held by different cultures.

Three professionals believed that the onus lied with early interventionists to prepare themselves to work with culturally diverse families. This learn-as-you-go approach involved doing research and making appropriate contacts so that families' needs could be met. Another professional stated that her feelings of preparedness depended on the family with whom she was working.

When participants were asked if they had received adequate training to prepare them to work with culturally diverse families, only two felt that they had, and eight said that they had not. In responding to this question, participants described how other experiences had prepared them to work with culturally diverse families. Two themes emerged from this discussion. The first was more personal in nature, and the other related to participants' on-the-job learning. In regards to the first theme, many professionals spoke about their previous involvement with culturally diverse populations, both growing up and in other jobs. Through their work in other provinces and countries, early interventionists had served a range of cultures. One individual described how this had been a learning opportunity for her, as she was able to ask questions of families. It was clear that this was a very valuable experience:

I found them to be extremely interesting and I retained that knowledge, so it still helps out today what I learned from them. That hands-on

experience was much better than what I learned in university, because you can only picture so much from the textbooks.

Professionals also demonstrated an awareness of diversity. One professional noted that she grew up in an ethnically diverse area, and had friends of various cultures as a child. She believed that this had contributed to the sensitive way in which she worked with culturally diverse families. Another mentioned how she “recognized even growing up that most people just don’t really have an idea about who’s around them and we just assume there’s one monoculture, but there isn’t, it’s a big quilt of lots of different cultures.” Interventionists also demonstrated their sensitivity by not making culture-based assumptions, seeing families as individuals, and being open to learning.

Participants demonstrated this openness by taking the initiative in their learning. They felt it was important “to seek out and read up on things yourself,” as this provided them with a background upon which they could build. As there was little training specific to cultural awareness, they utilized knowledge they had gained from other training opportunities to inform their practice. Participants mentioned training in family-centred practice, the “culture of privilege versus the culture of under-privilege,” and those that promoted sensitivity and reflectiveness as being of great use to them.

I think the training in understanding what family-centred care is and the practice of that, those are the things that I think I’ve had a lot of opportunities to work with, so that’s good. And those are the things that will help in working with any family including one who is culturally diverse, like listening skills, and just showing them respect, and yah...I

think being open, sharing something of yourself and asking questions when you're not sure about something.

The second theme that emerged from participants' statements involved learning over time from families, colleagues, and community partners. Early interventionists noted that their learning was an ongoing process, and that families were their greatest teachers. With each new family, they learned new skills and information that they could carry with them to their interactions with others. They viewed each family as unique, and as such, engaged in a process of learning that took place over time. This time was both necessary and valuable, as it allowed a relationship to form, and professionals to gain knowledge that was imperative if appropriate services were to be provided.

[I]t's usually worked out really well because they're appreciative of what you're doing for their family and you kind of learn over time how certain things work with them, differences from some other families, or you get comfortable with them so you can ask them.

Professionals also spoke about learning from colleagues and community contacts. One individual spoke about going to her coordinator with questions when she was unsure, and receiving helpful tips and advice. Another participant mentioned the Metropolitan Immigrant Settlement Association (MISA), and noted that they had been invited to speak at a staff meeting about cultural sensitivity, although the event was eventually cancelled.

Participants were also asked if they were aware of any professional development covering the topics of cultural diversity or sensitivity. Seven were aware of such opportunities, and three were not. Of those who demonstrated an awareness, four mentioned MISA. They noted their workshops on sensitivity training, and about being

aware of different cultures. One individual had participated in a MISA workshop about the immigrant experience when she was employed in another profession. The YMCA Centre for Immigrant Programs and the Dalhousie School of Social Work were also noted. Two individuals mentioned that they were aware of professional development on these topics, but had not sought them out because they felt that they did not need them. Another noted that these opportunities were rarely advertised, and that “it’s left up to us to have the professional integrity to find out what we need to know.”

The fact that interventionists must rely on their own resourcefulness in preparing themselves to work with culturally diverse families became very clear from a review of participants’ statements. As a result, they feel unprepared. Although MISA emerged as a significant community connection and valuable resource, only one participant mentioned actually taking part in one of their professional development sessions, and not as an early interventionist. Most professionals demonstrated a strong desire and openness to further learning.

Question 8: What kinds of resources were available to help interventionists provide services in culturally sensitive ways?

When participants were asked about the kinds of resources available to help them provide services in culturally sensitive ways, it became clear that this is an area in which professionals remain largely unsupported. It also appeared that professionals were unsure of what was available for culturally diverse families until they became involved with one. This is clear from the following statement: “I don’t think we really know what’s out there until we need to access it.”

MISA was the most frequently mentioned resource. This organization helped interventionists to locate translators, and provided them with contact information for local cultural organizations. When participants began to work with a culturally diverse family, MISA was often their first contact. One professional noted that this organization was also a useful connection for families, as they offer English courses, and a number of other programs for newcomers. Participants also mentioned their awareness of other culturally sensitive community resources, such as daycares that offered services in various languages, and cultural societies.

In terms of the tangible resources that could be used in professionals' day-to-day interactions with families, there were few. Access to translation services was especially difficult as the Department of Community Services does not fund this service. As such, interventionists must go through other sources of short-term funding to obtain translators. In reference to this challenge, one interventionist said the following:

Translators are a big issue. We've been struggling with that for some time Coming into the home and not speaking the language is not appropriate at all, we need to make sure that if we are doing services in families' homes, that we can offer support, especially if English is a second language, in their native language The issue is it's usually short-term funding, it's not sustainable, so if you have a partnership with the family for a lengthy time, it can be very difficult.

Likely due to the great difficulty associated with accessing interpreters, few participants had done so. Two participants noted that translators could be accessed through other avenues, including social workers employed at the IWK Health Centre, and occasionally

through schools. These were for very specific circumstances however, and left interventionists with few options when they required an interpreter to accompany them on home visits or to translate materials.

When asked what they did when these circumstances arose, interventionists used creative approaches. One participant mentioned using a multilingual family member as a resource, and others used translation websites, or accessed a fellow staff member, as centres often had at least one employee who spoke French. They also recruited other culturally diverse families to act as translators. One family had offered to do so; however, this service was yet to be taken advantage of.

Many early interventionists noted their reliance on one family member's ability to speak English, and had observed that this was often the case. Problems arose however, when this person could not be present during visits. One interventionist reflected on this:

[G]enerally if you've got a couple, parents who have little ones [who] come to be on our service, usually one of them will speak reasonably good English. Again, do we have a right to expect that? Of course not, but it is certainly very fortuitous when it happens, you know, because at least you've got one parent who can help to facilitate the service delivery . . . because their English is strong enough to at least be able to do that, but there are certainly gaps.

When asked if forms commonly used with parents had been translated into different languages, participants' statements demonstrated some confusion, as some verified that they were, and others denied this. Others' statements provided clarification, and it appears that forms filled out with parents, such as intake forms and parent surveys,

are not translated, but that some informational handouts are. Examples cited by participants of such translated forms included ones concerning communication, and gross and fine motor development.

Other noted resources included books, the Internet, and children's materials. Most participants stated that their libraries lacked many books that could help them to meet the unique needs of culturally diverse families. One interventionist mentioned a book that she had used; however, it was more than 15 years old. Professionals did find the Internet to be a useful tool, and had used it to translate, find general information about various cultures, and as mentioned by one participant, to find pictures that portrayed culturally diverse children. Another professional noted that their children's book and toy library was becoming increasingly culturally sensitive, as both were demonstrating children of different ethnicities.

And we've just gotten even, which I really like, and I'm taking advantage of, is some culturally diverse dolls, because . . . sometimes you don't think about it, but one staff member did think it would be really nice if we [had] different dolls from different cultural backgrounds, and I used one for that specific cultural background and [took] it there. And you just feel like maybe . . . it would nice for the little person to see themselves in these toys. So we have that now, we didn't before have much of anything toy-wise. We're starting to get more in books, like the children's books, stuff about different cultures, or at least the kids in the books are from different cultures.

