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# Family-Centered Early Intervention: Clarifying Our Values for the New Millennium

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The term family-centered early intervention refers to both a philosophy of care and a set of practices. Both have been used to guide research, training, and service delivery for well over a decade. Unfortunately, though, the universal adoption of family-centered values and practice in early intervention is problematic for a number of reasons. This article will discuss these reasons in the context of the current state of early intervention and provide recommendations for the new millennium.

Family-centered early intervention remains an elusive goal for our field. The following stories illustrate some of the challenges associated with this goal.

## MICHAEL

On April 29, 1999, my son Michael was born. He was unresponsive and very floppy. It was a horrible time because unlike when my daughter was born, all the nurses left us alone most of the time and kept shutting the door to my room. Because we insisted, a geneticist came to see him the next day. He ordered an MRI, ultrasound, and bloodwork and said he would get back to us the next week. Michael's pediatrician told my sister that she (the pediatrician) used to work with multihandicapped children, but hopefully Michael wouldn't turn out that way. We learned the next week that Michael had Prader-Willi syndrome.

Michael's first problem was with eating. As with most children with this syndrome, Michael's low tone interfered with his sucking and swallowing. My pediatrician told me it was okay because these children have a problem with eating too much. She also said we did not need early intervention until he was older.

We changed pediatricians (to one who was a father of a child with a disability) and started early intervention. After a brief phone conversation with someone from the county program, a packet of materials was sent to us (about an inch thick). My husband and I could not make sense of them, so we waited until a service coordinator

came to see us. I then signed about ten forms including insurance forms, and she scheduled assessments for Michael to see if he could get early intervention.

The early intervention evaluation was done by a feeding specialist and physical therapist because these were his primary needs. The two professionals came separately because they worked for separate agencies. They both expressed concern about Michael's lack of responsiveness and both told me that there was a Prader-Willi group home in the next town for when Michael was older. The reports they did on Michael were mailed to us about a week later. They were very detailed and very negative. While reading them, both my husband and I cried.

Next came our IFSP meeting. My mother, sister, and another parent were there with the service coordinator and another early interventionist. The evaluations were read, and when the service coordinator asked me if I had any questions, I asked, "How come the reports were so negative, and they didn't say anything positive or hopeful about Michael?" She told me that the therapists were doing their job, documenting Michael's needs. The service coordinator then asked me what I wanted for Michael and myself. I told her I wanted Michael to learn to do things any other baby did, like take a bottle and sit up and roll over. The service coordinator recommended weekly physical therapy and weekly feeding sessions. She said I could also have a special educator. I told her that would be too much because I was trying to get a routine for Meghan, Michael, and myself. I was also going back to work part-time. The service coordinator repeated that she thought I'd like the special instruction teacher, and

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we would benefit greatly from it. I asked her if it would harm Michael if he didn't get special instruction. My friend vehemently stated no, as did my sister. I started to cry then because I wanted to do what was best for Michael, and I don't think the service coordinator thought I did. She then asked if I had trouble getting Michael out into the community. I told her that Michael had attended a carnival and went out in a baby jogger with me every day. So she said that she wouldn't worry about natural environments, and anyway, he was only a month old. I asked what that meant, and she said not to worry about that now. The meeting then ended when I started to cry again because I thought she was talking about a special environment that Michael needed. On the way out, the service coordinator asked my sister what kind of work I did. When she was told that I had a master's degree in special education and was going back to teaching, she replied she had no idea that was my background.

Michael now receives physical therapy (PT) 2 times a week, weekly special instruction and speech, and the therapists just recommended two times a week OT. I pretty much go along when they recommend more services. The PT told me that she's concerned about weak stomach muscles. After the OT did the assessment, she called back and said she was sorry, but she made a mistake. Instead of doing 6-month skills, as she had told me, he was only really 2 months developmentally because she thought he was premature. She asked if I was upset. I told her no because I thought he was doing great anyway. My husband and I only want what's best for Michael, and early intervention is what they say he needs.

## CAMERON

My son Cameron has received early intervention services since he was discharged from the NICU two and one-half years ago. He is seen weekly by a physical therapist and an occupational therapist at my house. The dates and times of these visits change each week based on the availability of the provider. These visits always occur between 8 a.m. and 5 p.m. while my husband and I are working. One of us has to either take a day off from work or miss the visit.

