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FAMILY AND SERVICE COORDINATOR AGREEMENTS IN THE
DEVELOPMENT AND IMPLEMENTATION OF THE
INDIVIDUALIZED FAMILY SERVICE PLAN
(IFSP)

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ABSTRACT

FAMILY AND SERVICE COORDINATOR AGREEMENTS IN THE DEVELOPMENT AND IMPLEMENTATION OF THE INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

by

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Part C of Public Law 105-17 (originally Part H of Public Laws 99-457, 101-476, and 102-119), the Individuals with Disabilities Education Act (IDEA) of 1997, strengthened incentives to states to provide services for infants and toddlers, from birth to age three, who have disabilities or are at-risk for developmental delays. The law and its regulations require that the Individualized Family Service Plan (IFSP) is a written plan for services to be developed and implemented for the child and family. Inclusion of family members as full participants in the design and implementation of services is emphasized.

This study was designed to determine if families and their service coordinators agree on IFSP goal/outcome
appropriateness, services provided, the family's priorities and concerns, and the effectiveness of services as well as whether or not the IFSP helps to create the family-centered services. The results were used to test four major assumptions in the law and literature related to the factors above.

A survey instrument was used to obtain the level of agreement and other information on the topics above from families and service coordinators. The questionnaire also had six open-ended questions and provided respondents with comment sections for response elaboration. The ratings were analyzed using frequency counts, Chi-square test of Independence, and correlations to determine agreements and differences between the family and their service coordinator.

Results of this study suggest that the basic assumptions made about families and service coordinators in the law appear to have been met. Most family and service coordinator responses generally showed the IFSP process to be effective and supported its continued use.
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CHAPTER 1

INTRODUCTION

This chapter provides an overview of a study based on mandates in the Individuals with Disabilities Education Act (IDEA) and its amendments of 1997. The mandate for use of the Individualized Family Service Plan (IFSP) is the genesis of the statement of the problem, purpose of the study, and significance of the study. The specific research design and items required to address the purpose are presented following a summary of the law and the IFSP mandate.

The IDEA Amendments of 1997

On June 4, 1997, President Clinton signed into law the Individuals with Disabilities Education Act (IDEA) Amendments of 1997, P.L. 105-17. This law amended and reauthorized the IDEA. The 1997 amendments added a number of major provisions to the IDEA that will result in substantial changes in special education, as well as in the roles of administrators, general educators, special educators, teacher trainers, and related specialists. These amendments create some next steps in providing special education and related services (Yell & Shriner, 1997).
The congressional process of the reauthorization provides an opportunity to strengthen and improve laws. The intent of the IDEA amendments (Senate Report, 1997, p. 5) was to:

1. Strengthen the role of parents.
2. Ensure access to the general education curriculum and reforms.
3. Focus on teaching and learning while reducing unnecessary paperwork requirements.
4. Assist education agencies in addressing the costs of improving special education and related services to children with disabilities.
5. Increase attention to racial, ethnic, and linguistic diversity to prevent inappropriate identification and mislabeling.
6. Ensure that schools are safe and conducive to learning.
7. Encourage parents and educators to work out their differences using nonadversarial means.

Originally, the Individuals with Disabilities Education Act (IDEA) was divided into nine parts or subchapters. In the IDEA amendments of 1997, the law was restructured into four parts:

1. Part A contains the general provisions of the law (e.g., definitions).
2. Part B details the funding program that requires states receiving federal assistance under the IDEA
to ensure a free appropriate public education to all qualified children and youth with disabilities residing in a state. Part B also contains the procedural safeguards designed to protect the interests of children and youth with disabilities.

3. Part C (originally Part H) extends Part B protections to infants and toddlers with disabilities and offers incentives for states to provide services to infants and toddlers (birth to age 3).

4. Part D is composed of the discretionary or support programs. These programs have been enacted to address various concerns regarding the education of students with disabilities. Part D contains provisions regarding state improvement grants for educating students with disabilities, research, personnel preparation, technical assistance, dissemination of information, parent training, and technology development.

Public Law 105-17

Public Law 105-17 was enacted in 1997 and expanded the educational opportunities through Part C for infants and toddlers with disabilities, or for those at-risk of disability and their families by offering states incentives to provide early intervention services to children from birth through age 2 and their families. Part C also asserted (as in the previous Part H) that a major goal of early intervention
is "to enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities" (Education of the Handicapped Act Amendments of 1986, P.L. 99-457, 100 Stat. 1145).

States are required to develop criteria for admission to services, methods for evaluation of infants and toddlers, and a program plan called the Individualized Family Service Plan (IFSP). The goal for such early intervention programs is to improve developmental outcomes for the infant or toddler and to enhance family support (Wayman, Lynch, & Hanson, 1991). To achieve this goal, it was believed that programming must be tailored to individual child needs as well as family needs (Meissels & Provence, 1989).

The IFSP is only one of the 14 components of the law, but is noteworthy because it was mandated to be a proactive process for developing a family-centered system of services (Brown, 1991; Johnson, McGonigel, & Kaufmann, 1989). The IFSP was a promise of appropriate early intervention for children and families that most likely can be met only through interagency and interdisciplinary partnerships among parents and service providers (McGonigel, Kaufman, & Johnson, 1992). Under this policy, early interventionists who provide services to individual families are assumed to have the skills necessary to evaluate and understand how each family defines an IFSP as being family-centered.

For a family to participate actively in family-centered services, it also was assumed that the members of the family...
could and would perceive their empowerment. The family-centered philosophy in the IFSP is based on concepts of enabling and empowering families, as discussed by Dunst and colleagues (1988).

"Enabling families means creating opportunities for families to apply their competencies and to acquire new ones as necessary to meet their needs and needs of their children. Empowering families in early intervention means interacting with families in such a way that they maintain or acquire a sense of control over their family life and attribute positive changes that result from early intervention to their own strengths, abilities, and actions" (p. 5).

Some authors have stated that family empowerment can be observed when families act to change the condition of their lives and acquire control to manage their own family according to their preferences and priorities (Kalyanpur & Rao, 1991). In traditional service models, prior to enactment of Part C, the service providers have held the power of decision making and intervention planning. Families, reportedly, were expected to be fairly passive recipients of decisions and information from service providers (Turnbull & Turnbull, 1990). In the current view of family-centered practices, families have moved into the "power" position.

The Individualized Family Service Plan (IFSP) is a major mandate of the Part H/C provisions of P.L. 102-119 and P.L. 105-17 to provide programming for infants and toddlers and their families. The law establishes parents as educational decision-makers and recognizes the critical role parents and families assume in the development of a child. It strongly
supports early intervention and the belief that a comprehensive program for the whole family is necessary to foster optimal development in the child. It also intends for family members to become full team members, and have the ultimate decision-making authority.

An Individualized Family Service Plan (IFSP) is a "blueprint for guiding resource mobilization designed to meet child and family needs" (Dunst & Deal, 1992), and is developed collaboratively by the family and other team members. The IFSP became an increasingly critical instrument in implementing early intervention programs in the early 1990s (or as states approached Year-5 of Part H implementation) and currently is a working policy and process for effective early intervention planning and programming. In learning the process of creating an IFSP document, personnel also learned they were required to make major shifts in ways they traditionally rendered services to children (Dunst et al., 1992). The new process assumed that early intervention personnel could make a transition from directing a child's intervention program to enabling and empowering the family to be primary decision-makers (Meisels & Shonkoff, 1990).

Part C of P.L. 105-17 extends Part B protections to infants and toddlers with disabilities and the 1997 amendments emphasize serving them in natural environments. The effective date of these amendments was July, 1998.
Statement of the Problem

Prior to 1986, the professionals providing services to families of children with special needs tended to focus intervention directly on the child (Bazyk, 1989; Bailey, Simeonsson, Yoder, & Huntington, 1990). Currently intervention programs are supposed to recognize the valuable role that most family members assume in the overall well-being of the child with special needs, not as para-professionals, but as parents, brothers, sisters and extended family members (Dunst, Trivette, & Deal, 1988; Bailey, Winton, Rouse, & Turnbull, 1990; Raver & Kilgo, 1991). Such recognition requires a shift from the child-centered to a family-centered service delivery system (McGonigel et al., 1991).

The content of the Individualized Family Service Plan (IFSP) is reflective of the shifting views about what constitutes preferred practice in early intervention for infants and toddlers with or at-risk for disabilities. Traditionally, early intervention was child-focused and the major purpose was to enhance the developmental outcomes for young children with disabilities. Over the past few years, however, it has been argued that a primary mission for early intervention is family support (Bailey et al., 1992). According to Zigler and Black (1989), the ultimate goal of a family support program is "to enable families to be independent by developing their own informal support networks" (p. 11). In early intervention, numerous labels
have been applied to the family support movement, including parent empowerment (Dunst, 1985; Dunst et al., 1988), family-focused intervention (Bailey et al., 1986), and family-centered care (Shelton, Jeppson, & Johnson, 1987). Although their models differ in some respects, each incorporates the following basic assumptions. First, children and families are inextricably intertwined. Intentional or not, intervention with children almost invariably influences families; likewise, intervention with and support of families typically has an influence on the children. Second, involving and supporting families is assumed to be a more powerful intervention than one designed exclusively for the child. Third, family members should be able to choose their level of involvement in program planning, decision making, and service delivery. Fourth, professionals should attend to family priorities for goals and services, even when those priorities differ substantially from professional priorities.

Early interventionists who provide for services to families must be able to evaluate and understand how each family defines an IFSP as being family-centered. No standards, however, are designed to obtain this information from a family. Various authors have stated that the interventionist typically fosters the family's growth as the ultimate decision makers in planning and implementing of a program for their child with special needs. The interventionist also should understand the ways in which family characteristics and experiences influence families in
constructing their conceptualization of family-centered early intervention (McWilliam & Bailey, 1993).

To meet the principal intent of the law, and to be in procedural compliance with it, the IFSP document is to be in writing and contain seven components designed to enhance and clarify services (Eck, 1994). Inherent in the inclusion of requirements for content of the IFSP is the assumption that those who implement the process will comply with the requirements.

Further, Bailey and Simeonsson (1984) identified the following critical assumptions concerning family involvement:

1. Families have unique needs and each child and family should be evaluated and treated as a unique unit.

2. Services to infants or toddlers will be enhanced when parents have full membership on the interdisciplinary team.

3. Parents need help to teach and manage their at-risk or developmentally delayed infant or toddler and outcomes for that child will be enhanced when the family receives support.