It is clear that participants have few resources to assist them in supporting culturally diverse families. Participants communicated their find-as-it-becomes-necessary approach, and demonstrated a desire for greater information and support.

Question 9: What kinds of barriers did early interventionists say existed when working with culturally diverse families?

When discussing barriers they had encountered in their work with culturally diverse families, three themes emerged: communication challenges, cultural barriers, and lack of supports. Professionals frequently cited communication challenges, and eight participants noted how language differences could make this especially difficult. One individual described the problems associated with having phone conversations with family members for whom English was a second language:

Mom doesn't speak English very well so it's been really challenging, especially over the phone with the language barrier because at least in person you can tell that she's not sure what you're saying, and try to come at it a different way or simplify it or whatever, but over the phone it can be pretty hard.

Another interventionist worried that language barriers prevented families from fully understanding their service delivery options, as these were not discussed as thoroughly as they may have been with English-speaking families:

I find because language can be an issue . . . there may be things that are less fully talked through before they get put into practice for a child you know, because it's like well we did talk about this, so I guess we'll go

ahead and do this, but you know does the family really understand all of what you were just saying to them? Or maybe you're implementing something that maybe they're not in complete agreement with because they're not even, they really didn't have a complete understanding of what you were even talking about.

Communication barriers presented additional difficulty when interventionists were uncertain of how to appropriately address potentially uncomfortable topics. Participants mentioned being unsure of how to ask families about their finances when looking into eligibility for funding programs, and about parents' relationships, such as whether or not they got to spend time together alone. One interventionist said, "there's just barriers to even really helping them the way they need to be helped because you're not sure what you can say and what you can't."

The second theme, cultural barriers, encompassed interventionists' lack of awareness of cultural differences and sensitivity, and the challenges involved with building relationships. Many participants noted having to confront their own lack of understanding as a barrier. This involved not knowing about different cultures' childrearing practices, beliefs about child development and learning, and views on disability. One interventionist spoke about working with a mother who had adopted a very fatalistic view of her daughter's diagnosis:

I found it really challenging, because I could see that the mom was really traumatized . . . and even though I and all the other people who were working with this family really could see how beautifully [the child] was coming along, [the parents] were so traumatized from the beginning with

the diagnosis and whatever the doctor had said to them about the prognosis, that it was really hard . . . for this mom, probably just walking in the door, and going to work with her was that reminder oh . . . what did I do wrong? Like it wasn't just something that happened, but something [she] did in [her] life caused this to happen. And that was really really hard.

Others spoke about different disciplining practices. If parents used physical approaches to punishment, interventionists noted their difficulty in determining if this was a cultural practice. Trying to distinguish whether or not these practices were harmful to the child, and subsequent decisions about when to step in were also extremely challenging.

Participants also had to learn about parents' roles in each family, and about the different responsibilities of mothers and fathers in various cultures. One individual noted how service delivery-related decisions could not be made if the father was absent during visits, as he was the family's primary decision maker:

[A]nother thing that does come to mind is decision making in the family, and sometimes if the roles are defined within the family in terms of responsibilities . . . in this one situation, the mom was responsible for the childrearing and child development part, but the dad was more the decision maker, as in what services might be involved and that kind of thing. Sometimes it was tricky just trying to talk to both of them and the dad because of the time the dad had available and the priorities he had.

Early interventionists met these challenges by trying to be sensitive and open to the differences they encountered. One participant described a culturally diverse family

she was working with who was trying to decide whether to enroll their child in a playgroup. Although the interventionist felt that this would be good for the child, she did not know if it was culturally appropriate. She described how she worked to strike a delicate balance between suggesting services that she thought would be beneficial, while at the same time not pressuring the family to take part in them.

A number of professionals noted how a lack of sensitivity could be a barrier when working with culturally diverse families. One participant mentioned that it was important to “respect other ways of doing and other ways of being,” and to meet families where they are. She said,

for me it doesn't really matter who they are, what they are, what kind of a cultural group they . . . are a part of, or what kind of a sub-cultural group they are a part of, I am the person who needs to make them feel comfortable and find ways to connect. It's not their job to try to connect with me, it's my job to try to connect with them.

Another barrier that was mentioned was the difficulty in building relationships with families who did not understand early interventionists' roles. Participants found that a disconnect occurred when the two parties had different expectations. Individuals also discussed how some families may resist becoming involved with early intervention because they are unsure of what professionals are going to do. They may think that their parenting will be judged, or fear that their children will be taken away. It is difficult to communicate good intentions when trying to overcome the barriers that language and cultural differences may present.

The third theme referred to a lack of supports for both families and professionals. Professionals noted that many of the culturally diverse families they worked with were not supported in ways that other families might be. As culturally diverse families may have moved from another country or region, they often had little social support. They may have left their extended family, and were either intimidated or unsure of where to go to establish new social connections. Participants also discussed how families often did not have strong financial supports, and as a result, lived in less nurturing neighbourhoods. In relation to this, one interventionist said,

nothing is across the board, but often these are families who are lower income, because many, some people have left their country of origin because of living conditions and wanted a so-called better life in Canada, so sometimes, for some families that's a barrier. It's a barrier to their life, their day-to-day life . . . sometimes they're living, because of their lower income . . . in neighbourhoods that maybe are not as safe, may not be as nurturing, may not be as stimulating for that child, and another neighbourhood might be. I find these can be families that are a little bit more isolated, not only isolated by the benefit of having a child with special needs, but they're isolated because they don't know as many people, they're trying to figure out a new city potentially.

Another professional reflected that families' financial difficulties could be a consequence of their qualifications not being recognized in Canada. As a result, individuals may have been employed in professions they were overqualified for, or had to enroll in further schooling to upgrade their credentials.

One professional discussed how early interventionists were not supported by the kinds of resources they needed to best support culturally diverse families. This is also clear from participants' previous statements about the existing lack of information, training and materials related to cultural diversity, awareness, and sensitivity.

Although professionals had encountered a number of barriers in their work with culturally diverse families, it must be acknowledged that they worked to overcome these. This is exemplified in the following statement:

I try to think of it that way and think I don't have to be just like you to have a beneficial relationship with you, just because I maybe look different or come from a different background, use different language or whatever. And it's, I've come to see that . . . the situations that I've felt the most intimidated in . . . that I've really had to work the hardest at, have been the ones that have been the most rewarding in the end, they were the relationships that carry on after it's not a formal professional relationship anymore, and so I think . . . there's really something to be said about just putting in the extra effort to overcome the barriers.

Professionals did not see these barriers as insurmountable, and persevered to overcome them. Most noted that their relationships with culturally diverse families had been very special ones, and had allowed them to learn new approaches that served to improve their practice.

Question 10: What supports and resources did early interventionists believe should be in place to assist culturally diverse families?

When participants were asked about the kinds of supports and resources that should be in place to assist culturally diverse families, nine mentioned improved access to translators. Professionals believed that this could assist both professionals and families, and would be a valuable addition to home visits and inter-professional meetings. One individual noted that utilization of such a service would facilitate improved understanding for some culturally diverse families, and as such, would also increase the likelihood of their full participation.

I think language is a huge issue . . . if you can't explain yourself, or if you can't understand what's being said to you then it's got to be a huge disadvantage. A smile can only get you so far as far as universal language, you have to be able to understand that, you know, when somebody says well I'm going to refer your child to this, no they're not going to be taken away from you, and they're not going to be put in a special building or institution or whatever, you're going to go and they're going to give you information and it's going to help you, but if you don't have somebody who speaks their language and can relay that information, I'll guarantee you they won't be at that appointment, not unless their child is medically frail or has a medical condition.

Others believed that interpreters would be helpful in translating forms commonly used with parents, and helping families to navigate the system of services by acting as case managers.