Last April Cameron turned two, and I requested an IFSP meeting because I wanted to be present during these visits and I also wanted to be included in the "therapy." Previously, the therapists would enter my home, take Cameron from me, provide "hands on" therapy, and then schedule our next session. I did not feel my family was benefiting from these sessions. During the IFSP meeting, we were asked what our priorities were for Cameron. I responded that I desperately wanted to learn to play with my son. Cameron has multiple challenges including severe motor delays, which makes it difficult for us to interact with him. We also wanted Cameron to be

involved with his community. I was hoping they could assist us in finding a playgroup or some type of group setting in which Cameron could be around typical children and have an opportunity to make friends. At the end of our meeting I was asked to sign the IFSP, which identified the following goals: Cameron would lie on his stomach 5 times a day for 20 minutes each time. Mom and Dad would perform Cameron's oral-motor therapy before each meal. Cameron would work on improving his vision by looking in a mirror at himself. When I asked about community activities, my service coordinator said, "Well you know Cameron best; you know what he would enjoy." She then told me it was the state's policy only to support parents to do what they would naturally do if their child didn't have early intervention. But as a first time parent, I did not even know where to start. If I had been given some choices of opportunities, I would have been able to make a decision about the best places for Cameron.

I signed the IFSP because I was told that services could not continue unless it was signed. I was concerned because I did not think this would do anything for Cameron's development, and I knew it was not addressing our needs as a family. I also knew that I had a stack of previous IFSPs in which Cameron had not attained a single goal. I am starting to feel like a failure as a parent.

## ISAIAH

My son Isaiah has received early intervention services since he was seven months old. He had a very weak suck at birth. We spent 10 days in the hospital after he was born teaching him how to nurse. When he entered early intervention, his legs, neck, and abdomen were very floppy while his arms were very tense. His left side was significantly weaker than his right. He was extremely sensitive to any kind of stimulation and could only tolerate being in a few positions.

We moved to a different state for my husband's new job when Isaiah was 14 months old. My first priority was to make sure he didn't have a gap in early intervention services. Yet the state we were moving to refused to send my service coordinator or myself any information about the early intervention system until I had an in-state address. They explained they needed the address to document our contact. They also told me that assignment of services was dependent on the city we would be living in. This meant that I wouldn't be able to contact any provider of services without an address, even though we knew which metropolitan area we would be moving to. They neglected to tell me that most providers in this metropolitan area serve most of the surrounding cities. It took over a month to set up services once we did move. Isaiah was just on the cusp of gaining new skills in our

old environment; in that month without services, I desperately prayed he wouldn't backslide.

Isaiah's best motivator is other children. I have explained this to every early intervention provider and therapist who has worked with him in our new location. Yet no one has ever offered me concrete ideas about how to get him into an environment where he can safely watch, learn from, and play with other children. When I have told his therapists about the different activities I have found on my own and how frustrating getting into them can be, not one has ever offered to come with us to help Isaiah get the most out of the activity.

I finally decided I would have to put Isaiah in some kind of daycare to get him around other kids in a structured, secure, stable setting and, of course, find a job to pay for it. It breaks my heart to know that I, his own mother, can't motivate him to walk or crawl. Yet when I told this to his physical therapist, she said, "You can't be expected to work with him that way. You're not a physical therapist. He needs you to be his mother." How does that jibe with the fact that early intervention is supposed to teach me how to be my son's best teacher?

Settling Isaiah into daycare was a nightmare. He still wasn't walking or crawling at 18 months, although the other children in the room were learning how to run and jump. The daycare didn't believe me when I tried to tell them about Isaiah's needs. This happens because he is very cute and alert and interested in his environment—he just doesn't move. Early intervention did not offer to help me communicate these concerns, nor were they available to help with the initial fears the caregivers had when Isaiah first entered daycare. The early intervention therapists now work with Isaiah at daycare, and they leave written reports for me. Yet, I feel left out of the loop and removed from his development. For example, when he finally learned the sign for "more," I didn't know it because the report didn't say anything.

At almost 24 months of age, Isaiah is finally starting to crawl and walk with a walker. He is happy, sociable, and eager to explore his environment. To me, the rapid progress in his short life is due to two major decisions on my part, neither related to early intervention: to teach Isaiah to nurse because it helped him use both sides of his body and to calm down when on overload and to enroll him in daycare with other children.