Unlike the IFSP, other legislated service plans, such as the Individualized Education Plan (IEP) and the Individualized Program Plan (IPP), are professionally driven and developed through a process where professionals share with parents the evaluation information and desired goals and objectives (Campbell, Strickland, & LaForme, 1992). P.L. 94-142 mandated an active role for families, but reviews suggest the intent envisioned in the legislation has not been realized and that professionals placed relatively little
value on parents' input (Smith & Simpson, 1990). In contrast to P.L. 94-142, P.L. 102-119 and the most recent amendment, P.L. 105-17, the Individuals with Disabilities Education Act (IDEA) placed greater emphasis on the requirement of family involvement in the development of the service plan, the IFSP (Bailey, Palsha, & Simeonsson, 1991). The extent to which the family can be involved in an informed and meaningful way is dependent on the extent to which the professionals who evaluate and have prescribed interventions for the child are able to make recommendations that can be understood and utilized by the involved family members (Eck, 1994). Also the family member(s) must be able to communicate precisely and clearly the needs of the child as well as the family.

Need for Research

The Individuals with Disabilities Education Act (IDEA), Part C, created major challenges and opportunities for the development and delivery of family-centered early intervention services to children with disabilities and their families. Part C is unique in that the family, rather than just the child, is the recipient of services (Krauss, 1990). The Individualized Family Service Plan (IFSP) is the mechanism that allows for expansion of the intervention focus to include goals, services and outcomes for families and their children (McBride, Brotherson, Joanning, Whiddon, 1993).
Farel, Shakelford, and Hurth (1997) indicated that the IFSP process is a core tenet of Part C that mandates the family's central role as partners with professionals in identifying appropriate interventions for the infants and toddlers with special needs. The service coordinator is responsible for assisting the family through this process, from assessment of the child's developmental status and family concerns, priorities, and resources, through the development, implementation, and monitoring of the IFSP.

Although this family-centered process for developing the IFSP is assumed to require a significant change in the orientation and perceptions of professionals in working with families (Bailey, Buysse, Edmondson, & Smith, 1992), studies of family and service provider perceptions and experiences of how the process works are lacking. Little is known about how congruent the perspectives are between those providing and those receiving early intervention services (Sexton, Snyder, Wadsworth, Jardine, & Ernest, 1996). Although some surveys of families and service providers have been conducted, analyses of their perspectives on their roles in early intervention and the IFSP process have not been reported (Farel et al., 1997).

The assumptions that underlie the required IFSP process for obtaining family involvement need to be tested because the link between the professional and family recommendations in developing the IFSP goals or outcome statements appears to be critical to provision of appropriate services (Eck, 1994).
Further, services provided to infants and toddlers need to be evaluated to establish which factors, if any, lead to improved outcomes for these children and their families (Eck, 1994). Yoder (1990) also called for research on the assumptions related to family involvement and provisions of family supports. Campbell (1991) stated the link between evaluation and the IFSP process requires flexibility to ensure that early intervention services address the changing needs of infants, toddlers and families.

**Purposes of the Study**

This study was designed to determine if families who have children eligible for services under Part C of the Individuals with Disabilities Education Act (IDEA) and service coordinators agree to the appropriateness of the goals, services provided and outcomes as developed in the Individualized Family Service Plan (IFSP). Responses of the two groups were used to test the effectiveness of the IFSP policy and processes in effecting family-centered services and helping to validate four basic assumptions in the law.

**Research Exegesis and Formation**

Four of the fundamental assumptions embedded in the law and discussed in the literature were selected to be tested. Each assumption became a category under which specific research items could be grouped. Each item is a research question arising from the assumption but written in the form
of a statement for the purpose of determining levels of agreement between the families and service coordinators.

Responses to the statements will reveal realities in the development and implementation of the IFSP and, in combination, test the validity of each assumption.

**Assumption A.** Families and service coordinators work together in a manner that enables the family to demonstrate ability to participate in identifying its specific strengths (priorities)*, needs (concerns)*, and goals/outcomes in the IFSP.

**Note (*)&:** Terms concerning families, such as strengths and needs, as used in P.L. 99-457 were changed. After P.L. 102-119, terms "priorities" and "concerns" were used when assessing views of the families. The Clinic that served as the research site indicated that families preferred the use of the terms *priorities* and *concerns* in place of the terms used earlier in the law (Public Law 99-457, 1986).

The eight research items with two items containing subcategories (a total of 11 questions) and 2 open-ended questions below tested the levels of agreement and answers of families and service coordinators. The combined responses and commonalities are used to test the validity of Assumption A. The same presentation format (i.e., the statement of assumption, research statement and open-ended questions for each assumption) applies to all four assumptions.
Research Statements

1. The IFSP is developed at a time when the family is ready to set goals/outcomes.
2. At least one family member has equal influence with the service coordinator in developing the IFSP.
3. The family's native language or other mode of communication is used in a) developing the IFSP; b) implementing the IFSP.
4. The service coordinator assists the family in identifying an accurate list of family priorities and concerns.
5. The service coordinator gives priority to the goals/outcomes of the family in the IFSP.
6. The family considers the goals/outcomes in the IFSP to be appropriate.
7. IFSP goals/outcomes were developed to meet the priorities and concerns of a) child; b) parents; and c) all family members.
8. When the IFSP is reviewed, the IFSP goal/outcomes are being met.

Open-Ended Questions

1. Please list the family priorities and concerns in developing the IFSP; and
2. Please list three specific IFSP goals/outcomes by priority.
**Assumption B.** Families and service coordinators can identify services needed to reach the IFSP goals/outcomes and see that those services are provided.

**Research Statements**

1. The service coordinator uses the IFSP goals/outcomes in determining the services to be provided for the a) child; and b) family.
2. The service coordinator gives the family an opportunity to choose the services desired.
3. Some services on the IFSP were not provided to the a) child; and b) family.

**Open-Ended Questions**

1. Please list those services needed but not provided; and
2. Please list any barriers that prevent families from getting services.

**Assumption C.** Families and service coordinators select services for listing in the IFSP that address the priorities, concerns, and goals/outcomes of the child and family.

**Research Statements**

1. The family is provided with understandable information related to the priorities and concerns of the a) child; and b) family.
2. The family members are treated as team members in determining the services provided for the a) child; and b) family.
3. At least one family member has influence equal to that of the service coordinator in determining which services will be received.

4. The family and service coordinator agree that the services provided are the services needed for the a) child; and b) family.

5. Children receiving services have opportunities to interact with children who do not require special services.

6. The agency had enough money to obtain or continue the services required to meet the priorities and concerns of the a) child; and b) family.

7. The services are provided in a manner that effectively meets the priorities and concerns of the a) child; and b) family.

8. The family was placed on a waiting list before receiving services.

9. Use of an IFSP helps to coordinate services provided for the a) child; and b) family.

10. IFSP meetings are scheduled when it is convenient for the a) family; and b) service coordinator.

11. The IFSP is reviewed at least every six months.

12. Use of the IFSP is effective in identifying a) family priorities; b) family concerns; c) family goals/outcomes; d) child priorities and concerns; e) child services; and f) family services.
Open-Ended Questions

1. Please list services you consider to be most effective in meeting the priorities and concerns of the a) child; and b) family.

Assumption D. Families and service coordinators can evaluate effectiveness of the development and implementation of the IFSP.

Research Statements

1. The types of professionals needed to provide the services required by the IFSP are made available to the a) child; and b) family.
2. Professionals developing and implementing the IFSP are qualified.
3. Use of the IFSP should be continued.
4. Changes and improvements are needed in the process of developing and implementing the IFSP.
5. Families and children would receive services, even if the IFSP requirements were dropped.

Open-Ended Questions

1. Please list the most critical improvements needed, if any, in a) developing; and b) implementing the IFSP.
Significance of the Study

This study is designed to contribute to understanding the effectiveness of the policies and processes for the Individualized Family Service Plan, as a major requirement in Part C of IDEA. This study also should help determine if the four major assumptions in the law regarding the interactions of families and service coordinators in using the IFSP effectively are valid. Further, the findings of this study should provide new or expanded information for families and their children at-risk for and with disabilities in this country.

The researcher is from Korea and hopes these findings may assist the future development of Early Childhood Special Education (ECSE) in Korea. This study may also provide directions and guidelines for early childhood special education programs in other developing countries.

Assumptions and Limitations

Assumptions

The study will be based on the following assumptions:

1. Survey respondents have knowledge of their current Individualized Family Service Plan (IFSP).

2. Survey respondents answer questions with candor and without fear that their responses could negatively affect the services coordinators provide or the families receive.
Limitations

The following limitations are pertinent to the study:

1. Only families who are receiving or have received services at Special Children's Clinic in Las Vegas, Nevada, and whose children are ages birth to 3 years are included in this study.

2. The definition of the IFSP process and important, but subtle, differences among research items may have created ambiguity or difficulty for some families and service coordinators in choosing to complete the questionnaire items.

3. The low return rate of responses from families, in particular, limits the degree to which these results may be generalized.

4. One component of Section 1433 of IDEA requires a family-directed assessment of resources. Determining the resources of and available to the families was considered to be a complex task beyond the scope and purpose of this study. However, family resources may have had some effect on those factors that were studied and, therefore could be a limitation.

5. Nine of the 17 service coordinators served more than one family; thus, the need for the nine coordinators to complete a questionnaire on more than one family could have contributed to some contamination in their responses.
Definition of Terms

The following terms are defined as they specifically apply to the study:

**Individualized Family Service Plan (IFSP)**

The Individualized Family Service Plan (IFSP) is required by P.L. 99-457, P.L. 101-476, P.L.102-119, and P.L. 105-17. The IFSP is a written plan for providing early intervention services for Part H/C eligible children and their families. The initial IFSP is written with the family, participants in the multidisciplinary evaluation, the family service coordinator, and other service providers who will provide services to the child and family. P.L. 102-119 requirements for the IFSP appear in Appendix B and were used in designing the questionnaire for this study.

**At-risk Infant or Toddler**

The term 'at-risk infant or toddler' means an individual under 3 years of age who would be at risk of experiencing a substantial developmental delay if early intervention services were not provided to the individual.

**Developmental Delay**

The term 'developmental delay', when used with respect to an individual residing in a State, has the meaning given such term by the State under U.S.C. Sec. 1435(a)(1).

**Early Intervention Services**

Early intervention services mean developmental, behavioral, cognitive, language, medical, social, and related services that are provided to eligible infants and toddlers.
ages birth to 3 years using preventive, remedial, and/or compensatory service delivery models (Bailey & Wolery, 1992).

According to the new IDEA Amendments of 1997, the term 'early intervention services' means developmental services that:

(a) are provided under public supervision;

(b) are provided at no cost except where Federal or State law provides for a system of payments by families, including a schedule of sliding fees;

(c) are designed to meet the developmental needs of an infant or toddler with a disability in any one or more of the following areas:

i. physical development;

ii. cognitive development;

iii. communication development;

iv. social or emotional development; or

v. adaptive development.