Other tangible resources that professionals would like to see in place included resource books addressing cultural diversity for early interventionists, and literature written in various languages for parents. Another thought that culturally diverse families should have access to parenting support, as many are socially isolated and receive little assistance in this area. In discussing the shame that accompanies having a child with special needs in different cultures, one interventionist thought that culturally diverse families should have access to counseling services. This could help them to adjust to a new culture, and to their child's diagnosis.

And services for counseling, if anybody who has a child who had differences, they go through a grieving process, they've lost huge on, you know, the dream that they had for the child, the life they were going to have with this child, and so they have to adjust everything, but they are going to go through a grieving process in the meantime, so they need to understand that that's normal I think it's important for people to understand that, and people who have cultural differences maybe they're not supposed to feel that way, but maybe they do, and they need somebody to tell that to, somebody who understands.

Interventionists also discussed the benefits that could be gained if increased partnering existed among community organizations. It was noted that this could help professionals in finding information and in offering families a wider range of services.

That's the other thing is sometimes there's just not enough advertisement for agencies out there, and it's like down the road we find out they've been operating for like three years and no knowledge, so I find that's a

concern in this area is there's not a lot of advertisement going on for different agencies and different services and different resources.

One participant spoke about her dream for a centre that would encompass many of the above-cited elements under one roof:

I guess, my fantasy would be if there . . . were like a really large, well-funded kind of centre where people could go to access all kinds of different services, like maybe people from early intervention and other services in the community could kind of have people located there . . . so that we were sort of teaming everyday with those people . . . with the people who worked in this agency and with the families that came there . . . it would sort of streamline things and there would always be somebody there that we could ask questions of . . . there would be translators available and, you know, maybe there would be a case manager that was part of the . . . culture of the family.

Professionals also desired more training and professional development related to cultural sensitivity.

Interestingly, three interviewees communicated their desire for a staff that reflected greater diversity. They believed that this would show that they were open and accepting of diversity, and communicate their cultural sensitivity. In relation to this, one interventionist said,

in an ideal world if we had more culturally diverse staff, it would be really neat, even the van driver, students in the playgroup, even students and

stuff we get, we're all from the same cultural background, so it would be just really neat for families to see that I think.

Despite having access to few resources, participants noted a wide range of supports that could assist them to work with diverse families in culturally sensitive ways, and that could help culturally diverse families to take the most away from their early intervention experiences.

Chapter 5

Discussion & Recommendations

Introduction

Family-centred practice, which governs the nature of family-professional relationships within early intervention environments in Canada and the United States, is a philosophy that acknowledges the primacy of the family. Interventionists, working from this paradigm, build on families' unique strengths, develop individualized and flexible service plans that are based on family priorities, and encourage families to share their knowledge about their child with special needs. Interventionists respect family decisions, and support them by providing appropriate resources. Family-centred professionals employ such approaches in order to minimize families' stress and increase their confidence and competence (Beckman, 2002; Trivette & Dunst, 2005).

Due to changing demographics, the creation of family-centred legislation, and relevant research findings demonstrating its importance, cultural sensitivity is becoming an increasingly vital component of family-centred practice. These factors, along with our knowledge of family systems and ecological theories, which inform us of the connection between a child and his or her environment, highlight the rising need for professionals to respond to families in culturally sensitive ways.

This research was developed from a constructivist approach, and attempted to address these issues through utilization of two measures: surveys and interviews. Eleven Executive Directors of early intervention programs across the province of Nova Scotia completed the Cultural Diversity in Early Intervention Survey, a measure that aimed to assess the degree of cultural diversity associated with various centres. Questions inquired

about the number of culturally diverse families served by each centre, the services they had access to that would support their staff to serve these families, and the challenges they had encountered. The survey data was analyzed quantitatively, including determination of means, percentages, and in some cases, the range. Interviews were conducted with ten early intervention professionals employed in two urban centres in the Halifax Regional Municipality. These discussions centred around participants' early intervention experiences and perceptions of family-centred care and cultural sensitivity. The interview data was analyzed qualitatively using a modified grounded theory approach (Weston et al., 2001). A constant comparative approach was utilized, in which all the data from emergent categories were pulled together and compared. This allowed for overarching themes to be developed from participants' statements.

In an effort to answer the research questions, the following discussion relates important findings of this study to those obtained in previous research. Areas where further research is needed are also highlighted.

Early Intervention

Participants' responses to questions pertaining to their early intervention experiences communicated an understanding of the field that closely aligns with previously developed definitions. The previously cited definition by Shonkoff and Meisels (2000) was chosen as a comparative measure as it clearly demonstrates all the elements fundamental to early intervention. It alludes to the multidimensional, individualized, and goal-oriented nature, and highlights the centrality of the family. Interventionists' descriptions of their profession also demonstrated these key components. They had a clear understanding of their role within the family-professional

partnership, which was to support the child and family and to facilitate their service delivery. They also acknowledged the lifespan of the child and family together, and sought to provide services in ways that would increase the potential of both. According to Wehman (1998), acknowledging that a child's developmental potential is not fixed is an underlying principle behind early intervention.

Participants' responses also demonstrated that they had a deep respect for families, and many shared beliefs and attitudes that communicated an interest and desire to help individuals with special needs. As a result, individuals sought educational and career opportunities that allowed them to do this. These experiences eventually led to their involvement in early intervention, a profession that exceeded their expectations. These sensitive ways of thinking form the foundation of family-centred service delivery, as one must have a true respect for families' unique circumstances, practices, and beliefs in order to emphasize their strengths and engage in nonjudgmental interactions.

Participants' expectations before becoming directly involved with early intervention also demonstrated ways of thinking that are supported by the family-centred philosophy. Many of the main tenets of this ideology were either directly communicated or strongly implied in their responses. As participants had yet to specifically discuss the concept of family-centred practice, it is unwarranted to conduct an examination looking for each of the principles within participants' descriptions; however, it is important to note that their responses communicated that these elements were pertinent components of their jobs. For example, they expected to be involved with in-home support in order to encourage child development and help families to achieve a greater potential. According

to Raver (2005) and Trivette and Dunst (2005), these are important goals of family-centred practice.

Participating early interventionists' perceptions of their profession support the critical elements identified in well-supported research. It is also clear that professionals enjoyed their jobs as they allowed them to form relationships and support families of children with special needs, a group in which most demonstrated a long-standing interest. It would be beneficial to explore families' perceptions of their early intervention experiences, in order to see if the two align. This would provide a more multidimensional perspective, as gaps could be highlighted and families could identify changes they would like, thus informing professionals of valuable ways they could improve their practice.

Family-Centred Practice

Participants demonstrated a very well-developed and clear understanding of the family-centred philosophy. This was evidenced both from their explanations of what the concept of family-centred practice meant to them, and from their explanations of how they implemented this approach into their interactions with children and families. Interviewees strongly adhered to a belief system that placed families at the centre, and saw them as knowledgeable contributors who provided invaluable information about their needs and priorities. They also noted the importance of listening to families, having an awareness of their unique circumstances, and of individualizing services accordingly. These approaches are identified in the early intervention research as being crucial to facilitating family involvement and in achieving the goals of improving child and family

functioning, minimizing stress, and developing their confidence and competence (Beckman, 2002; Raver, 2005; Trivette & Dunst, 2005).

Most participants saw the importance of putting the family in the “driver’s seat” of service delivery. This was seen as a way of acknowledging that the family knows their child best, and of ensuring that their needs were accurately reflected in service plans. Although the idea of placing the family in the expert role is widely accepted in early intervention (Beckman, 2002), one professional communicated an approach that differed. She believed that it was important for service plans to reflect the goals of both families and interventionists. Despite her understanding of the fact that families are the most knowledgeable about their children, she felt it was important to “stick to some of what your beliefs are as well.” This is in stark contrast to recommended practices and to what other participants communicated, as others noted putting aside their own priorities for a child in favour of the family’s (Trivette & Dunst, 2005).