The concept of family-centered care is not new; it was first used as a descriptor of service delivery in the 1960s (Wiedenback, 1967). Since the 1970s, families have been integrally involved in early intervention (Lilly, 1979; Tjossem, 1976). During the 1980s, the term family-centered care was formalized, as was family empowerment (Dunst, Trivette, & Deal, 1988), into a set of principles to guide service delivery for children with special health care needs (Shelton, Jeppson, & Johnson, 1987).

These principles were adapted by the early intervention field to describe the service delivery philosophy espoused in P.L. 99-457, Part H (now Part C) of the Early Intervention Program for Infants and Toddlers under the Individuals with Disabilities Education Act (IDEA; Florian, 1995). During the 1990s, family-centered early intervention became conceptualized around three values: (a) an emphasis on families' strengths rather than deficits, (b) the promotion of family choice and control over desired resources, and (c) the development of a collaborative relationship between professionals and parents (Dunst, Trivette, & Deal, 1994). Over the years, the philosophical basis for family-centered care was further refined into a set of practices that have been validated through research (Dunst, 1997; McWilliam, Tocci, & Harbin, 1998; Trivette, Dunst, Boyd, & Hamby, 1996) and used as a foundation for early intervention personnel training programs in this country and abroad (Granlund & Bjorck-Akesson, 1999; McBride & Brotherson, 1997). Currently, families are considered to be integral to the successful early intervention for their children (Bailey et al., 1998; Bromwich, 1997; Guralnick, 1998; Roberts, Innocenti, & Goetze, 1999).

In this issue, my colleague Carl Dunst has proposed an early intervention model that integrates a variety of family-centered factors that contribute to the competence and learning of children, which to me is the foundation for early intervention in the new millennium. However, the actualization of such a model is still an elusive goal for many. This is painfully evident in the above stories, all of which occurred in 1999. These three families did not have the opportunity to experience family-centered early intervention as exemplified in either philosophy or practice.

It would be easy to dismiss these stories as aberrations (as I wish I could); however, when compared to recently published literature on early intervention practice, they are not surprising (cf. Filla, Wolery, & Anthony, 1999; Strain, 1999; Warren, 1998). For example, studies have suggested that IFSPs still stress child outcomes to the exclusion of more broad-based family mediated outcomes and support strategies (Boone, McBride, Swann, Moore, & Drew, 1998; Bruder, Staff, & McMurrer-Kaminer, 1997; Farel, Shackelford, & Hurth, 1997; McWilliam et al., 1998; Summers et al., 1990); studies have also shown that service providers struggle with the delivery of services that include families (Filer & Mahoney, 1996; McBride & Peterson, 1997; McWilliam et al., 1995; McWilliam, Tocci, & Harbin, 1998). Additionally, both providers and researchers struggle with whether parent education and intervention on parent-infant interaction is encompassed within a family-centered framework (Mahoney et al., 1999; McCollum, 1999), whether early intervention should be child-centered or family-centered (Able-Boone, 1996; Beckman, Frank, & Newcomb,



1996), and whether the emphasis in early intervention should be relationship focused (Kelly & Barnard, 1999).

Rather than put blame on any one cause as the reason for the lack of family-centered early intervention, I feel that all levels of our field must take responsibility for contributing to this situation. The inability of our field to enforce rigorous evidence-based standards of practice within a value-driven model of family-centered early intervention has caused frustration, anguish, and confusion among parents and professionals alike. It is with a note of impatience, then, that I propose a renewed emphasis on the values that should guide us as we attempt to facilitate children's development and competence. I state this as one who is impacted personally by the field's inability to come to consensus on a collective vision of family-centered early intervention. Besides the stories I hear from my students and as a member (and former chair) of my state Interagency Coordinating Council, I am intimately involved with Michael, Cameron, and Isaiah and interact with their families on a daily basis. Of most relevance to me as I write this article is the fact that Michael is my nephew, and I am as responsible as any for the shortcomings in our field that are currently impacting his life. In this article I will attempt to provide a vision for the field of family-centered early intervention in the new millennium—one that begins with values. I will do this by revisiting where we have come from, where we are, and where we should be.