(d) meet the standards of the State in which they are provided, including the requirements of this part;

(e) include:

i. family training, counseling, and home visits;

ii. special instruction;

iii. speech-language pathology and audiology services;

iv. occupational therapy;
v. physical therapy;
vi. psychological services;

vii. service coordination services;

viii. medical service only for diagnostic or evaluation purposes;

ix. early identification, screening, and assessment services;

x. health services necessary to enable the infant or toddler to benefit from the other early intervention services;

xi. social work services;

xii. vision services;

xiii. assistive technology devices and assistive technology services; and

xiv. transportation and related costs that are necessary to enable an infant or toddler and the infant's or toddler's family to receive another service described in this paragraph.

(f) are provided by qualified personnel, including:

i. special educators;

ii. speech-language pathologists and audiologists;

iii. occupational therapists;

iv. physical therapists;

v. psychologists;
vi. social workers;

vii. nurses;

viii. nutritionists;

ix. family therapists;

x. orientation and mobility specialists; and

xi. pediatricians and other physicians.

(g) to the maximum extent appropriate, are provided in natural environments, including the home, and community settings in which children without disabilities participate; and

(h) are provided in conformity with an individualized family service plan adopted in accordance with Sec. 1436.

Evaluation and Assessment

The pertinent rules and regulations define evaluation as "the procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility consistent with the definition of infants and toddlers with disabilities including determining the status of the child in each of the developmental areas" (Federal Register, Vol. 58, No. 145, July 30, 1993, p. 40, 971). Assessment is defined as "the ongoing procedures used by appropriate qualified personnel...to identify the child's unique strengths and needs and the services appropriate to meet those needs, and the resources, priorities and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or
toddler with a disability" (p. 40, 971).

**Family Service Coordinator**

Family service coordinator is the person who is the most immediately relevant profession for the development and implementation of the IFSP.

**Service Providers**

Service providers are those individuals who make contacts with the family and/or young child to provide training, counseling, therapy, or to facilitate other services. This group may include individuals from the same professionals listed under professionals providing evaluations and other services.

**Professionals Providing Evaluations and Other Services**

Qualified professionals who evaluate the child may include special educators, speech and language pathologists and audiologists, occupational therapists, physical therapists, psychologists, social workers, family service coordinators, nurses, nutritionists, and physicians and other medical personnel. Qualified professionals evaluate the child using a number of methods, write evaluation reports and formulate recommendations.

**Family**

Family is a unit generally defined as parents and their children or others closely related by blood or other factors. For this study, the family determined who made up its membership and who would be the responding member(s) to the questionnaire. The respondents are identified at the end of
Chapter 3.

**Family-Centered Intervention**

Family-centered intervention is a recognition that the family is the constant in a child's life and that service systems and personnel must support, respect, encourage, and enhance the strength and competence of the family (McGonigel et al., 1991). Family-centered is a combination of beliefs and practices that are family-driven; families have major roles in decision-making in their child's service delivery program (Dunst et al., 1991). Proponents of family-centered models view professionals as instruments of families, and intervene in ways that (a) are individualized, flexible, and responsive, and (b) support and strengthen family functioning (Dunst, Trivette, & Deal, 1994; Dunst, Trivette, & Thompson, 1990). The central role that the family assumes in the development of the child is recognized in family-centered intervention (McWilliam & Bailey, 1993).

**Family-Allied Intervention**

Family-allied intervention calls for family members to carry out interventions planned and developed by the professional (Dunst et al., 1991).

**Family-Focused Intervention**

Family-focused intervention shows appreciation for parents' capabilities, and the family and professional develop intervention together (Dunst et al., 1991).
Family-Directed Assessment

Family-directed assessment allows the family to identify their concerns, priorities, and resources, including the supports and services necessary for the family to enhance the development of their child with the assistance of the professionals.

Family Strengths and Needs

Family strengths are characteristics that family members identify as contributing to the growth and development of the child and family. Among the areas of family life that many families identify as strengths are coping strategies, nurturing relationships, communication, religious or personal beliefs, family competence, and family/community interconnectedness (Turnbull, 1991).

In a family-centered IFSP process, a need exists only if a family member expresses a desire for services to be obtained or outcomes to be achieved (Bailey et al., 1990). Operationally, a need is an individual's or group's judgment of the discrepancy between actual states or conditions and what is considered normative, desired, or valued from a 'help seeker's' and not a 'help giver's' perspective (Dunst, Trivette, & Deal, 1995). In this study, the words used by the Special Children's Clinic (Priorities and Concerns) had to be used instead of "strengths" and "needs".

Family Concerns, Priorities, and Resources

The identification of family concerns, priorities, and resources is based on an individual family's determination of
which aspects of family life are relevant to the child's
development (Kaufmann & McGonigel, 1991). Family concerns are
areas that family members identify as needs, issues or
problems they want to address as part of the IFSP process.
Family priorities are a family's agenda and choices for how
eyear intervention will be involved in family life. Family
resources are the strengths, abilities, and formal and
informal supports that can be mobilized to meet family
concerns, needs, or outcomes (Kaufmann et al, 1991).

IFSP Goal or Outcome

A goal may be defined as a stated outcome desired as a
result of some action; a change or action intended to benefit
the child or family member (The American Heritage College
Dictionary, 1997). IFSP outcomes are statements of the
changes families want to see for their children. Goals help
to focus intervention services, and goal setting contributes
to the establishment of ethical and appropriate relationships
with families (Bailey et al., 1990, p. 16).

Transition Plan

The steps taken to transition the child from Part H/C
services to 619 services at 36 months. It must include
training of parents and procedures to prepare the child for
change.

Literature with study results and observations
supporting the need for this study is reviewed in the
following chapter.
CHAPTER 2

REVIEW OF LITERATURE

The federal Infant and Toddler Early Intervention Services Program was created by Congress through Amendments to the Education of the All Handicapped Children's Act in 1986 (Public Law 99-457). In 1991, the program was reauthorized (under P.L. 102-119) as Part H of the Individuals with Disabilities Education Act. Under Part H, the U.S. Department of Education provided grants to the states to implement a coordinated and comprehensive system of early intervention services for infants and toddlers with disabilities, ages birth to 3, and their families.

Since the enactment of P.L. 99-457 (Part H) in 1986, early intervention programs for young children with disabilities rapidly expanded as states and local communities began to meet requirements established by this law (Bailey, Buysse, Edmondson, & Smith, 1992). Many early intervention programs were required to attempt to shift from traditional models in which decisions were made primarily by professionals to family-centered models that emphasize collaboration with parents and stress supporting and strengthening families (Minke & Scott, 1995).

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Several required elements of Part H (newly revised from Part H to C in 1997) were intended to restructure the system that delivers and coordinates services for families caring for infants and toddlers with disabilities (Swan & Morgan, 1993; Winton, 1993). They represented an attempt to improve the early childhood service system through training professionals to implement family-centered standards of practice (Thompson, Lobb, Elling, Herman, Jurkiewicz, & Hulleza, 1997).

States have developed criteria for admission to services, methods for evaluation and assessment of infants or toddlers and an Individualized Family Service Plan (IFSP). The goal for such early intervention is to improve developmental outcomes for the infant or toddler and enhanced family support (Wayman, Lynch, & Hanson, 1991). To achieve this goal, programming must be tailored to the individual child and family needs (Meisels & Provence, 1989). Some authors have indicated that the IFSP is a promise to children and families that can be met only through interagency and interdisciplinary partnerships among families and professional service providers (McGonigel, Kaufman, & Johnson, 1992). The professionals who evaluate the child generally make recommendations for services and often serve as teachers, resource personnel and supporters of the family. However, it is the family's informed opinions that, by law, should center the services for their needs and those of the infant or toddler (Healy, Keesee, & Smith, 1985).
The Individualized Family Service Plan (IFSP) is intended to be a product of a conference at which the family works with service coordinators and with other members of their support network to tailor a plan to meet the family's strengths and needs. The IFSP is a written document and a process requiring that families and professionals work collaboratively to develop and implement the plan. The IFSP, with its emphasis on including the family, constitutes a significant departure from previous policies and practices that tended to emphasize only services to the child (DeGangi, Royeen, & Wietlisbach, 1992). The IFSP is the mechanism that allows for expansion of the intervention focus to include goals, services, and outcomes for families as well as their children (McBride et al., 1993). Guidelines regarding how to conduct the process of the IFSP have been set forth by professionals and families, and the processes used to determine outcomes for the IFSP continue to be defined.

The purpose of this chapter is to provide an overview of early intervention as a service delivery system, investigate the meaning of the family-centered practice, and determine if data exist to show the extent to which it is being implemented from the perspectives of both families and service coordinators who have participated in developing IFSPs. Particular focus will include: (a) the historical and current perspective of early intervention; (b) the rationale and process for working with families; (c) philosophy and conceptual framework; (d) family-centered approach; (e)
Individualized Family Service Plan (IFSP); (f) identifying and assessing family strengths, needs, and outcomes; (g) personnel preparation for early intervention services; (h) perceptions concerning family-centered services; (i) and new amendments of 1997 regarding programs for infants and toddlers.

Historical and Current Perspective of Early Intervention

The term of early intervention has been used to describe a variety of services for young children with special needs and for their families. Significant growth in services provided has occurred, especially because of a federal mandate, and incentives for infant and toddlers programs. Expansion of early intervention has emphasized working with diverse populations in a variety of settings and new ideas about the goals of early intervention as well as the methods by which those goals are to be achieved (Bailey & Wolery, 1992).

Bailey and Wolery (1992) stated that three broad historical themes formed the background for the current status of early intervention programs. First, society has become concerned about the care and welfare of young children. Early reflections of this concern included the passage of laws prohibiting child labor and requiring public education. More recently, parents and professionals have recognized that appropriate interventions in the early years are critical to the child's physical, emotional, social, and
cognitive development. Thus increased attention has been focused on the quality of early experiences for all children. A second major theme was society's concern for the rights and needs of individuals and of minority groups. The most visible example of this effort was the enactment of The Education of All Handicapped Children's Act (Public Law 94-142) in 1975. A third societal trend was an increased focus on support for both individuals and families as a primary goal of human service programs. Health and human services across a variety of state, federal, and private agencies are being evaluated in terms of the extent to which they promote independence and self-determination (Bailey et al., 1992).

The most visible events shaping early intervention programs for infants and toddlers who have, or are at-risk for, disabling conditions are recent legislative acts and mandates (Bailey & Wolery, 1992). These events, however, are embedded within a broader historical context (Meisels & Shonkoff, 1990).

Health and Welfare Context

Throughout history, infancy has been viewed as a particularly vulnerable time of life from medical, cognitive, and social perspectives. In 1903, federal funding for "crippled children" programs was recommended by the Children's Bureau of the Department of Labor as a result of several years of study on the effects of poverty on infant mortality and disclosure of the unmet needs of children with disabilities. The resulting programs were mandated to reflect
the first collaborative approach to assessment and intervention by multiple disciplines (Meisels & Shonkoff, 1990).