Research has demonstrated however, that many professionals struggle in conceding ultimate decision-making power to parents (McBride, Brotherson, Janning, Whiddon, & Demmitt, 1993; McWilliam, Snyder, Harbin, Porter, & Munn, 2000; Trivette & Dunst, 2005). Adopting such an approach is reminiscent of the professionally-dominated days of service delivery, and may point to a need for ongoing training in order to refresh interventionists about current approaches to service delivery.

As previously stated, when interventionists were asked how they implemented the discussed theoretical approaches into practice, their responses also reflected a true understanding of the family-centred philosophy. Participants spoke about employing family-focused and responsive approaches, and about utilizing positive communication

strategies. This reflects four of the five components identified by professionals and families as important for family-centred professionals to demonstrate, including a family orientation, positiveness, sensitivity, responsiveness, and friendliness (McWilliam, Tocci, & Harbin, 1998). The final component, knowledge about child development, disabilities, and the community, was not specifically referenced in their discussions concerning family-centred practice, but was mentioned in relation to other concepts. Participants noted their understanding of child development when talking about how they got involved with early intervention, as all are educated in this area. They mentioned community awareness when they spoke about collaborating with other professionals, and linking families with appropriate services.

The communication strategies employed by professionals are also supported by research. Dunst (2002) and Dunst and Trivette (1996) noted that family-centred professionals should demonstrate both *relational* and *participatory* aspects in their communication. *Relational* communication strategies involve listening, being nonjudgmental and respectful, and believing in families' competencies. Professionals who are individualized, flexible, and responsive to family priorities utilize *participatory* communication practices. The latter approach also involves encouraging full family participation. Professionals' descriptions of implementing family-centred services incorporated all of the above elements.

This examination of participants' perceptions of family-centred practice has shown that they understand the theoretical underpinnings of the concept, and believe they are incorporating them into their interactions with families. The disconnect that has been identified in previous research is also important to note however, as an abundance of

studies showcasing early interventionists' developed conceptual understanding and lacking implementation abilities exist (Mahoney & Bella, 1998; McBride et al., 1993; McWilliam et al., 2000; Melanson, 2007; Trivette & Dunst, 2005; Turnbull et al., 2007; Wehman & Gilkerson, 1999). As families were not involved in this particular study, these same comparisons cannot be made.

Other researchers have suggested, however, that this disconnect can be circumvented if interventionists clearly explain the nature of early intervention and family-centred practice to families, and encourage them to take a leading role in service delivery (Melanson, 2007; McBride et al., 1993). It is important to acknowledge that when participants were asked if they thought families' early intervention expectations were met, professionals highlighted their role in clearly explaining the above to families. They felt that this not only facilitated their involvement, but ensured that families developed appropriate expectations, which improved the likelihood that they would be fulfilled. Utilization of such approaches also facilitates the development of an open and honest family-professional relationship, in which both can freely discuss their concerns. It is possible that this may be a distinguishing factor between early interventionists who can and cannot operate from a truly family-centred place.

The results relating to participants' perceptions of family-centred care demonstrate a number of important findings. As identified in previous research, participants in this study also appear to have a strong conceptual knowledge of this approach to practice. Although one interventionist's statement led to questions regarding how well these concepts are implemented in their day-to-day practice, it must be noted that for the most part, interventionists' descriptions of their practices aligned with their

conceptual understandings. The findings emphasize the necessity of including families in such studies, as their valuable perspectives can provide a more developed picture of this issue, and can highlight areas where change is needed.

Cultural Sensitivity

As almost all centres (nine of eleven) were currently serving culturally diverse families, and all interviewed professionals had at least one family on their caseloads whom they considered to be culturally diverse, interventionists' understanding of cultural sensitivity is of crucial importance. It should be noted that professionals were the sole determinants of whether or not families were culturally diverse. It is therefore possible that families who would identify themselves as such were not recognized. This is of consideration as a high proportion (over 50%) of Nova Scotians identify with an ethnicity other than Canadian (Statistics Canada, 2001).

Chan (1990) and Lynch (1992b) have discussed three critical components to becoming culturally sensitive: becoming self-aware; seeking culture-specific knowledge; and gaining the skills necessary to engage in successful interactions with diverse individuals. These were essentially reflected in participants' descriptions of the concept. The first, self-awareness, was the least represented component, as only one professional mentioned it. Although she noted the value in understanding one's own background before beginning to learn about and understand others', the ultimate purpose, which is to appreciate how one's ways of being represents only one perspective, was not mentioned (Lynch, 1992a; Turnbull & Turnbull, 1990).

Seeking culture-specific information was also communicated, as participants spoke about asking families about their backgrounds and practices. Many thought that

learning such information served as a starting place from which relationships with families could be built. It also demonstrated a genuine desire to learn, which Lynch (1992b) believes is a desirable characteristic for culturally sensitive individuals to possess. Professionals also did not make culture-based assumptions about what families' beliefs and practices might be based on. An avoidance of stereotyping based on culture-specific knowledge is another important quality of culturally sensitive professionals (Bowe 2007).

Although early interventionists noted that they tried to be sensitive and respectful when interacting with culturally diverse families, no specific mention was made of seeking the skills that would allow them to do this. Lynch (1992b) notes that culturally sensitive individuals should observe families' unique nonverbal and verbal patterns of communication, and attempt to match their own styles of interaction to this. Practices of this sort were not mentioned.

The findings cited above demonstrate that participants' understanding of cultural sensitivity are inchoate. They demonstrated a genuine respect for all families, and an enthusiastic desire to learn. This latter aspect is of utmost importance, as this will encourage a continual quest for knowledge, which will serve to further develop their understandings of the concept. An exploration of participants' training in cultural sensitivity and an assessment of the resources they have available to support them in providing services to culturally diverse families will provide a more detailed picture. It is unfair to expect professionals to have a more developed understanding of a concept if they have not received the support to do so. These areas will be further explored in this discussion.

Participants' responses regarding how culturally sensitive practices were implemented within their early intervention programs focused more on their approach, as opposed to a discussion of the specific practices they implemented. The overarching theme to this approach was openness; professionals were open to learning about different practices, to sharing personal information about their own backgrounds and beliefs, and to participating in families' traditions. Few specific culturally sensitive practices were mentioned, with the exception of one interventionist who spoke about trying to integrate culturally relevant activities into her home visits, and another who said that she tried to learn a few words in a family's first language in order to communicate with their children.

The works of Chan (1990) and Bruder, Anderson, Schutz, and Caldera (1991) have identified key elements that should be included in culturally sensitive programs. Chan (1990) suggested providing sessions and handouts in families' first languages. Bruder et al. (1991) incorporated cultural roles and norms into service plans, and paired families with a bilingual interventionist. The inclusion of such culturally sensitive components led to increased parental participation and fewer identified needs. Interviewed professionals made no mention of having access to such services.

It appears that professionals' failure to discuss specific culturally sensitive practices may be due to the fact that services that could support them to do so are unavailable, as opposed to the idea that professionals are actually culturally insensitive. Their conveyed openness to and acceptance of diversity demonstrates that if they had access to such services, professionals would be happy to take advantage of them. The qualities of openness and acceptance should not be discredited as insufficient however, as

these allow families to direct service, which is a fundamental element of family-centred practice. As cultural sensitivity is a component within the family-centred philosophy, its basis is the same. Although professionals likely satisfy many of culturally diverse families' needs by working from such a perspective, research has demonstrated that this is not enough, as such families typically experience fewer positive intervention outcomes than families of white children (Bailey, Scarborough, Hebbeler, Spiker, & Mallik, 2004). It is therefore essential that the early intervention experiences and perceptions of culturally diverse families be obtained. This will allow us to identify what specific factors these families feel are missing, and will better prepare professionals to satisfy an increasing demand.