## FAMILY-CENTERED EARLY INTERVENTION

### *Where Have We Been?*

The rich history of our field during the past 30 years has provided a foundation about child growth and development in the context of interventions aimed at minimizing the impact of a child's delay or disability and promoting his or her competence. An important component of this process is the family because it is within this unit that the child spends most of his or her time. Conceptualized from an ecological model of human learning and development (Bronfenbrenner, 1992), early intervention views child, parent, and family functioning as complex: The processes that influence early learning and development are produced by the interaction of the environments experienced by a child and the characteristics of the people (including the developing child) within these environments (Dunst, Trivette, & Jodry, 1997). This framework suggests that early learning and development varies as a function of both person and environmental characteristics and the combined influences and interactions between these characteristics. These characteristics have further been conceptualized as falling into two categories: risk and opportunity factors (Garbarino, 1992). For ex-

ample, risk factors can impede child development and negatively impact child (and family) outcome; however, opportunity factors can enhance child development and resilience and positively impact child and family outcome.

The family context and the experiences provided within this context are extremely critical to a child's development (Dunst, 1999b; Guralnick, 1999). Thus, the importance of families has been acknowledged by early intervention for many years, and family-centered models are a logical expansion of practices that aim to maximize intervention efforts. Besides the obvious fact that the caregiving family is the constant over the child's life span, it should also be acknowledged that families spend the most time with their child. Even in the rare instances where a toddler receives up to 20 hours of structured interventions (e.g., recommended for a child with autism), this represents only 20% of a child's waking time. Because most children in early intervention receive far fewer service hours than this (Bruder & Staff, 1998; Kochanek & Buka, 1998), it is obvious that families (or other caregivers) have the opportunity to provide the greatest influence on a child's developing competence.

The most prevalent data that have been collected on family factors that influence child competence have focused on parent characteristics. For example, parents' education level, socioeconomic status, and environment have been related to child development (Garbarino, 1990; Werner, 1990). In early intervention, these characteristics have also been related to service delivery patterns (Bruder et al., 1997; Kochanek & Buka, 1998; Sontag & Schacht, 1993). Other family factors that have been identified over the past 20 years as contributing to child competence include parents' ability to follow intervention recommendations for facilitating child development, parent-child interaction patterns, and quality of life improvements (Bricker, Bruder, & Bailey, 1982). The first two are fairly straightforward (although challenging) to measure, and findings suggest that interventions employed in these areas result in improved child competence (Kaiser, Hancock, & Hester, 1998; Kaiser et al., 1996; Mahoney, Boyce, Fewell, Spiker, & Wheeden, 1998; McCollum & Hemmeter, 1997). However, quality of life indices are considerably more complex to describe and measure as the construct implies a family's personal interpretation of their well-being, life satisfaction, and interpersonal relationships. Bailey, et al. (1998) identified specific challenges to describing family quality of life, including definitional aspects and measurement challenges. Nonetheless, quality of life factors may serve as an important facilitating factor (or risk factor) to child competence and well-being (Roberts et al., 1999). An additional contributing factor to overall quality of life is the availability of social support for families, in particular informal support networks. A review of literature per-

taining to the role of social support in early intervention concluded that social support has direct, mediational, and moderating influences on the behavior and development of children with disabilities and their families (Dunst et al., 1997). In particular, informal support (personal networks) showed the strongest relationship to both family and child outcomes (Dunst, 1999b).

Parental attitudes and belief systems represent another variable that enhances children's competence (Guralnick, 1999). Accumulated evidence pertaining to parent and family belief systems indicates that beliefs influence any number of child referenced variables (Sigel, McGillicuddy-Delisi, & Goodnow, 1992). This includes, but is not limited to, parents' beliefs and home learning environments (Johnson & Martin, 1985), parents' beliefs and child rearing practices (Sameroff & Fiese, 1992), parent's beliefs about child social competence (Mills & Rubin, 1992; Mize, Pettit, & Brown, 1995), parents' beliefs and decisions about child education practices (Schaefer & Edgerton, 1985), parents' beliefs about their need for early intervention (Affleck et al., 1989), and the interaction between parents' beliefs about early education and parent education and family socioeconomic status (Sigel, 1985). Special consideration has also been placed on the cultural belief systems of families (Chen, Brekken, & Chan, 1997; Turnbull, Blue-Banning, Turbiville, & Park, 1999) as beliefs about how children learn and parental roles have been attributed to ethnicity, and both acculturation and enculturation (Dunst, Trivette, Hamby, Raab, & Bruder, 1999; Leyendecker & Lamb, 1999). Lastly, renewed emphasis has been placed on family orchestrated learning experiences as a factor that contributes to child competence (Dunst, Bruder, Trivette, Raab, & McLean, 1998; Guralnick, 1998).