Then, Title V of the federal Social Security Act of 1935 significantly expanded health care and social services to indigent persons and children with disabilities. This three-part federal program continues to influence national health services to children in the following areas: (a) maternal and child health; (b) services for children with disabilities including prevention, referral, evaluation, treatment, and follow-up; and (c) child welfare services for economically deprived and other environmentally at-risk children (Lesser, 1985). Federal funds to provide health services to special populations of children were allocated in 1939 as an extension of Title V. The states were directed to expend the funds on programs for biologically at-risk newborns, personnel training, and medical research (Meisels & Shonkoff, 1990).

Special Education Context

Before the 18th century, the concept of special education, regardless of the term used to describe it, was enigmatic to a world that did not have a sophisticated knowledge base with which to understand it (Beirne-Smith, Patton, & Ittenbach, 1994). As a result, people around the world held a variety of attitudes and perceptions toward people whose mental abilities and behaviors varied from the norm.
Basically, no consensus among Western societies existed as to who "deviant people" were, why they acted the way they did, and how they should be treated (Perrin, 1994). Different societies' responses to these questions ranged from treating these individuals as buffoons and court jesters to perceiving them as demons or as persons capable of receiving divine relations. Throughout history, different patterns of treatment developed, including Euthanasia, assignment to subservient roles, imprisonment, and institutionalization (Meisels & Shonkoff, 1990).

The field of special education was influenced by Jean-Marc Itard. The first formally recorded efforts of special education began with his development of a "physiological method of education for disabled children" (Meisels & Shonkoff, 1990, p.10). Itard was a student who, in the late eighteenth century, experimented with behavior modification and sensorimotor training to teach the "wild boy of Aveyron" (p.10). Itard emphasized the relevance for initiating intervention early in a child's life and stated, "If the idiot cannot be reached by the first lessons of infancy, by what mysterious process will years open for him the golden doors of intelligence" (Talbot, 1964). Nearly 200 years passed before specific special education policies were implemented and before intervention programs for infants and toddlers were recognized as efficacious.

Several key legislative events created programs in many states and, finally, at the federal level during the latter
half of the twentieth century. They led to the provision of early services and most recently emphasized public-supported early childhood intervention programs for infants and toddlers (Perrin, 1994). The first federal public commitment to young children with special needs was the initiation of Head Start in 1965. Head Start’s overarching goal was to "break the cycle of poverty, based on the assumption that the best way to do this is to intervene in the early years" (Bailey & Wolery, 1992, p.3). In the three decades since its inception, Head Start has expanded the services to include children with disabilities, staff training, interagency coordination, requirement of teacher certification, and consideration of a downward extension of services for infants and toddlers (Bailey et al., 1992).

In 1968, Congress enacted P.L. 90-538, the Handicapped Children's Early Education Assistance Act. This act created the Handicapped Children's Early Education Program (HCEEP) to establish models for providing early intervention services. The HCEEP established experimental preschool and early education programs for children with disabilities 5 years of age and younger. Because there was at that time no mandate for early intervention, the program was intended to develop multiple models for serving children and families, demonstrate that they could be implemented, train others in how to implement them, and evaluate their effectiveness (Heward, 1996).
Congress allocated funds to develop demonstration projects that provided strategies for training staff, evaluating children's progress, and assessing the outcomes (DeWeerd & Cole, 1976). Twenty-four projects were funded in 1969. Subsequently, nearly 600 demonstration projects were funded, addressing a wide range of topics and children. Some have addressed specific groups of children, such as those with visual impairment or fetal alcohol syndrome. Others have demonstrated special models or components of services, such as rural service delivery, integration into day care, interagency collaboration, or family-centered services.

Karnes and Stayton (1988) conducted a survey of 96 HCEEP projects that focused on children ages birth through 2 years. They found that the projects operated within a variety of agencies, most frequently universities or public schools. Most reported a developmental learning model, but program practices were not always consistent with the model. Most (70%) used a home-center combination model and were staffed by professionals from a wide array of disciplines. In 1990, P.L. 101-476, the Individuals with Disabilities Education Act (IDEA) reauthorized and renamed the HCEEP as the Early Education for Handicapped Children Program. Increased emphasis was placed on identifying and serving infants and toddlers in need, facilitating the transition from medical to early intervention services, promoting the use of assistive technology, and serving children exposed prenatally to maternal substance abuse (Bailey & Wolery, 1992).
In 1973, the national Council for Exceptional Children (CEC) created the Division for Early Childhood (DEC). The DEC was the first formal organization for early intervention personnel and parents concerned with issues pertaining to young children who were disabled. In 1977, DEC initiated production of its own professional journal, the *Journal of the Division for Early Childhood*, with exclusive attention devoted to topics in early intervention (Peterson, 1987).

In 1975, Congress passed P.L. 94-142, which changed the Education of the Handicapped Act to the Education of All Handicapped Children's Act (EAHCA). P.L. 94-142 recognized the importance of early intervention and expanded the federal law to apply to children ages 3 to 21. This revised national policy extended the right to education from the early age of 5 to age three with a promise of increased federal financial assistance (Turnbull, 1990). Although the law did not formally support services to infants and toddlers with disabilities, states were allowed to expend P.L. 94-142 funds for early intervention purposes. The law also authorized local education agencies to be units for serving preschool populations. The law further encouraged states and local school districts to provide services to younger children with disabilities by offering incentive funds (Preschool Incentive Grants) to those states that elected to do so (Turnbull, 1990).

In 1986, Congress passed P.L. 99-457, amending EHCA. This legislation extended all of the rights, protections, and
mandatory services of P.L. 94-142 to 3 to 5-year-old children with disabilities. This legislation also provided incentives and a framework for states to implement services for infants and toddlers with disabilities and for their families. An additional component of the law recognized that working with infants is different from working with preschoolers, and it puts particular emphasis on early intervention as a family-centered service rather than as just a child-focused service. The requirements for implementation of family-centered concepts such as family assessment, service coordination, and Individualized Family Service Plans (IFSP) suggested that personnel in early intervention would need expertise in involving and supporting families (Bailey & Simeonsson, 1993).

P.L. 99-457 introduced a discretionary program (Part H) to help states develop a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers at risk for developmental delays or having disabilities. It emphasized services for their families (Trohanis, 1987). Meisels and Provence (1989) stated that the Act, P.L. 99-457, marked an historic turning point in federal and state policy for disabled and developmentally vulnerable young children and their families for two reasons: (1) infants and toddlers were not included previously in federal educational legislation (partially accurate) and (2) central to the legislation was
an emphasis on the family as the primary planners of services for their young child.

In 1990 (P.L. 101-476) and 1991 (P.L. 102-119), the basic law and regulations were modified as the Individuals with Disabilities Education Act (IDEA). While much of P.L. 99-457 remained as the basic components of the law, changes concerned strengthening, clarifying and reauthorizing educational and related services for preschool children in Part H, which had been landmark legislation. It created the new federally funded program for children with disabilities and at-risk children for disabilities from birth through 2 years (Eck, 1994). P.L. 102-119 revised the terminology referring to developmental areas to include: cognitive development, physical development, communication development, social or emotional development and adaptive development.

P.L. 102-119 altered the wording in several requirements and amended the content of the plan from the seven requirements listed in P.L. 99-457 to include an eighth major requirement that other services and funding sources be listed (Eck, 1994). The changes in the requirements from P.L. 99-457 to P.L. 102-119 demonstrate the evolving philosophy, assumptions, and framework of the law as legislators and policy makers attempted to evaluate implementation and made adjustments they hoped would better serve eligible children and their families (McGonigel et al., 1991). The modified format guides professionals as they shift their focus from working with children to working with families. From a
structural perspective, the IFSP planning document requires the multidisciplinary team to define the current status of the child with the family and to plan outcomes. The goals state what is to be done, who is to do it, conditions under which it will happen and the criteria by which success will be evaluated (Bailey et al., 1990). Selection of goals requires the family and other members of the team to review what they have learned, make choices among competing priorities, develop outcomes as well as plan strategies, activities and services to achieve desired outcomes (Eck, 1994). IFSP outcomes are changes family members want to see for their child and themselves. An outcome can focus on any area of child development or family life that a family feels is related to its ability to enhance the child's development. An outcome must be functionally stated in terms of what is to occur (process) and what is expected as a result of these actions (product) (Dunst et al., 1988).

In 1997, President Clinton signed into law the Individuals with Disabilities Education Act Amendments, P.L. 105-17. This amendment added a number of major provisions to the IDEA that could result in substantial changes in the early childhood special education (Yell & Shriner, 1997). In passing the amendments, Congress noted that the IDEA had been successful in ensuring access to a free appropriate public education and improving educational results for students with disabilities. Regarding programs for infants and toddlers, Part H of P.L. 102-119 was changed into Part C of P.L. 105-
17. Part C, particularly, requires policies and procedures to ensure that, to the maximum extent appropriate, early intervention services are provided in natural environments and extends Part B protections to infants and toddlers with disabilities and strengthens incentives for states to provide services to infants and toddlers (birth to age 3). The entirety of Part C of the IDEA took effect on July 1, 1998.

The Rationale and Processes for Working with Families

Working with families has always been a significant part of early intervention (Bailey, Darkes, Hebbeler, Simeonsson, Spiker, & Wagner, 1998). A major goal of early intervention in Part H/C is to enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities. Families and professionals soon realized, however, that working with families often led to activities other than teaching or providing therapy for the child, leading a number of authors to argue that working with families is justifiable on the basis of supporting the family, even if such support does not directly enhance the child's development (Bailey et al., 1986). Three themes regarding working with families have emerged in recent years (Bailey et al., 1998). First, families vary considerably in resources, priorities, concerns, and culture. Thus an individualized approach is needed to accommodate individual family preferences, which for some families may include a desire for services that go beyond promoting child

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development. Second, families should be partners in planning and providing services. Thus, the relationships between parents and professionals need to recognize, value and support a partnership in ways that are culturally appropriate and consistent with the roles parents desire. Finally, families are to be viewed as the ultimate decision-makers and long-term care givers of the children. Enabling families to feel competence as advocates becomes a significant goal under requirements of Part C (Bailey et al., 1998).

Part H of P.L. 102-119, required early intervention professionals to develop an Individualized Family Service Plan (IFSP) with families. In creating the plan, professionals were required to assess family resources, priorities, and concerns or factors that should be considered in determining goals and activities. The plan also could include expected outcomes for families. A service coordinator was to be assigned to support the family's efforts to gain access to and coordinate services (Bailey et al., 1998).

The Individualized Family Service Plan (IFSP) has the potential to guide professionals as they move from child-centered to family-centered planning and services (McGonigel et al., 1991). The federal Act provided states with incentives to develop these early intervention programs. The critical and unique role of the family in the child's development was very evident in Part C of the legislation.