An important finding of this study is that resources to help professionals provide services in culturally sensitive ways are scarce. Across the province, only four centres were aware of supports and services for culturally diverse families of children with special needs, and only one had accessed them. This shocking statistic poignantly illustrates how great the need is for improved access to service.

Access to translation services was a particularly significant issue. Although participants identified a great need for this, few had sought such services. As interpreters are not funded, they can only be accessed by tapping into short-term, special funding, or by involving other organizations, such as hospitals or schools. Forms that are filled out with parents, such as intake forms and parent surveys, are also only available in English. These represent significant barriers for both professionals and the culturally diverse families with whom they work. Chan (1990) and Bruder et al. (1991) have identified that providing services in families' first languages is an essential component of culturally

sensitive programs. At this point, early interventionists remain unable to fulfill this requirement. This may represent a serious source of risk for culturally diverse families and children involved in early intervention, as an inability to communicate inhibits the development of an open, honest, and reciprocal family-professional partnership, an element that is of critical importance in this field. It also makes it less likely that a family's needs will be met, as interventionists may not have a true understanding of what those needs are (García Coll, & Magnuson, 2000).

Most participants felt unprepared to work with culturally diverse families in other ways as well. These feelings stemmed from their lack of exposure to relevant training opportunities and to those that would further their knowledge, such as professional development. Only two participants felt that they had received adequate training to prepare them to meet the needs of culturally diverse families. Interestingly, no one spoke about receiving training specific to cultural diversity, awareness, or sensitivity. The few who felt prepared said that a combination of their personal and professional experiences had contributed to their comfort in providing culturally diverse families with a sensitive approach to service delivery. Others spoke about utilizing practices they had learned about through participating in other training sessions, including sensitivity and reflectiveness training. These findings highlight the tremendous need that exists for early interventionists to have access to cultural sensitivity training.

Participants' application of other knowledge to the domain of cultural sensitivity demonstrates their resourcefulness; however, the fact remains that this is an ineffective way of meeting diverse families' needs. All interview participants were currently serving at least one family whom they considered to be culturally diverse, and most felt

unprepared in training and unsupported in resources to successfully do so. If early intervention programs are going to open their doors to all families, employees must be provided with the support they require. If this does not occur, service delivery for culturally diverse families is held to a lower standard. Improvements in training would improve professionals' feelings of preparedness, and subsequently their abilities to serve diverse families of children with special needs.

In addition to the barriers of lack of training and supports, interview and survey participants discussed the barriers they encountered when working with culturally diverse families. These included communication challenges, cultural barriers, and a lack of support not only for professionals, but for families as well. The presence of language barriers was frequently cited by professionals. This issue was exacerbated by the fact that access to translators was so difficult, as previously discussed. Participants also noted that their own lack of understanding of different cultural practices could be a barrier, as it could lead to misunderstandings. Lynch (1992b) suggests that gaining such knowledge is crucial to becoming culturally sensitive. Participants did discuss asking families about their practices, contacting cultural organizations in the community, and using the Internet in order to further their existing cultural knowledge. In discussing support barriers, participants noted how these were issues for professionals and families, and mentioned culturally diverse families' social isolation as an example.

The latter two points demonstrate three of the desirable characteristics that culturally sensitive individuals should possess, including a sincere attempt to understand others' points of view, and an openness and genuine desire to learn (Lynch, 1992b).

When given the opportunity, participants discussed the resources they would like to see in place to assist culturally diverse families. The fact that improved access to translators was the most frequently cited response comes as no surprise. Early intervention is based on the premise of establishing open communication between professionals and families, as this is seen as a critical contributor in children's experience of success. As language was often noted to be a common barrier that inhibited open communication, it is understandable that professionals have a great desire for services that will amend such challenges. The fact that one professional mentioned pairing families with a bilingual case manager is of particular importance, as this is a component of Bruder et al.'s (1991) successful culturally sensitive home-based program.

Participants also communicated a desire for a greater range of appropriate literature that could be used by both parents and professionals, further training and professional development, and additional support services for parents, such as counseling and parenting assistance. Interestingly, three professionals wished that their staff were more culturally diverse. This latter component has been identified in research to be important in culturally sensitive programs, as professionals who share culture with families will have an implicit understanding of families' cultural norms and values, and will therefore be better able to incorporate them within service delivery (Bowe, 2007). Researchers also believe that rapport development between professionals and families will be more readily established in these situations, and that culturally diverse professionals may serve as more suitable role models for culturally diverse children (Bowe, 2007).

The above-cited desired supports and services demonstrate that professionals have a well-developed understanding of the kinds of supports and services that would be of great assistance to culturally diverse families of children with special needs. This serves to reemphasize the point that participating professionals aim to provide culturally sensitive services, but are unsupported by training and resources to do so. Were these supports available, professionals would likely be very adept at meeting diverse families' unique and varied needs.

Summary

The purpose of this study was to ascertain early interventionists' perceptions regarding their early intervention experiences, and of family-centred care and cultural sensitivity. As this study had a relatively small participant group that came from two centres within the same municipality, results should not be generalized beyond this setting. It is likely however, that many of the issues that participants identified are mirrored in centres around the province. This was indicated to some extent in the surveys that were returned from early intervention programs across Nova Scotia. As such, the results have great value and will serve to shed light on participants' struggles in providing culturally sensitive services.

Overall, participants demonstrated strong conceptual understandings of early intervention and family-centred care that closely aligned with previous research. Although one participant made reference to a practice that conflicts with the family-centred philosophy, this finding appeared to be an anomaly, as all other participants spoke about implementing practices that were family-centred in nature. The inclusion of families in similar studies is necessary if the full picture is to be garnered. Without their

valuable perspectives, we cannot know if families are receiving what professionals say they are providing.

When participants were asked to discuss the concept of cultural sensitivity and to describe how they implemented this into their interactions with culturally diverse families, their lack of preparation and lack of support to do so became overwhelmingly clear. Early interventionists had not received training specific to cultural sensitivity, and as a result, pulled from other knowledge to meet families' needs. Although many participants mentioned a community contact, the Metropolitan Immigrant Settlement Association (MISA), that was a great asset to them in their work with culturally diverse families, interventionists had access to few tangible resources, most notably, translators. Eighty percent of interview participants noted that language differences often presented unique barriers when working with culturally diverse families, yet they did not have access to the services that could help to ameliorate such challenges.

The overall finding that early intervention professionals require greater training and resource support in order to effectively meet the needs of culturally diverse families of children with special needs is of tremendous importance. They must be supported to do so by their profession and through government policy. Without such measures, interventionists are left to apply the "learn-on-the-job" approach that emerged as common among many participants. Providing professionals with appropriate training and resources will improve their confidence and their abilities to serve diverse populations, thereby improving families' early intervention experiences and helping children to reach their greatest potentials.

Recommendations

Research

1. Early interventionists employed within one municipality were interviewed. It would be beneficial however, to further examine how the issue of cultural sensitivity exists within other areas of Nova Scotia. It is possible that other centres in the province serve families from backgrounds that were not represented in this study. This could serve to broaden our perspective of the strategies used and challenges faced by early interventionists who work with culturally diverse families of children with special needs.
2. It must also be noted that all involved early interventionists were employed in urban programs. It would be beneficial to conduct similar research with rural programs, in order to examine their perceptions of cultural sensitivity, and to gain an understanding of how the challenges they face differ from those encountered by professionals working in urban settings.
3. Although Halifax is a diverse city, and the participating centres served families that reflected this, it would be valuable to conduct a similar study in cities, such as Vancouver or Toronto, that have an even greater range of diversity, and likely have greater access to services and supports. It is possible that early interventionists employed in such settings could present unique perspectives from which others could learn.
4. Families' perspectives of their early intervention experiences must be obtained in order to ascertain their views on the issues studied. Commonalities among families' perceptions and perceived issues of concern could be identified, which

- would provide a basis for discussion between families and professionals, and would serve as a valuable learning opportunity.
5. While participants in this study saw themselves as family-centred, gaining parents' perceptions would add another dimension. The issue of whether a gap exists between what professionals say they are providing and what families feel they are receiving could then be examined.
 6. In order to obtain a more multidimensional picture of the issue of cultural sensitivity, culturally diverse families' perceptions must be obtained. It became clear in this study that many families were uncomfortable with being interviewed. Perhaps these populations could be reached through less intrusive measures, such as surveys. Access and language issues, however, will need to be addressed.
 7. The perceptions of other stakeholders in the early intervention process must also be investigated (i.e. involved professionals and government personnel), as their perceptions and beliefs also impact the delivery of services to culturally diverse families.