As a result of these cumulative findings, it has been recommended that early intervention provide families with a sense of confidence and competence about their children's current and future learning and development (Dunst, this issue; Bailey et al., 1998; Turnbull & Turnbull, 1997). In particular, parents should be given information in a way that supports their ability to parent their child and facilitate learning without threatening self-confidence and cultural, religious, or familiar traditions. Family diversity and the reciprocal nature of the relationship between family members and early interventionists should be the driving force within a family-centered approach.

### **Where Are We Now?**

Despite the rich, cumulative history about the importance of families within the early intervention process, there remain many questions about the implementation of policies and practices that support family-centered early intervention. From Michael's entry into the system,

to Cameron's need for effective interventions, to Isaiah's transitions, it is apparent that their parents are not integrally and appropriately involved in their children's interventions. There may be many reasons for the individual situations portrayed by the stories, yet the application of appropriate family-centered practices seem to stem from four identified areas of concern: the research-to-practice gap (Carnine, 1999; Rule, Losardo, Dinnebeil, Kaiser, & Rowland, 1998); the current status of training in early intervention (Winton, McCollum, & Catlett, 1997); the complexity of Part C service requirements (Dunst, 1999a); and, most importantly, the attitudes of those in early intervention.

Numerous problems have been cited with current research models; most notably about the translation of findings into practice (cf., Abbott, Walton, Tapia, & Greenwood, 1999; Brandtstadter, 1980; Dunst, 1989; Malouf & Schiller, 1995; Paine, Bellamy, & Wilcox, 1984; Rule et al., 1998). These problems occur within the field of family-centered early intervention, as it has been documented that program administrators and practitioners are not using research findings on family-centered practices nor do they value a family-centered philosophy (Bruder & Staff, 1999; Johnson et al., 1992; Romer & Umbreit, 1998). A number of reasons have been identified as contributing to this research-to-practice gap. First, is the implementation of research studies that do not provide operationalized descriptions of the independent variable(s) that are responsible for change in the dependent variable(s). This lack of descriptive information then inhibits any replication efforts of the practices responsible for positive outcomes. An additional reason for the research-to-practice gap could be the lack of attention paid to the differences and necessary interrelationships between the research process and the subsequent dissemination of research findings. That is, when researchers produce important outcomes, they may erroneously assume that the practices responsible for the outcomes will be unquestionably embraced and wholeheartedly implemented by practitioners. One last reason for the research-to-practice gap may be the failure of researchers to address the needs and objectives of different audiences in the development and implementation of both their research and dissemination activities. In an effort to remedy this research-to-practice gap, a number of specific activities have been validated (Abbott et al., 1999; Carnine, 1999; Paine et al., 1984). Unfortunately, they have not been used extensively, again, suggesting a gap between knowledge and practice.

Another barrier to the adoption of family-centered early intervention is the lack of effective training models for personnel responsible for the delivery of services. Criticism has been leveled at the type of preservice training available to both undergraduate and graduate students in early intervention (Kilgo & Bruder, 1997), and

this criticism has also been applied to inservice activities (Bruder & Nikitas, 1992; Gallagher, Malone, Cleghorne, & Helms, 1997). Currently, each professional discipline involved in early intervention has its own training sequence (some require graduate degrees, others require undergraduate degrees), and there is no guarantee that graduates will have any exposure to young children and their families. Compounding these differences in training are differing philosophical and treatment options that affect the delivery of services within a discipline-specific area, such as motor therapy (Horn, 1997), or a specific etiology, such as children with autism (Dawson & Osterling, 1997) or children with cerebral palsy (Adams & Snyder, 1998). These challenges are complicated by a lack of professional standards specific to those providing intervention across professional disciplines. In particular, specialty standards for infants and toddlers with disabilities are virtually nonexistent (Bruder, Hains, & Yates, 1995).