Emphasis on family goals is consistent with abundant literature supporting the view of the child within the family
and involved family members as decision-makers (Bailey et al., 1990) because families generally have established their own relationships, daily routines and particular place in the environment (Eck, 1994). They are at a challenging point to effect child change because they should know their child and typically spend more time with the child than anyone else, thus representing the greatest potential influence in the child's life.

Family involvement as a required component of early intervention is not a new concept. The Handicapped Children's Early Education Program (HCEEP) in 1968 required the inclusion of families. However, family roles in early intervention primarily were as receivers of services or information, as determined by the professional. The program focus, whether home-based or center-based, was on the child. In the past, professionals generally assumed a major role in making decisions about what services were necessary for the child. At times this created additional stress for families (Simeonsson & Bailey, 1990).

The passage of P.L. 94-142 in 1975 guaranteed parents the right to be active participants in their child's educational program planning (McCollum & Maude, 1993). Parents essentially were to cooperate in writing their child's individualized education plan, share ideas for targeted goals and objectives, and give consent to evaluation and placement. The professional's role was to explain the child's needs and services to the family, then develop and
implement the appropriate educational program. In many situations, the family involvement was increased by providing parents teaching activities and therapies to do in the home. But even in early intervention, the professional tended to maintain the role of expert in the relationship with families (Simeonsson & Bailey, 1990; Turnbull & Turnbull, 1990).

Following enactment of Part H of P.L. 99-457 in 1986, however, the family was identified as an active consumer of early intervention services who should decide on the level and type of involvement they wanted the intervention to have in their lives (McCollum & Maude, 1993). The rules and regulations of the law clearly stated that Congress intended for families to assume a collaborative role in the planning and provision of early intervention services (Maloney & Drenning, 1993) and, further, assumed they could and would be permitted to do it.

The new legislation also provided professionals an opportunity to redefine parent and early interventionist collaboration to reflect a family-centered orientation. Families were to be involved in the decision-making process from policy development to individualized service delivery (Turnbull & Turnbull, 1990). Early interventionists were to modify common practices to strengthen families and enhance family resources (Dunst et al., 1988).

In a family-centered approach, professionals are required to work collaboratively with parents of infants and toddlers with disabilities in developing an Individualized
Family Service Plan (IFSP). Professionals collaborate with families to select and implement early intervention services, requiring active efforts to support families as full partners. Logical extensions of this perspective are an emphasis on family choice and strengths (Allen & Petr, 1996). It then becomes incumbent upon professionals to make services accessible, individualized by family needs and preferences, and flexible in accordance with family priorities (Bailey et al., 1998).

Bailey et al. (1992) believe that a family-centered perspective should contain all aspects of service (e.g., establishing program philosophy, screening, child assessment, team meetings, program planning, intervention activities, service coordination, and transition), not limited to social work or counseling. Procedures to develop the IFSP now require that the child's parent(s)/legal guardian(s), if they so choose, to be full, participating members of the multidisciplinary team (Roberts, Wasik, Castro, & Ramey, 1991).

Dinnebiel, Hale, and Rule (1996) consistently suggested that the essence of a family-centered approach lies in the relationship that exists between parents and professionals, citing desirable characteristics of this relationship to include trust, mutual respect, open and clear communication, a collaborative attitude, and interpersonal skills (Dinnebiel & Rule, 1994; Dunst, Johanson, Rounds, Trivette, & Hamby, 1991).
Philosophy and Conceptual Framework

Historically framed questions of satisfaction with services have addressed perceptions of the appropriateness, efficacy, responsiveness, usefulness and individualization of services for both the family and the child (Bailey et al., 1998). A positive view of the interactions and services in early intervention constitutes one valid indicator of the efficacy of those services. Most evaluations of the effectiveness of early intervention have assessed changes in child development or behavior, usually with standardized instruments, direct observation, or clinical judgment rated from the perspective of a professional evaluator. With family outcomes, the question is whether families think their child received the services they felt were needed and whether they perceive those services as having a positive impact on development and behavior (which are examined in this study).

Such outcomes traditionally have been assessed with parent satisfaction measures. Satisfaction with services is an important outcome because of its conceptual fit with a family-centered perspective and because consumer satisfaction has been related to more active participation and follow through in medical and educational services (Cadman, Shurvell, Davies, & Bradfield, 1984) as well as to the perceived benefits of services (Meyers & Blacher, 1987). Although seemingly a straightforward and easily measurable construct, the meaning of responses to satisfaction measures can be difficult to assess because many parents have no
standard against which to judge the services their child is receiving (Simeonsson, 1988).

Satisfaction with child services is a critical outcome because families typically rate services for the child as being of highest priority (Bailey et al., 1998). In selecting outcome measures, evaluators should take care to ensure that some important goals are accomplished. Dimensions to consider would include: (a) the amount of services provided, differentiating special education, various therapies, and other services; (b) the quality of services received regarding whether services directly address perceived needs; (c) the extent to which services are provided to have affected the child's development; and (d) an assessment of whether families believe that goals established for the child on the IFSP were attained. The questionnaire designed for this study addressed the factors outlined above.

Interactions between families and professionals constitute encounters in which mutual expectations are defined, needs and resources identified, services planned and implemented, and outcomes documented (Simeonsson, Huntington, McMillen, Dodds, Halperin, Zipper, Leskinen, & Langmeyer, 1996). They operate in a transactional fashion, such that parents and professionals construct views of each other as individuals and as representatives of their respective groups. Early intervention can have a defining role in determining how families perceive professionals and services. Ideally, families should have encounters that support the
belief that the services provided are accessible and helpful, and that service providers will be supportive, responsive, and respectful (Bailey et al., 1998). The extent to which this outcome is achieved varies as a function of families' initial expectations regarding the nature of encounters with professionals and the extent to which those perspectives are met.

Families may feel positive about their individual service provider, but negative about the service system. For example, McWilliam et al. (1995) found that although individual professionals and professional-family relationships were among the most positive experiences reported by six case study families, these same families reported having to struggle for services. Despite these struggles, early intervention may be one of the most positive experiences that parents of children with disabilities will encounter.

The requirements in the law for an Individualized Family Service Plan (IFSP) for all children and families receiving early intervention services validate the principle that infants and toddlers with special needs must be served within the context of their families. The development of the IFSP process that supports the caregiving role of families is a complex task involving many people (McGonigel, 1991). Despite the variety of perspectives that are necessarily reflected in this process, it is critically important that all those
involved share a family-centered philosophy and conceptual framework.

In recent years, the family-centered philosophy has steadily gained acceptance in early intervention (McGonigel, 1991). By the time P.L. 99-457 was enacted, near unanimity existed among early intervention organizations and practitioners on the primary importance of the family (Gilkerson, Hilliard, & Shonkoff, 1987).

The individual needs and circumstances of each state and program influenced the specific IFSP policies and procedures adopted. If family-centered early intervention is to become a reality, however, common principles that form a framework for the IFSP must be shared by families and service providers to enable and empower families as they invite early intervention programs into their lives (McGonigel, 1991).

Legislators and early interventionists described the central role of the family as family-focused, family-centered, and family-driven. The appropriate philosophical attitude for the early interventionist was enablement and empowerment (Dunst et al, 1988).

"Enable" and "empower" are words that have gained increasing acceptance as terms embodying both the spirit and the heart of family-centered services (Dunst & Trivette, 1987). Enabling families means creating opportunities and ways for families to apply their present abilities and competencies as well as acquire new ones as necessary to meet their needs and the needs of their children. Empowerment
means a family's ability to meet needs and achieve aspirations in a way that promotes a clear sense of intrafamily mastery and control over important aspects of family functioning. Empowering families in early intervention means interacting with families in such a way that they maintain and acquire a sense of control over their family life and attribute positive changes that result from early intervention to their own strengths, abilities, and actions (Dunst et al., 1988).

The philosophy of enablement and empowerment has also received considerable attention (Dunst et al., 1988) because it assumes the family of a child with disability is more capable of the decision-maker role as the result of enablement. Enablement assumes a result that provides parents with skills and knowledge to successfully manage their child. Empowerment also assumes families will have the opportunity to make decisions about their child's early intervention. The interventionist becomes responsible for preparing and assisting the family toward independence and competence in caring for their child with disability. The early interventionist with an empowerment perspective is assumed to encourage partnership, effective communication, and problem-solving strategies supportive of families (Swick, 1994).

McGonigel (1991) outlined ten principles underlying the IFSP process and these principles were rooted in the belief, thus assumptioning, that family-centered early intervention seeks to build on and promote the strengths and competencies
present in all families. Their principles are as follows (p. 8-12):

(1) Infants and toddlers are uniquely dependent on their families for their survival and nurture. This dependence necessitates a family-centered approach to early intervention.

(2) States and programs should define 'family' in a way that reflects the diversity of family patterns and structures.

(3) Each family has its own structure, roles, values, belief, and coping styles. Respect for and acceptance of this diversity is a cornerstone of family-centered early intervention.

(4) Early intervention systems and strategies must honor the racial, ethnic, cultural, and socio-economic diversity of families.

(5) Respect for family autonomy, independence, and decision-making means that families must be able to choose the level and nature of early intervention's involvement in their lives.

(6) Family/professional collaboration and partnerships are the keys to family-centered early intervention and to successful implementation of the IFSP process.

(7) An enabling approach to working with families requires that professionals reexamine their traditional roles and practices and develop new practices when necessary—practices that promote mutual respect and partnerships.
(8) Early intervention services should be flexible, accessible, and responsive to family-identified needs.

(9) Early intervention services should be provided according to the normalization principle, that is, families should have access to services provided in as normal a fashion and environment as possible and that promote the integration of the child and family within the community.

(10) No one agency or discipline can meet the diverse and complex needs of infants and toddlers with special needs and their families.

The Family-Centered Approach

Family-centered intervention is consumer driven. The professional works for the family and looks for ways to increase parental decision-making power. Family-centered intervention recognizes the complex relationship among family members and between the family and the community (Dunst et al., 1991). The central role that the family has in the development of the child is recognized in family-centered intervention (McWilliam & Bailey, 1993). Family-centered early intervention practices reflect a recognition that the family has its own individual structure, roles, values, beliefs, and coping styles. Showing respect for these diversities is believed to lay the foundation for effective family-centered early intervention programs (Dunst, Johanson, Trivette, & Hamby, 1991; McGonigel, Kaufmann, & Johnson, 1991).
The expected role of parents in intervention and educational components of their child's programming has changed during the twentieth century. The 1960s, reportedly, reflected a trend of passive role by parents concerning decisions about their child's education programs. Professionals were expected to make educational decisions and then interpret these decisions to parents. Many parents, reportedly, expected not to question professionals and to be appreciative recipients of services (Turnbull, & Turnbull, 1990). The passive role seems to have reversed since the passage of landmark legislation (such as Public Law 94-142 and its amendments Public Laws 99-457, 101-476, 102-119, and 105-17). However, Turnbull and Turnbull (1990) suggested that parents still assume passive roles in some parent-professional practice arenas.