Early Intervention / Families

8. It became clear from the interviews, that to a large extent, professionals were unsure if they were meeting families' expectations. Early interventionists must have these conversations with families, so that if necessary, alterations to service delivery can be made. They must also ensure the creation of a comfortable and open relationship, so families may freely discuss concerns and goals.
9. Participating early interventionists mentioned that if families were unsatisfied, it was often related to a desire for service delivery that was more frequent and

- intensive. Professionals must be very clear with families when communicating the nature of the program. This will decrease the likelihood of a disconnect between what families would like and what they receive.
10. This research, as well as studies done in the past, indicates that the cultural backgrounds of early interventionists are fairly narrow. Programs should attempt to attract culturally diverse staff.

Training / Professional Development

11. It appears that early interventionists may need an opportunity to review the components involved with family-centred practice. Ongoing training is needed to ensure that professionals have a well-developed understanding of the concept and can effectively implement such practices into their interactions with families.
12. As confusion regarding whose goals should be included within families' IFSPs was a noted finding in this study, participants may also need ongoing training that addresses appropriate development of families' service plans. Such training should address IFSP development for culturally diverse families as well.
13. Few early interventionists had received training in the area of cultural sensitivity, and as a result, were not confident in their abilities to meet culturally diverse families' needs. They described the majority of the learning as taking place on-the-job. Interventionists need training in the areas of cultural diversity and sensitivity to improve both their confidence and their abilities. Individuals can also utilize a team approach, and collaborate with their colleagues in their quest to learn.

14. Participants knew of few professional development opportunities related to the areas of cultural diversity or sensitivity. Professionals need to be exposed to such opportunities and must be supported to do so. It is also important that they take the initiative in seeking out such relevant opportunities.
15. If professionals are to meet the needs of culturally diverse families, they require the communication skills that will allow them to effectively do so. In-services that address practices and beliefs of cultures, and appropriate communication strategies would be of great value.
16. Undergraduate and graduate-level programs preparing individuals to become early interventionists should examine their current curriculums to determine if cultural sensitivity is adequately addressed. They also need to be mindful that people's beliefs and knowledge develop over time, and must encourage students to engage in reflective practices.

Professional Groups

17. The Early Childhood Interventionists Association of Nova Scotia (ECIANS) demonstrates a theoretical support for cultural sensitivity. They must put their culturally sensitive mandate into action by advocating for increased funding that will support those in the field working with culturally diverse families.
18. Professional organizations, such as the Metropolitan Immigrant Settlement Association (MISA), need to be aware of the unique challenges early interventionists face in their attempts to work with and meet the needs of culturally diverse families of children with special needs. It would be beneficial if a group, such as MISA, offered training that was specifically related to the field.

19. There must be greater awareness among community organizations of each other's existence and area of expertise. Professionals could use each other as resources, both benefiting themselves and the populations whom they serve.
20. Early intervention programs must work to create a greater awareness of their existence within the community. This could be achieved by developing one brochure in various languages that held basic information about the nature of early intervention, and had the contact information for all provincial centres. These could be delivered to local immigrant organizations.

Government / Policy

21. Early interventionists cannot take advantage of training opportunities if they do not receive the financial support to do so. Greater funding must be set aside to encourage professionals' continued learning.
22. The government must take a leadership role in promoting family-centred practices, especially as they relate to culturally diverse families. Documents that outline training guidelines and requirements for professionals must be produced, and legislation that formerly establishes a family's right to early intervention must be put into place.
23. Professionals feel unsupported in their attempts to serve culturally diverse families, as they have few resources to help them. Early intervention programs require funding specifically intended for resources, such as culturally sensitive book and toys for their playrooms, and books for their children and adult libraries.
24. Programs need funding for translators as it is difficult for professionals to form relationships with families without a common language. Translators are needed

to support families' participation in inter-professional meetings and to support interventionists on visits. Involvement of translators on intake visits is of special importance, as this is when the nature of the program is initially explained. The greater understanding parents have, the more likely they are to take advantage of the service.

25. Common forms used with parents also arose as an issue, as they exist only in English. If parents do not understand what is being asked of them, they are unlikely to provide interventionists with the information they require to best meet families' needs. Translating such forms will ensure greater parent understanding and involvement. MISA may be a critical partner in this process.

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APPENDIX A

Cultural Diversity in Early Intervention Survey

Cultural Diversity in Early Intervention Survey

Please answer the following questions relative to your own early intervention program.

1. Approximately how many families does your early intervention program currently serve?

2. Of these families, approximately how many would you say have culturally diverse backgrounds?

- b. Could you give some examples of the different cultures/ethnicities being served by your program?

3. Have you had families in your program for whom English was a second language?

YES ___ NO ___

- a. If yes, approximately how many?

- b. Are the services of a translator needed to work with any of your families?

YES ___ NO ___

- c. Does your program have access to translators?

YES ___ NO ___

4. Has having families from culturally diverse backgrounds presented any unique challenges to the early interventionists in your program?

YES ___ NO ___

- a. If yes, could you share some of these challenges?

5. Are any of your families recent immigrants to Canada (less than five years)?

YES ___ NO ___

6. Are you aware of any supports and services for culturally diverse families of children with special needs in your area?

YES ___ NO ___

- a. Please note the supports and services for culturally diverse families that are familiar to you.

- b. Have you accessed these supports or services?

YES ___ NO ___

7. Does your program do any outreach that is specifically aimed at culturally diverse families of children with special needs?

YES ___ NO ___

- b. If yes, can you briefly describe what your outreach efforts include?

8. Other comments?

APPENDIX B

Demographic Questionnaires

Demographic Information – Families

Gender MALE FEMALE

Age 18-25 26-30

31-35 36-40

41-45 >45

Ethnicity: _____

Education Some high school High school diploma

Community college diploma Bachelor's degree

Master's degree Other: _____

Occupation: _____

Number of children in your household:

Regarding your child receiving early intervention services:

Age: _____

Length of time involved with your Early Intervention program: _____

Your child's diagnosis: _____

Demographic Information – Early Interventionists

Gender MALE FEMALE

Age 18-25 26-30

31-35 36-40

41-45 >45

Ethnicity: _____

Education High school diploma

Community college diploma 1 year 2 years 3 years

Bachelor's degree Major: _____

Master's degree _____

Other: _____

Number of years working as an early interventionist: _____

Have you attended any professional development sessions recently?

YES NO

If yes, please note some of the topics covered.

APPENDIX C

Interview Questions

Interview Questions – Families

1. How did you get involved with early intervention? (How did you hear about it?)
2. Tell me about your family.
3. Prior to your involvement with early intervention, can you please tell me what your expectations were?
 - a. Do you feel that your expectations have been met?
4. Early intervention programs in Nova Scotia follow a family-centred approach. How would you describe a family-centred approach to early intervention?
5. Please share with me your personal experiences in terms of how your early intervention program is family-centred?
(cue if necessary – examples?)
6. Family-centred approaches encourage early interventionists to respond to families in culturally sensitive ways; however, there is very little information on what it means to be culturally sensitive. In your opinion, what does this mean?
7. Based on your experience, are culturally sensitive practices being used, and if so how?
 - a. Are you comfortable with these practices? (Cue if necessary – Satisfied? Not Satisfied?)
8. Are you aware of any community resources for culturally diverse families?
 - a. Do you feel that they are adequate?
9. In your opinion, what kinds of barriers exist for culturally diverse families who are involved with early intervention?