In an effort to remedy this situation, specific training recommendations have been made for all involved in the delivery of early intervention (Buisse & Wesley, 1993; Striffler & Fire, 1999; Winton et al., 1997). These recommendations include both discipline-specific skills in infancy, early childhood development and family-centered practices, as well as interdisciplinary and interagency skills necessary for the implementation of early intervention. These skills also include being able to function as a team by sharing and utilizing other team member's expertise for both assessment and program planning. The most promising strategy for doing this is through interdisciplinary or interprofessional models of training (Casto et al., 1994), although multiple barriers exist to the adoption of these models, and as a result, they are not very prevalent (Kilgo & Bruder, 1997; Striffler & Fire, 1999).

Another reason that may inhibit the delivery of family-centered early intervention could be the current emphasis on early intervention systems under Part C of IDEA (cf. Dunst, 1999a). The programmatic requirements of Part C are complex, therefore, necessitating a high level of professional values, knowledge, and skills on the part of state and local administrators. Unfortunately, it has been documented that most early intervention administrators feel that they need additional training in specific skills not taught to them in preservice programs in order to do their job (Johnson et al., 1992). Compounding this lack of competency among administrators is the fact that state and local systems of early intervention currently use finance models that are composed of billable services that by tradition are child-focused within a rehabilitative model of intervention, thus making family-centered practices difficult to implement and necessitating a high level of commitment and creativity on the part of those administering services (Coolman, Foran, & Lee, 1998; Jackson, 1998). Regulatory requirements, such as funding

streams that are categorical- and discipline-specific, may in fact be a barrier to effective service implementation, and these must be overcome (Kates, 1998; Roberts et al., 1999). Unfortunately, it is becoming clear that the structure of Part C early intervention systems may be mired in bureaucratic requirements that put the focus on variables other than family-centered services.

A last and most important reason for the lack of implementation of family-centered early intervention may be the attitudes of those in early intervention who still see themselves as "expert" and the family as "client." While it is true that professionals have a lot of knowledge and expertise about effective interventions that should be shared with families, it is also true that families have a lot of information to offer early interventionists about their unique situation, their child's competencies, and the activities they participate in and learn through. Attitudes are the hardest things to teach and change (Harris, 1980), and attitudes are powerful determinants of both child and family outcomes (Affleck et al., 1989). Attitudes don't just permeate individuals, but they are embraced and reflected by agencies, organizations, communities, and constituents of communities such as those conducting research, training and service delivery. If one part of a system does not demonstrate family-centered attitudes, it is hard for the others in a system to override the damage this causes. However, a number of strategies have been used successfully to positively impact attitudes toward family-centered early intervention, and these are available for use by researchers, administrators, trainers, supervisory personnel, and others (cf. Capone, Hull, & DiVenere, 1997; Catlett & Winton, 1997; Edelman, 1991; Johns & Harvey, 1993; McBride & Brotherson, 1997; McWilliam & Bailey, 1993; Snyder & McWilliam, 1999).

### **Where Are We Going?**

I would like to think that as the field of early intervention gets older, it can also get wiser. This would mean using our collective knowledge base to ensure the delivery of early intervention services to children in a manner that is family-centered in both philosophy and practice. What does that mean? Philosophically, I think that the field needs to both individually and collectively clarify its values about why and how we implement early intervention. Beginning with why we are involved with early intervention, I would hope it is because all of us in the field want to help children succeed. If so, we need to renew our commitment to helping families (however they define themselves) help their children become competent within a reciprocal learning relationship built on respect. We must always remember that the children we serve belong to their families, and we are privileged to be in their lives for a short time. Except in instances of abuse and ne-



glect, our responsibility is to support the family in their caregiving role so that they can facilitate their child's learning and development. This allows us to focus on, and contribute to, the difference that can be made in the lives of families as they become more able to facilitate the changes they want for themselves and their child.

How do we accomplish early intervention? I would hope that this would reflect the value we have for evidenced-based practices, as opposed to interventions based on habit, ungrounded philosophy, or ignorance. As previously stated, the field of early intervention for children with disabilities has empirical evidence supporting certain practices that facilitate family and child competence. These practices include treating families with dignity and respect; being culturally and socioeconomically sensitive to family diversity; providing choices to families in relation to their priorities and concerns; fully disclosing information to families so they can make decisions; focusing on a range of informal, community resources as sources of parenting and family supports; and employing helping practices that are empowering and competency-enhancing (Dunst, 1999a). Considerable literature has been amassed on the individual and collective use of these practices, as they add value to early intervention by contributing to improved family and child outcomes (cf., Dunst, Brookfield, & Epstein, 1998; Dunst, Trivette, Boyd, & Hamby, 1996; Mahoney & Bella, 1998; McWilliam, Tocci, & Harbin, 1998; Thompson et al., 1997; Trivette & Dunst, 1998). The field of early intervention, and the broader field of disabilities, is beginning to coalesce around the value for recommended practices as both a vehicle to translate research to practice and to reform pre- and inservice training activities (Odom & McLean, 1996; Peters & Heron, 1993).