The role of parents as teachers emerged in the mid-1970s, and some years after the Head Start movement. The parents' role as teachers of their children with disabilities was based on the premise that if parents were trained in what to do with their child, they would be effective teachers. The premise was generalized to all parents (Turnbull & Turnbull, 1990), until it was demonstrated that not all parents were trained or able to teach their children (Sparling, Berger, & Biller, 1992; Turnbull & Turnbull, 1990).

Under the more recent, changing philosophy, interventionists have needed to recognize the child as only one part of a family system and respect the family's
priorities, concerns, and needs as well as permit the families to participate in early intervention at the level they desired (McGonigel et al., 1991). According to Able-Boone, Sandall, Stevens, & Frederick, (1992); Bailey et al., (1992); Bailey, McWilliam, & Winton, (1992); Dunst & Deal, (1992); Leviton, Mueller, & Kauffman, (1992); and Meisels & Shonkoff, (1990), many parents, legislators, and professionals came to recognize and respect the role of parents as family members. The central role of parents in early intervention programming for infants and toddlers is based on the assumption that needs of all family members (not just the needs of the child with disability) must be addressed and met in order for maximal benefit of intervention to be realized. Family systems theory has been the impetus for transition to the current family-centered early intervention service delivery model (Dunst, Trivette, & Deal, 1992; Turnbull & Turnbull, 1990).

Parents and interventionists have different views on what constitutes the best interest of the child (Bailey, 1987; Stonestreet, Johnston, & Acton, 1991). It takes skill, patience and understanding to access resources in a complex service delivery system and time to deal with the many activities and resources involved with the child who has special needs (Dunst et al., 1988). Stonestreet et al. (1991) believed that it would take time for both parents and professionals to master the skills needed to join together as true partners in education for children with disabilities.
Dunst et al. (1988) had described several characteristics of interactions that may help empower family members to take a leadership role in meeting their own needs in family-centered practices. First of all, they contend

"interventionists must realize that every interaction with parents holds the opportunity to convey a philosophy of equal partnership. Second, all communication must reflect an attitude of trust and respect for the family members. Further, they believe that conversations between parents and interventionists must be honest, address the priorities expressed by the parents and focus on seeking solutions to the concerns raised by family members in order to comply with a family-centered model. Third, helpful solutions will be expressed as actions so that family members can identify concrete ways of meeting their own needs. Last, interventionists will portray their respect for families by holding the information on family matters in the strictest confidence" (p. 52-54).

Sexton, Aldridge, and Snyder (1994) outlined similar family-centered indicators to those of Dunst et al. (1988). They recommended that early interventionists be aware of and sensitive to the multiple variables influencing all aspects of the individual, family, and community systems. Interventions needed to occur within natural family and program routines and be inclusive. A team approach, where the family was given the opportunity for equal membership status was to be used for assessment, program planning and related decisions.

In summary, a family-centered early intervention philosophy reflected the belief that the family was the constant in a child's life, and therefore, the family was central to all decisions regarding the child's care.
Bernheimer, Gallimore and Weiser (1990) stated that the family emphasis of P.L. 102-119, Part H, (P.L. 105-17, now revised as Part C) not only makes intuitive and conceptual sense, but also reflects best practice in early intervention. Emphasis on family goals is consistent with abundant literature supporting the view of the child within the family and involved family members as decision-makers (Bailey et al., 1990). According to Cartwright (1981), families are at a strategic, pivotal point to effect child change because they know their child better than anyone else.

McGonigel et al. (1991) stated that the Individualized Family Service Plan (IFSP) has the potential to guide professionals as they move from child-centered to family-centered planning and services. Professional's and parent's ability to communicate with one another and work as partners on the multidisciplinary team are also crucial to implementation of the ideal in the legislative history of P.L. 102-119 (McGonigel et al., 1991). Bailey et al. (1990) stated if communication between families and professionals does not occur, the IFSP or goal document is likely to have little meaning.

**The Individualized Family Service Plan (IFSP)**

A family-centered approach to intervention involves identifying and utilizing the needs and resources of the entire family system and documenting them in an Individualized Family Service Plan (IFSP) (Dunst et al.,
1988). Dunst and Trivette (1989) have called the IFSP "the most significant requirement of the Part H (now, C) discretionary program" (p. 87). The IFSP is a written plan for providing early intervention services for Part H/C eligible children and their families. The IFSP is only one of the 14 components of the statewide multidisciplinary interagency program of early intervention services, but is noteworthy because it is a proactive family-centered system of services (Johnson, McGonigel, & Kaufmann, 1989).

The initial Individualized Family Service Plan (IFSP) is written with the family, participants in the multidisciplinary evaluation, the family service coordinator, and other service providers who will provide services to the child and family. The IFSP requirements call for the IFSP to be updated every six months, or more often if the family requests it. There are many appropriate formats for an IFSP, but they must include those elements in the Federal Rules and Regulations governing implementation of P.L. 105-17 (Federal Register, June 4, 1997) that are presented below:

"(1) A statement of the infant's or toddler's present levels of physical development, cognitive development, communication development, social or emotional development, and adaptive development, based on objective criteria;

(2) A statement of the family's resources, priorities, and concerns relating to enhancing the development of the family's infant or toddler with a disability;
(3) A statement of the major outcomes expected to be achieved for the infant or toddler and the family, and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes or services are necessary;

(4) A statement of specific early intervention services necessary to meet the unique needs of the infant or toddler and the family, including the frequency, intensity, and method of delivering services;

(5) A statement of the natural environments in which early intervention services shall appropriately be provided, including a justification of the extent, if any, to which the services will not be provided in a natural environments;

(6) The projected dates for initiation of services and the anticipated duration of the services;

(7) The identification of the service coordinator from the profession most immediately relevant to the infant's or toddler's or family's needs (or who is otherwise qualified to carry out all applicable responsibilities under this part) who will be responsible for the implementation of the plan and coordination with other agencies and persons; and

(8) The steps to be taken to support the transition of the toddler with a disability to preschool or other appropriate services."

P.L. 102-119 altered the wording in several requirements and amended the content of the plan from the seven
requirements listed in P.L. 99-457 to include an eighth major requirement that other services and funding sources be listed.

The changes in the requirements from P.L. 99-457 to P.L. 102-119 demonstrate the evolving philosophy and framework of the law as legislators and policy makers evaluated implementation and made adjustments to better serve eligible children and their families (McGonigel et al., 1991). The modified format guides professionals as they shift their focus from working with children to working with families. From a structural perspective, the IFSP planning document requires the multidisciplinary team to define the current status of the child within the family and to plan goals. The goals state what is to be done, who is to do it, and conditions under which it will happen and the criteria by which success will be evaluated (Bailey et al., 1990). Selection of goals requires the family and other members of the team to review what they have learned, make choices among competing priorities, develop outcomes, as well as plan strategies, activities and services to achieve desired outcomes. Outcomes are changes the family wants to have occur with and for their child and self (McGonigel et al., 1991).

Since the passage of P.L. 99-457 in 1986, there have been numerous studies of IFSP pilot projects, examinations of the nature of successful IFSP processes, and the development of methods for tracking and evaluating progress in IFSP design (Gallagher & Desimone, 1995). Dunst and Deal (1994)
stated that the IFSP was the cornerstone of the family-centered model. If it is to be that cornerstone, the IFSP needs to be perceived and used as a living document rather than a mandatory requirement.

Gallagher and Desimone (1995) pointed out that one goal of IFSP research is to learn more about problems with process, implementation, and differing values and perceptions among families and professionals. To better learn about possible problems with the IFSP procedure, DeGangi, Royeen, and Wietlisbach (1992) recommended that organizations involved with the IFSP process conduct focus groups separately with their staff and with the parents they serve.

Early childhood intervention specialists need information on practices and procedures that are both helpful and positively perceived by both families and practitioners. To achieve this goal, Summers, Dell'Oliver, Turnbull, Benson, Santelli, Campbell, and Siegel-Causey (1990) conducted nine focus groups, a mix of parents and professionals, to find out about families' and practitioners' expectations of families for outcomes of early intervention and their preference for informal data collection and communication over structured interviews. This study addressed two questions: (1) what are families' and practitioners' opinions about the expected outcomes for families of early intervention and (2) what are families' and practitioners' preferences for the methods to be used in gathering information on family strengths and needs for the Individualized Family Service Plan? The
researchers share principles for early intervention services, preferences for identification of family strengths and needs, and the outcomes that are most desired from program services.

With respect to outcomes, results suggest that families and practitioners may have expectations for early intervention services that go beyond the historical view that family support in child development programs consists mainly of parent training (Benson & Turnbull, 1986). Outcomes related to enhanced parent-child relationships were mentioned, and these respondents did expect early intervention programs to help parents learn more about such areas as child nutrition and safety, providing early stimulation, and working with their child's special needs.

In this study, meeting informational needs was emphasized by the families of younger children, while building family-professional relationship skills and meeting needs for general family well-being were emphasized more often by the families of older children. This finding suggests that future research on family outcomes might focus on the issue of the appropriate or anticipated optimal sequence for providing services associated with these outcomes.

Bailey, Winton, Rouse, and Turnbull (1990) also examined 25 IFSPs submitted to the U.S. Department of Education in 1986 as part of an effort to develop guidelines for designing IFSPs. They evaluated the IFSPs based on the structure, individuality, and qualitative aspects of the IFSP goals.
Each IFSP was examined to determine the presence of key legislative requirements. Each family goal was coded according to domain of family functioning, structural dimensions, level of parent involvement, and time specifications for goal attainment. Results indicated that most family goals were child-focused. Although statements of who was to achieve the goal and operational specification of behaviors were generally present, conditions and criteria for goal attainment were not generally found. Only 13% of the goals involved generalized use of problem-solving skills.

Findings from this analysis raised several key questions about the focus of family goals, the identification and use of family strengths, and the specificity and complexity of family goals. Ultimately, the appropriateness of the goals submitted cannot be evaluated without knowing the families for whom they are intended. However, it is believed that these submissions reflect the current status of family goal writing and will stimulate further thinking and discussion about both format and content. These findings also suggest the most critical outcome of the IFSP process is not the written document, but the partnership that develops between families and professionals. Bailey et al. (1990) say if this process does not occur, the goal document is likely to have little meaning.

A study by Eck (1994), of IFSPs, summarized in the Early Childhood Reporter, reflected little congruence between recommendations of early intervention professionals and the
goals selected by families. The research pinpointed the lack of effective communication between the family and the professional as the primary reason for the absence of agreement. According to Eck (1994), "It is up to professionals to figure out what puts families at ease, because what we envisioned is not working" (Are IFSPs leaving families in the dust?, 1994, p. 8).