10. Ideally, what supports and resources would you like to see in place to assist culturally diverse families?

Interview Questions – Early Interventionists

1. Tell me about your profession.
2. How did you get involved with early intervention? (How did you hear about it?)
3. Please tell me what your expectations were of early intervention programs before you were employed in this profession?
 - a. Do you feel that your expectations have been met?
 - b. Do you think that families' expectations are being met?
4. Early intervention programs in Nova Scotia follow a family-centred approach. What does this concept mean to you?
5. Please share with me how you provide services in a family-centred way? (cue if necessary – examples?)
6. Family-centred approaches encourage early interventionists to respond to families in culturally sensitive ways; however, there is very little information on what it means to be culturally sensitive. In your opinion, what does this mean?
 - a. Tell me about how you try to incorporate practices such as those you mentioned in your own interactions with families?
 - b. Of the families currently on your caseload, what percentage do you consider to be culturally diverse?
7. How prepared do you feel to work with culturally diverse families?
 - a. Have you had adequate training to prepare you to do this?
 - b. Are you aware of any professional development that covers this topic?

8. What kinds of resources are available to help you provide services in culturally sensitive ways? (cue if necessary – examples? such as translators, knowledge of community groups, common forms translated into other languages)
9. In your opinion, what kinds of barriers exist when working with culturally diverse families? (cue if necessary –differing languages, values, and beliefs? How so?)
10. Ideally, what supports and resources should be in place to assist culturally diverse families?

APPENDIX D

E-mails to Executive Directors

Executive Director
Early Intervention Program

September 29, 2008

Dear _____,

My name is Emily White and I am a graduate student in the Master of Arts (Child and Youth Study) program at Mount Saint Vincent University. As part of my degree requirements, I am conducting research to investigate cultural sensitivity in early intervention. The aim of this research is to gain a deeper understanding of the perceptions held by culturally diverse families and professionals regarding early intervention and the use of culturally sensitive practices.

As per our earlier conversation and your verbal agreement to participate, I am interested in learning more about the diversity of families that take part in your early intervention program. In order to do this research I am asking that you fill out and return the short, attached survey. If you are willing to participate, please complete the survey within two weeks, and email your responses back to me, [REDACTED]. The attached questionnaire should not take more than 20-30 minutes to complete.

Please understand that participation in this study is completely voluntary, you may skip or decline to respond to any questions that you are uncomfortable answering, and may withdraw from the study at any time. All information obtained in this study will be kept strictly confidential. The results of this study will be presented as group data. Only my supervisor and I will have access to the surveys. Data from the surveys will be used in the thesis and may be used in future publications and presentations to illustrate themes arising from the data; however, no names or identifying information will be reported.

Should you have any further questions or concerns regarding this study, please contact me, Emily White, at [REDACTED] ([REDACTED]) or my thesis supervisor Dr. Carmel French at 457-6187 (Carmel.French@msvu.ca). If you have any questions and wish to speak with someone who is not directly involved with this study, you may contact the University Research Ethics Board (UREB) c/o MSVU Research and International Office, by phone at 457-6350 or by email at research@msvu.ca.

I would like to thank you for considering my research project. It is my hope that this research will advance the field of early intervention.

Sincerely,

Emily White
Graduate Student
Mount Saint Vincent University

APPENDIX E

Letters to Executive Directors

Executive Director
Early Intervention Program

September 29, 2008

Dear _____,

My name is Emily White and I am a graduate student in the Master of Arts (Child and Youth Study) program at Mount Saint Vincent University. As part of my degree requirements, I am conducting research to investigate cultural sensitivity in early intervention. The aim of this research is to gain a deeper understanding of the perceptions held by culturally diverse families and professionals regarding early intervention and the use of culturally sensitive practices.

I am first interested in learning more about the diversity of the families that take part in your early intervention program. In order to do this, I am asking that you fill out and return the short, attached survey and return it to me within two weeks. The attached questionnaire should not take more than 20-30 minutes to complete.

As per our earlier conversation and your verbal agreement to participate, I am also asking that you distribute the enclosed packages to your staff and families currently involved with your early intervention centre. In order to maintain confidentiality, I am requesting that you attach address labels to families' packages. Each package contains a letter that explains the research purposes and the nature of participant involvement, a demographic questionnaire, and a consent form. My email address and telephone number will also be included, so that those who wish to participate can contact me and arrange to do so. A copy of this information has been enclosed for your reference. I am also requesting that I use a space at your centre to conduct participant interviews. Interviews will take place during your regular business hours or after hours if it involves a staff member who has access to the centre.

Those interested in participating can contact me to arrange a mutually convenient time and place for the interview to occur. Before beginning the interview, participants will be asked to sign an informed consent form, and to fill out a short demographic questionnaire if they have not already done so. The demographic information will serve to contextualize the interview data; however, demographic information and interview statements will not be matched, and no identifying information will be used in the final thesis, subsequent talks, or in published articles. Participants will be informed of their right to confidentiality and told that they are free to decline to answer any questions or to withdraw from the study at any time without penalty. Interviews will not commence until both parties have signed the informed consent form.

In total, interviews will take approximately 30-40 minutes to complete. They will be audio recorded, and later transcribed to facilitate data analysis. Interview data will be presented in the form of group data only, and any quotes that are used will not be accompanied by identifying information.

Please understand that participation in this study is completely voluntary, participants may skip or decline to respond to any questions that they are uncomfortable answering, and may withdraw from the study at any time without penalty. All information obtained in this study will be kept strictly confidential. The demographic questionnaires and interviews will be numerically coded and destroyed after they have been transcribed. Once the transcriptions are completed, participants will be contacted and given the opportunity to review their own transcript to determine if it reflects their perceptions and to suggest changes if necessary. All data will be stored in a locked file cabinet in the researcher's office and electronic files will be password protected. Only my supervisor and I will have access to the interview transcripts. A summary of the research findings will be shared with your program and participants through the addresses they provide when the thesis is completed.

Should you have any further questions or concerns regarding this study, please contact me, Emily White, at [REDACTED] ([REDACTED]) or my thesis supervisor Dr. Carmel French at 457-6187 (Carmel.French@msvu.ca). If you have any questions and wish to speak with someone who is not directly involved with this study, you may contact the University Research Ethics Board (UREB) c/o MSVU Research and International Office, by phone at 457-6350 or by email at research@msvu.ca.

I would like to thank you for considering my research project. It is my hope that this research will advance the field of early intervention. I will contact you in the near future to follow-up.

Sincerely,

Emily White
Graduate Student
Mount Saint Vincent University

APPENDIX F

Letters to Participants

Dear Parent/Guardian,

My name is Emily White and I am a graduate student in the Master of Arts (Child and Youth Study) program at Mount Saint Vincent University. As part of my degree requirements, I am conducting research to investigate cultural sensitivity in early intervention. The aim of this research is to gain a deeper understanding of your perceptions regarding early intervention and the use of culturally sensitive practices.

If you (one parent per family) are a recent immigrant to Canada (within the last five years) or are a member of a diverse cultural group, and are willing to take part in an interview, please contact me via telephone at [REDACTED] or email at [REDACTED]

[REDACTED] During the interview, you will be asked to discuss your early intervention experiences; interpretations of family-centred care and cultural sensitivity; and experiences with culturally sensitive service provision. We can then arrange a mutually convenient time and place to carry out the interview. Before beginning the interview, you will be asked to sign an informed consent form and to fill out a short demographic questionnaire if you have not already done so. You do not have to respond to any questions that you may be uncomfortable answering, and are free to withdraw from the study at any time without penalty. The demographic information will help me to contextualize the data I obtain from the interviews, and will help me to gain a better understanding of participants' statements. The interview will take approximately 30-40 minutes to complete, and will be audio recorded.