In addition to these observations on the value of family-centered philosophy and evidenced-based practices, there are a number of specific expectations I have that are unique to certain components of family-centered early intervention:

**Research.** I hope that in the new millennium all research in family-centered early intervention will be participatory. The participatory approach (Calhoun, 1993; Ketterer, Price, & Politser, 1980; Lytle & Cochran-Smith, 1992; Sagor, 1992) presumes that knowledge is socially constructed (Mishler, 1990), contextually grounded (Glaser & Strauss, 1967), and experience-based (Kuhn, 1970). The convergence of these perspectives provides a sound match with the focus of ecocultural theory, where the prevailing foundation is one that supports the expertise and knowledge of consumers. This is because consumers are the most knowledgeable about local contexts and conditions and most optimally situated to design, implement, and evaluate solutions that are most appropriate for those situations. Participatory research designs en-

sure that stakeholders from all levels in the system are involved in the design, implementation, and evaluation of research. A caveat in participatory designs (that is self-evident) is that participants are given opportunities to learn about research as a collaborative process rather than something done "to" them. To attempt to understand the complexities of family-centered early intervention without the integral involvement of families in all facets of research is not only ludicrous, it is unconscionable.

A second hope I have for research in family-centered early intervention is that researchers broaden their individual and collective perspectives to understand, appreciate, and build upon efforts of others, both in the small field of early intervention and the larger fields of family support, community action, adult education, child health and development, developmental disabilities, and education for older children. Only in this way will we be able to move beyond self-perpetuating agendas to rigorously address issues that can positively impact our current society and the children in it.

**Personnel Preparation.** We have amassed quite a literature on training models that encompass strategies for effective family-centered early intervention (cf. Winton et al., 1997). These strategies include the effective use of adult learning principles; team based training; supervision, mentoring, and coaching; case study methodology; and the provision of ongoing follow-up support (Bruder & Nikitas, 1992; Gallagher, 1997; Sexton, Snyder, & Lobman, 1997; Snyder & McWilliam, 1999; Winton, McWilliam, Harrison, Owens, & Bailey, 1992). Most recently there has been an emphasis placed on interprofessional models of preservice training (Kilgo & Bruder, 1997) and the building of learning communities as an inservice model of change (Senge, 1994).

I would hope that those responsible for training in the millennium will move beyond the current situation in which the norm is the use of ineffective training models (episodic, short-term workshops) to embrace and institute more effective models of change. In particular, the methodology of learning communities lends itself to all levels of early intervention. The core of this work is based on five "learning disciplines" that involve lifelong programs of study and practice (Senge, 1994, p. 6). These are personal mastery, mental models, shared vision, team learning, and systems thinking. Learning communities use a refined strategic planning process (see Senge) that allows a group or individual to develop a learning model to solve a current practice problem. The steps include (a) identify the symptoms of the problem, (b) map all the quick fixes, (c) identify the undesirable impacts on all levels of a system, (d) identify fundamental solutions, (e) map addictive side effects of quick fixes, (f) find interconnections to fundamental loops, (g) identify high-leverage actions. At each step, appropriate training content is



identified by the learner. Learning communities are ongoing with follow up provided both individually through technical assistance (phone, e-mail); in dyads via mentorship models; or in groups using technology, such as distance education models. Computer technology, can also be used to develop Web sites and listservs to facilitate the continuation of problem solving through dialogues.