Eck (1994) in this study raised questions about several fundamental issues relevant to improving the IFSP evaluation process: (a) what is the definition of a family goal, and how focused should it be on the child versus the parents? (b) how can statements about family strengths be employed usefully in the writing of the IFSP plan? (c) how precise should goal statements be? (d) what are the proper specificity and complexity of family goals?

Individualized Family Service Plans (IFSPs) are intended to enable family members to access services available to them in the community. One study conducted by Mahoney, O'Sullivan, and Dennebaum in 1990 documented that families who had developed an IFSP showed a marked increase in the amount of public assistance they requested and received. It has been shown that active coping strategies contributed more to successful family functioning than did more passive activities such as merely accepting offers of support (Bristol, 1987). It appears that interventionists can increase their ability to empower family members if they
encourage parents to take active roles in the development and achievement of goals in an IFSP.

**Identifying and Assessing Family Priorities, Concerns, Resources, and Goals/Outcomes during the IFSP Process**

Early interventionists are required to identify family priorities, concerns, resources, and outcomes during the IFSP process as part of the requirements of Part H, which was revised as Part C of P.L. 105-17 in 1997. However, little guidance is contained in this legislation about how to identify and assess them or determine if they are enhancing the development of the infant and toddler with disability.

The Individualized Family Service Plan (IFSP) differs from the traditional Individualized Education Program (IEP) along a number of dimensions (Sexton, Snyder, Rheams, Barron-Sharp, & Perez, 1991). One extremely important difference is that the development of an IFSP necessitates more expanded data collection procedures than those involved in the development of an IEP. That is, service providers must go beyond collecting and reporting child-focused assessment data to include a statement on the IFSP identifying the family's strengths, needs and outcomes that are related to enhancing the development of the child (Sheehan, 1989).

Regulations appearing in the Federal Register in 1989 stated that family assessment should be based on information provided by the family through a personal interview (Winton & Bailey, 1990). However, relying only or primarily on personal

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interviews with all families to identify family strengths, needs, and outcomes ignores research findings that indicate the written surveys can be useful for this purpose (Bailey & Simeonsson, 1988). Another limitation of a data collection procedure that only involves informal interviews is that such data are often very difficult to use for program evaluation purposes (Summers et al., 1990). Thus, current best practices issues indicate that identifying family strengths, needs, and outcomes should involve the use of multimethods (Sexton et al., 1991).

In discussing the IFSP, Bailey and Blasco (1990) observed, "a simple yet fundamentally important axiom is that if family members view the instrument as helpful, then quite likely it will be" (p. 197). The views and attitudes of direct service providers believed to be important. For example, if staff members believe an instrument is too intrusive or too long, chances are that it will not be provided to families as an information sharing option.

Assessment measures with family members can be controversial. Formal assessment measures have a great role in the development of the IFSP (Beckman & Bristol, 1991). First, assessment can provide information on the family's resources, priorities, concerns and unique characteristics (Olson & Kwiatkowski, 1992). Second, assessment can better identify the services that would be most beneficial to the children with special needs and their families (Dunst et al., 1988). Third, assessment helps professionals evaluate the
effectiveness of their intervention (Bailey et al., 1988). Fourth, assessment should help ensure that the IFSP accurately reflects family goals or outcomes. Finally, assessments ultimately lead to greater benefits to the child (Garshelis & McConnell, 1993). According to Garshelis and McConnell (1993), current research shows that professionals do not accurately predict the priorities and concerns expressed by family members. They recommended that surveys be combined with personal discussions to ensure that services are effectively delivered to family systems.

Although a wide variety assessment measures have been used in the literature (Bailey, 1987), research documenting the effectiveness of these measures has been very limited (Bailey et al., 1990). Several factors may influence how successfully assessment data are transformed into functional IFSP goals. First, it is vital that those who complete the assessment measures are fully aware of how the information on these measures will be used (Dunst et al., 1988). This type of informed consent may lead to the development of a mutually trusting collaborative relationship between parents and professionals. Second, information about the assessment may help parents to see the positive aspects of the assessment. The more favorably parents view the assessment tools, the more likely they are to find the information provided within these surveys useful (Bailey & Blasco, 1990). Third, parents should be able to choose which assessment measures they wish to complete (Bailey et al., 1990).
With regard to family goals/outcomes, unlike child outcomes, the identification of family outcomes has been more elusive (Bailey & Wolery, 1992). Many would argue that an effective family-centered approach is one that enhances the family's capacity to meet their child's special needs (Bailey et al., 1998). Dunst et al. (1988) maintained that such a perspective reflects a limited view of why we work with families, and suggested that the ultimate goal of early intervention is to enable and empower families, under the assumption that a strong and supported family is the essential outcome.

Based on early intervention efforts for infants with disabilities, Shonkoff, Hauser-Cram, Krauss, and Upshur (1992) stressed family outcomes in three areas: (a) amount and quality of mother-child interaction; (b) size and helpfulness of the family's social support network; and (c) reduced stress as perceived by parents. Turnbull et al. (in press) conceptualize family outcomes in broad classes: (a) motivation outcomes (self-efficacy, perceived control, hope, energy, and persistence); and (b) knowledge/skill outcomes (information, problem-solving, coping skills, and communication skills). These perspectives provide insights into possible benefits for families, but clearly the field has not reached consensus as to desired outcomes (Bailey et al., 1998). Also, it could be argued that because each family is unique, evaluations need to be individually designed to assess the extent to which preferred outcomes are achieved.
Assuming the field could agree on a desired set of family outcomes, how should those outcomes be assessed? Measurement issues are critical in any evaluation effort, but are especially complicated in the context of families (Henderson, Aydlett, & Bailey, 1993). A family typically consists of more than one member, thus an initial decision is who constitutes the family and which family members will participate in the outcome assessment. In the case of family assessment, the attainment of most family outcomes is a personal experience that can only be reported by family members themselves (Bailey et al., 1998). Most family assessment instruments have been limited to paper-and-pencil responses to survey items. Although the advantages of this method are simplicity and economy, the interpretation of responses is limited to the response sets provided on the protocol.

**Personnel Preparation for Programs for Infants and Toddlers with Disabilities**

There is extensive agreement in the literature regarding the roles of early intervention personnel in family-centered models of service delivery (Bailey, Farel, O'Donnell, Simeonsson, & Miller, 1986; Dunst et al., 1988). P.L. 102-119 was clear in its intent that early intervention services were to be delivered by professionals within the context of the family. As a result, practitioners have been challenged to support families in ways that optimize the development of
children who reside within the family (Brown, Thurman, & Pearl, 1993; Klein & Campbell, 1990).

P.L. 102-119, Part H, identified 10 disciplines responsible for provision of early intervention services to infants, toddlers, and their families. Those disciplines are audiology, early childhood special education, medicine, nursing, nutrition, occupational therapy, physical therapy, psychology, social work, and speech-language pathology (Brown et al., 1993). For one major function of a personnel preparation project at the Carolina Institute for Research on Infant Personnel Preparation, Bailey (1988) requested representatives from each of the 10 identified early intervention disciplines to define roles and mission statements relative to P.L. 102-119. A brief summary of the role of each early intervention discipline follows:

Audiology. Provides diagnostic evaluation, management of communication needs, and coordination of communication services to children with auditory disorders.

Early Childhood Special Education. Provides environments which foster infant's mastery of skills across developmental domains and promote self-confidence and independence.

Medicine. Provides health services to promote a family's ability to foster health, growth, and development for their child.

Nursing. Provides diagnostic and treatment services of human responses to illness and promotes health, wellness, and development for infants and their families.
Nutrition. Provides developmentally and ecologically appropriate nutrition services for infants and families.

Occupational Therapy. Provides purposeful activities, within the context of the family, to promote children's mastery of developmental skills in the areas of self-help, adaptive behavior, play, and sensory motor functioning.

Physical Therapy. Provides services for at-risk or disabled infants to promote sensory motor and neuromotor development within the content of the family.

Psychology. Provides psychological evaluation and intervention to obtain a comprehensive overview of the child and family functioning.

Social Work. Assesses families' basic needs and provides concrete resources to meet those needs.

Speech-Language Pathology. Provides services to children which promote communication skills across social and ecological contexts, such as with family and peers, in school and the community (Bailey, 1988, pp. 6-14).

Early childhood services as defined in Part H of P.L. 102-119 were to be delivered by a multidisciplinary team who would help develop the Individualized Family Service Plan (IFSP). Therefore, professionals engaged in early intervention were required to establish mutual goals with families and other professionals (Bailey et al., 1992), understand the development of typical and atypical infants, and apply knowledge of child development in a variety of

Perceptions Concerning the Individualized Family Service Plan (IFSP)

P.L. 102-119, Part H, provides discretionary funds to states. The funds are allocated to facilitate early intervention services for children aged birth to 3 years and their families. The central core of early intervention legislation has been respect for and direct involvement of the family in their child's early intervention program (Bailey et al., 1990; Dunst et al., 1988; Turnbull, 1990). In this section of the literature review, several recent studies on perceptions of families and professionals about family-centered services are reviewed.

Perceptions of Mothers

Findings of a 1990 study by Mahoney, O'Sullivan, and Dennebaum resulted in identification of components perceived by mothers of children receiving early intervention to be most relevant in family-centered early intervention. The 503 mothers who participated in the study agreed on the importance of the following five dimensions of early intervention family services:

1. Family activities precipitate involvement of parents in the early intervention system;
2. Family activities provide parents with information relevant to their child's disability and intervention program;

3. Family activities relate to direct involvement of families in the child's intervention program;

4. Family activities enhance the functioning of the family and its individual members; and

5. Intervention activities provide families with acquisition of resources not directly related to their individualized intervention program (Mahoney, O'Sullivan, & Dennebaum, 1990, p.13).

In the same study, Mahoney et al. (1990) compared mother's perceptions of relevance of the components with percentage of families receiving early intervention services. Findings indicated that the five components were not consistent with the actual services provided to the families. They emphasized that "programs can ascertain that they are truly providing family-centered services only if the parents themselves perceive that they are receiving the kinds of services that family-centered intervention entails" (p. 4).

Involvement of Fathers in Early Intervention

Sparling, Berger, and Biller (1992) conducted a study regarding involvement of fathers in early intervention programs. To examine fathers' involvement in decision making and intervention, they studied participation of fathers in developing the Individualized Family Service Plan (IFSP) development. The researchers found that fathers typically
were not identified in the IFSP as team members in attendance or as persons responsible for implementation of IFSP outcomes and activities. Some reasons were cited by the authors for minimal paternal involvement. First, primary caretakers of children in cases of single-parent households generally have been mothers. Second, fathers generally have not been as available as mothers for attending planning meetings. Third, studies addressing parent training found that professionals often direct home programs and other intervention activities to the mother, not to the father. Fourth, the authors found in studies investigating interaction of fathers with their children with disabilities that fathers were less likely to become involved in programming with a child when the family was under financial or emotional stress, or had minimal support system, or when the child had a poor prognosis for improving developmental and social competencies.