Please understand that your participation in this study is completely voluntary, and you may skip or decline to respond to any questions that you are uncomfortable answering, and may withdraw from the study at any time without penalty. All information obtained in this study will be kept strictly confidential and will not influence your participation in your early intervention program. The demographic questionnaires and interviews will be numerically coded and destroyed after they have been transcribed. Once the transcriptions are completed, you will be contacted and given the opportunity to review your transcript to determine if it reflects your perceptions and to suggest changes if necessary. All data will be stored in a locked file cabinet in the researcher's office and electronic files will be password protected.

The results of this study will be presented in group data only, and no individual participants will be identified. Quotes from the interviews may be used in the thesis and in future publications and presentations to illustrate important findings. Quotes will not be accompanied by any identifying information. A summary of the research findings will be shared with you and your program through the address you provide when the thesis is complete.

Should you have any further questions or concerns regarding this study, please contact me, Emily White, at [REDACTED] ([REDACTED]) or my thesis supervisor Dr. Carmel French at 457-6187 (Carmel.French@msvu.ca). If you have any questions and wish to speak with someone who is not directly involved with this study, you may contact

the University Research Ethics Board (UREB) c/o MSVU Research and International Office, by phone at 457-6350 or by email at research@msvu.ca.

I would like to thank you for considering my research project. It is my hope that this research will improve families' early intervention experiences. I will contact you in the near future to follow-up.

Sincerely,

Emily White
Graduate Student
Mount Saint Vincent University

Dear Early Interventionist,

My name is Emily White and I am a graduate student in the Master of Arts (Child and Youth Study) program at Mount Saint Vincent University. As part of my degree requirements, I am conducting research to investigate cultural sensitivity in early intervention. The aim of this research is to gain a deeper understanding of your perceptions regarding early intervention and the use of culturally sensitive practices.

If you are willing to participate in an individual interview that will ask you to discuss your early intervention experiences; interpretations of family-centred care and cultural sensitivity; and experiences with culturally sensitive service provision, please contact me via telephone at [REDACTED] or email at [REDACTED]. We can then arrange a mutually convenient time and place to carry out the interview. Before beginning the interview, you will be asked to sign an informed consent form and to fill out a short demographic questionnaire if you have not already done so. You do not have to respond to any questions that you may be uncomfortable answering, and are free to withdraw from the study at any time without penalty. The demographic information will help me to contextualize the data I obtain from the interviews, and will help me to gain a better understanding of participants' statements. The interview will take approximately 30-40 minutes to complete, and will be audio recorded.

Please understand that your participation in this study is completely voluntary, and you may skip or decline to respond to any questions that you are uncomfortable answering, and may withdraw from the study at any time without penalty. All information obtained in this study will be kept strictly confidential and will not influence your employment in your early intervention program. The demographic questionnaires and interviews will be numerically coded and destroyed after they have been transcribed. Once the transcriptions are completed, you will be contacted and given the opportunity to review your transcript to determine if it reflects your perceptions and to suggest changes if necessary. All data will be stored in a locked file cabinet in the researcher's office and electronic files will be password protected.

The results of this study will be presented in group data only, and no individual participants will be identified. Quotes from the interviews may be used in the thesis and in future publications and presentations to illustrate important findings. Quotes will not be accompanied by any identifying information. A summary of the research findings will be shared with you and your program through the address you provide when the thesis is complete.

Should you have any further questions or concerns regarding this study, please contact me, Emily White, at [REDACTED] ([REDACTED]) or my thesis supervisor Dr. Carmel French at 457-6187 (Carmel.French@msvu.ca). If you have any questions and wish to speak with someone who is not directly involved with this study, you may contact the University Research Ethics Board (UREB) c/o MSVU Research and International Office, by phone at 457-6350 or by email at research@msvu.ca.

I would like to thank you for considering my research project. It is my hope that this research will advance our current knowledge in the early intervention field. I will contact you in the near future to follow-up.

Sincerely,

Emily White
Graduate Student
Mount Saint Vincent University

APPENDIX G

Free and Informed Consent Form

(Letterhead)

Free and Informed Consent Form

Cultural Sensitivity and Early Intervention in Nova Scotia: An In-Depth Assessment
Emily White

I am a graduate student in the Department of Child and Youth Study at Mount Saint Vincent University. As part of my Master of Arts requirement, I am conducting research under the supervision of Dr. Carmel French. I am inviting you to participate in my study, *Cultural Sensitivity and Early Intervention in Nova Scotia: An In-Depth Assessment*. This project is being funded by the Social Sciences and Humanities Research Council of Canada. The purpose of the study is to examine your perceptions regarding early intervention and the use of culturally sensitive practices.

This study requires participants to complete a demographic questionnaire, and an interview. The interview will be audio recorded and will take approximately 30-40 minutes to complete. The results of this study will be presented in group data only, and no individual participants will be identified. Quotes from the interviews may be used in the thesis and in future publications and presentations to illustrate important findings. Quotes will not be accompanied by any identifying information.

Your participation is completely voluntary. You may decline to respond to any questions that you may be uncomfortable answering, and are free to withdraw from the study at any time without penalty.

Every effort will be made to maintain participants' confidentiality. Although interviews will be taped, the researcher will not identify participants by name on the recordings. Tapes and transcripts will be coded using a number system so as to ensure that participant anonymity is maintained. In the event that names, such as of family members or co-workers are mentioned during the interviews, they will be omitted from the transcripts, and therefore from quotations that may be used. The demographic questionnaires will also remain anonymous, and will be used only as a means of contextualizing data. Individuals' statements will not be linked with their own demographic information. No individual participants will be identified without their permission.

If you have any questions about this study, please contact Emily White at [REDACTED] or my thesis supervisor Dr. Carmel French at 457-6187 (Carmel.French@msvu.ca). This research activity has met the ethical standards of the University Research Ethics Board at Mount Saint Vincent University. If you have any questions and wish to speak with someone who is not directly involved with this study, you may contact the University Research Ethics Board (UREB) c/o MSVU Research and International Office, by phone at 457-6350 or by email at research@msvu.ca.

By signing this consent form, you are indicating that you fully understand the above information and agree to participate in this study.

Participant's signature

Date

Researcher's signature

Date

One signed copy to be kept by the researcher, and one signed copy to the participant.

APPENDIX H

Sample Coded Responses

Coded Responses

Question 3: What did participants indicate their expectations of early intervention were before being employed as early interventionists?

<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
<ul style="list-style-type: none"> -Working with children and families -In-home service -Being in families' homes -Knew I'd be working with kids with special needs -Working with families in their homes -Primarily engaged with helping a child with development -Had a broader range of community resources 	<ul style="list-style-type: none"> Working in families' homes 	
<ul style="list-style-type: none"> -What they've turned out to be -Something that I would enjoy -Knew what I was getting into -Knew what a program looked like -Had a clear understanding -Wasn't completely sure what they did 	<ul style="list-style-type: none"> Prior knowledge of early intervention 	
<ul style="list-style-type: none"> -Making friendships with families -Family trusts you -Family feels comfortable -Family connection -There to support families -Had their level of knowledge in mind -Expected to work with families in a more family-centred way -Worked with families in a germinal type of way -Allowed families to develop and come to greater potential -Working from a family perspective -Give ideas and activities to do with child at home to help development -Helping to understand child's condition 	<ul style="list-style-type: none"> Supporting families 	<ul style="list-style-type: none"> Supporting Families
<ul style="list-style-type: none"> -Learning a lot too from everybody -Taking advantage of educational opportunities (workshops and training) -Had worked with early interventionist before -Didn't know about so much paperwork 	<ul style="list-style-type: none"> Learning 	