**Program Administration.** When looking to the future, it is apparent that the type of personnel who are employed as state and local early intervention administrators need to have the capacity for leadership. This is the only way early intervention systems will be in the position to take on the challenges imposed by the changing demographics in our society, the increased service demands, decreased funding, and need for more integrated systems of care (Stayton & Bruder, 1999). In a study of nine early intervention communities across three states, it was documented that program leadership is an integral component to the quality of programs (Harbin & West, 1998). In addition, there was a strong link between the quality of the leaders and quality of service providers. In other words, knowledgeable and skillful leaders had selected and employed a higher proportion of quality service providers. Conversely, in communities where program administrators lacked quality leadership skills, service providers also tended to lack important characteristics and skills as well. Yet, little focus has been put on the cultivation of leadership skills and principles in either our personnel preparation programs or service delivery systems. It may be that in early intervention, we have adopted less of a leadership model and more of a management style attributed to the complexities of the Part C program. Unfortunately, in doing so we may have created systems that are more focused on structures, funding, procedures, and policies to the exclusion of values, vision, effectiveness, and results (Covey, 1991). Good management is a component of leadership, not a substitute.

Leadership can be broken into two parts: one dealing with vision, direction, values, and purposes and the other encompassing the motivation and inspiration of people. Leaders must establish and maintain a number of essential working principles that become inherent to the organization they are leading (DePree, 1992). These include a rational environment; a clear statement of the organization's values; openness to change and innovation; maturity; space for people to grow; momentum; effectiveness; and most importantly, stewardship (Block, 1996). In the field of family-centered early intervention, we must begin to demand that administrators display the leadership necessary to create and lead rational, value-driven, and innovative organizations.

**Service Delivery.** My hope for service delivery in this millennium is that decisions and practices will be devel-

oped in tandem with families' stories, dreams, and fears. This criteria should be evident throughout every facet of service delivery, beginning with first contacts, through the reciprocal exchange of information, education, and support, and ending at transition out of early intervention. Every family has a rich history and unique system that provides the context for the intervention process, and this is where service delivery should begin. My expectation is that within such a model, evidenced-based practices in early intervention can be embedded to ensure positive outcomes across families in particular (including the child) and the system in general.

The Early Childhood Research Institute on Increasing Children's Learning Opportunities through Families and Communities (directed by Carl Dunst and myself) has documented the abundant number of learning opportunities identified and used by families to develop their children's competence (both with and without disabilities). For example, in one of our studies of home and community life, 134 children with disabilities participated in visiting an average of 15 different locations where they experienced an average of 87 different kinds of activity settings that held unique value to the family. These activity settings, in turn, resulted in an average of 113 different kinds of learning opportunities (Dunst, Bruder, et al., 1998). Unfortunately, these data also revealed a blatant disconnect between what the families perceived as learning opportunities for their child in the home and community and what was occurring in the children's formal intervention programs. In the future, I hope that early interventionists will use and expand family-identified learning opportunities as a way to facilitate both child and family outcomes. In order to do this, services must be built around what families value and the activity settings they identify for their children.

## CONCLUSION

One prediction for the new millennium I am confident about: Most parents will not choose to have a child who needs early intervention. Yet, most professionals will still have a choice about participating in early intervention as a job, career, or avocation. To me this means that it is the responsibility of those of us who work in this field to create systems of early intervention that reflect a family-centered philosophy embedded within the implementation of validated early intervention practices. It is time to move beyond rhetoric and provide early intervention services and supports that are respectful, evidenced-based, and appropriate for each family's unique situation.

My most fervent hope for family-centered early intervention in the new millennium is that the stories told at the beginning of this article will be read as works of fiction in the not so distant future. The most important

value that can help this happen is empathy. Webster's *Third New International Dictionary* (Gove, 1993) defines empathy as "the capacity for participating in, or a vicarious experiencing of another's feelings, volitions, or ideas." Empathy allows all of us in early intervention (researchers, trainers, administrators, and service providers) to envision what the world is like for each family we serve so that we can provide help in the ways that are most sensitive and appropriate to their needs. This perspective was described as the "shoes test" by the Turnbells in the 1980s (1986)—that is, putting on another's shoes as a way of gaining their perspective. The value of empathy has as much relevance today as it did 15 years ago. If everyone who was involved with Michael, Cameron, and Isaiah's early intervention could embrace empathy and put on the shoes of these boys' parents, I would like to think the stories would be very different.

In closing, I hope that we all can empathize with the fact that time is passing: Michael, Cameron, and Isaiah are getting older, as is Michael's very impatient aunt who wants the most effective outcomes possible for him and his family and everyone else in early intervention. ♦

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