**Perceptions of Mothers and Fathers**

Mothers and fathers of infants and toddlers with disabilities from Massachusetts participated in a longitudinal study to rate early intervention services (Upshur, 1991). Ninety-one families where mothers and fathers both participated rated the helpfulness of early intervention program services "high" when the services were directed to the child and the parent. Upshur (1991) also compared ratings of mothers (N=152) with ratings of fathers (N=114) concerning the helpfulness of early intervention services. Both mothers and fathers agreed that "the child received the most
benefits, with mothers ranking second, followed by the family as a whole, and fathers ranking last" (p. 351).

The study by Upshur (1991) also addressed the helpfulness of early intervention services to the parents. Findings were that mothers and fathers differed significantly in their rank ordering of relative benefits of early intervention. Mothers ranked emotional support high, while fathers ranked learning to be an advocate for the child and how to meet the needs of other family members as high. Both mothers and fathers agreed that learning to work with their child was the area of the most benefit.

Able-Boone, Sandall, Loughry, and Frederick (1990) conducted a study of 30 parents (30 mothers, 28 fathers) of young children who resided in Colorado. Research methodology consisted of open-ended and focused-interview techniques. Three major categories emerged from interviews with the families: (a) understanding family life; (b) family service needs; and (c) issues around P.L. 102-119. Parent informants discussed changes in family life following the birth of their child with a disability; examples of changes were disruptions in family schedules, demands on family members for care of the child with disability, and lack of time and attention for siblings. Parents expressed several family service needs including setting realistic goals for the child, obtaining expected services from professionals, accessing services, and obtaining information about the child's disability and availability of services in the community.
Parents were interviewed to examine specific components of P.L. 102-119. When asked, only 33% of parents knew about P.L. 102-119 and its provisions. Parents emphasized a need for professionals to have an understanding of family dynamics and cultural diversities and to respect a family's privacy during family assessment procedures. Also, informants emphasized the importance of active participation by parents in the IFSP process and that only people involved with the child and family should be participants of the IFSP meeting. A preference for developing the IFSP in the family's home was expected by 27% of the parents interviewed in the study; parents felt that they would be more comfortable in their home and that attendance of other family members would be more likely should meeting be held at home.

**Perceptions of Professionals**

Three broad questions pertaining to family-centered services were the focus of a study by Bailey, Buysse, Edmondson, and Smith (1992):

1. What is the current status of a family-centered approach in infant intervention programs? To answer this question, professionals in four states were asked to rate current program practices in four areas of family support.

2. Do professionals perceive a discrepancy between current and ideal practices in working with families? To answer this question, professionals were asked to rate how they felt families should be involved in each of four areas of family support.
3. What do professionals perceive to be the barriers that make it difficult to achieve ideal levels of family involvement? (p. 299-300).

To study the research questions, Bailey et al. (1992) utilized several methods of instrumentation. A questionnaire which requested 237 professionals working in early intervention in four states (two southern states, one midwestern state, and one northeastern state) was used to rank family involvement in decision-making, parent participation in child assessment, parent involvement in team meetings, and family service provision. A 9-point scale was used with a rank of "1" reflecting professional control of service and a rank of "9" reflecting parent enablement.

Professionals ranked current status of family participation in the 4-5 range (moderate amount of family involvement) and an ideal family participation in the 7-8 range (high degree of family involvement). The significance of difference between typical and ideal roles was tested using paired t-test comparisons. Comparisons were highly significant at the p < .0001 level.

Professionals participating in the study perceived family and system barriers to account for 70% of the barriers contributing to the differences between current and ideal involvement of families in early intervention. Lack of professional skills or knowledge accounted for 15% of the barriers. Professionals who responded to the questionnaire also suggested that parents may choose not to participate or...
may not have the knowledge to participate in their child's early intervention program.

This study documents the perceptions of early intervention professionals in four states regarding typical and ideal practices in four areas of family involvement. The study is limited due to several factors: (a) it is unknown how representative the professionals in the study are of all early intervention professionals within each state; (b) the generalizability to other states is uncertain; and (c) the self-report nature of the data means that it only describes perceptions of practices, rather than documenting actual practices. Nonetheless, there are some important findings from this study. First, professionals perceive a substantial discrepancy between how they currently involve families in early intervention programs and how families ideally should be involved. Second, professionals readily identified reasons for the discrepancies. Family barriers and system barriers were equally mentioned overall and collectively accounted for more than 70% of the barriers identified. Only 15% of the barriers mentioned reflected a lack of skills or knowledge on the part of professionals. Finally, the findings were stable and consistent across the four states. Although some statistically significant differences among states were found in some items on ratings of typical and ideal practices, an inspection of the means indicates that these likely represent relatively small differences in actual practice.
Perceptions of Families and Professionals

A study was conducted by McBride, Brotherson, Joanning, Whiddon, and Demmitt (1995) to investigate the meaning of family-centered intervention and the extent to which it is being implemented from the perspectives of both families and professionals in developing IFSPs. In this study, practice indicators reflecting three principles of family-centered intervention were developed to evaluate current practice. Findings from semi-structured interviews indicated that professionals have an understanding of the change in focus from child to family. However, some incongruence occurred between family-centered attitudes and actual practice. Although families expressed overall satisfaction with services they were receiving, some professionals were clearly more family-centered than others in their practice.

This study provided specific information regarding the progress of the implementation of Part C of Individuals with Disabilities Act (IDEA) for young children with disabilities and their families. However, too little research documents the assumed efficacy of family-centered intervention. It is believed by some authors that values must drive our research and practice (Kaiser & Hemmeter, 1989).

The findings from this study provide us with an understanding of the movement towards family-centered practices. The shift from family-allied practices to family-focused services is discussed as being a crucial shift in paradigms from child-to family-centered practice.
Professionals are challenged to incorporate family systems theory fully into their service delivery practices (McBride et al., 1993). They are challenged to become more family-centered, even when parents give them the lead in decision-making. They are challenged to look to the future and help families build the competence and confidence that will carry them successfully through their whole life. Finally, researchers and practitioners are challenged to examine the efficacy of family-centered services for enhancing the development of children with disabilities and their families.

**Part C-Infants and Toddlers with Disabilities Based on the IDEA Amendments of 1997**

Part C contains the Infants and Toddlers program of the Individuals with Disabilities Education Act (IDEA) of 1997. It is a formula grant program designed to assist states in establishing a statewide comprehensive system of early intervention services for infants and toddlers with disabilities and their families.

Part C also extends Part B protections to infants and toddlers with disabilities and strengthens incentives for states to provide services to infants and toddlers (birth to age 3). The major content changes of Part C are as follows:

**Findings and Policy.** The new content restates current law, but modifies one purpose from developing an early intervention "program" to developing a "system of early
intervention services" and adding a purpose to expand services to at-risk children.

Definitions. In current law, definitions are provided for infants and toddlers with disabilities, early intervention services, council, and developmental delay. New content alphabetizes the definitions and adds "at-risk infant or toddler."

General Authority. New content of the law authorizes the secretary to make grants to "maintain", as well as "implement", a statewide, comprehensive, coordinated, multidisciplinary, interagency system.

Eligibility. New content requires that participating states have in effect a statewide system (former requirement for fifth and succeeding years).

Requirements. New content requires states to maintain current law, while clarifying that identification of each family's needs must be "family-directed" and dropping the implementation timetable. New content also adds a requirement that a state policy must be in effect that ensures availability of early intervention services.

Natural Environments. The home and community settings in which children without disabilities participate.

Personnel Standards. Earlier law required that: 1) personnel must be appropriately and adequately trained; 2) a state must establish and maintain standards; 3) to the extent that personnel do not meet the highest state standard applicable to a specific profession or discipline, steps a
state intends to take to retain or hire personnel who meet appropriate state standards must be outlined. New content retains the three current requirements and adds; 4) paraprofessionals must be appropriately trained and supervised in accordance with state law, regulation, or written policy; and 5) clarifies that a state may adopt a policy that includes requiring Local Educational Agency (LEA) to make ongoing good-faith efforts to recruit and hire appropriately and adequately trained personnel to provide special education and related services including, in a geographic area of the state where there is a shortage of personnel, the most qualified persons available who are making satisfactory progress toward completing applicable course work necessary to meet the standards within three years.

**Individualized Family Service Plan (IFSP).** New content is similar to earlier current law with an additional requirement for a justification whenever services will not be provided in the natural environment.

**State Application.** New content requires that financial responsibility among agencies be identified in the state plan.

**Assurance.** The same eight assurances are to be provided.

**Use of Funds.** The content is substantively same as previous law with the addition of Senate language specifically authorizing initiation, expansion, or improvement of collaborative efforts related to at-risk
infants and toddlers and not serving at-risk infants and toddlers as infants and toddlers with disabilities.

**Procedural Safeguards.** New content expanded the prohibition regarding who may not serve as a surrogate parent to include individuals or employees of providers of early intervention services.

**State Interagency Coordinating Council.** Current law requires that states establish an Interagency Coordinating Council (ICC) according to listed specifications to be eligible for funds. The content of the revised law substantively the same as previous law regarding establishment, meetings, management authority, and function. The number of members would be left to the state (except for certain required individuals). New content adds required members from Head Start agency and the state agency responsible for child care. It, also, provides for the permissive inclusion of other members selected by the governor (including Indian representation). New content also includes conflict of interest provisions governing council members and adds authorized activity that relates to advising appropriate agencies in the state with respect to the integration of services for infants and toddlers with disabilities and at-risk infants and toddlers.

**Federal Administration.** New content makes clear references to State Educational Agency (SEA), Local Educational Agency (LEA) and education of children with disabilities.
Allocation of Funds. New content describes allocations of funds for states, territories, and the Secretary of the Interior.

Federal Interagency Coordinating Council. New content established the Federal Interagency Coordinating Council (FICC) and it continues.

Summary

The development and implementation of an Individualized Family Service Plan (IFSP) process is a complex task involving many people (McGonigel, 1991). Despite the variety of perspectives that are necessarily reflected in this process, it is critically important under federal law that all those involved share a family-centered philosophy and conceptual framework. The requirement for an IFSP for all children and their families receiving early intervention services validates the principle that infants and toddlers with special needs must be served within the context of the families.

Current literature has shown a trend toward a family-centered approach, with emphasis on the family as the driving force in planning interventions. In a family-centered approach, interventionists need to recognize the child as part of a family system; recognize and respect the family's concerns, priorities, and resources; and permit the parents to participate in early intervention at the level they desire (Bailey, McWilliam, & Winton, 1992; McGonigel, Kaufmann, & Johnson, 1991). This means that early intervention programs that were previously child-focused must now have the flexibility, expertise, and resources to meet the needs of all family members as they relate to the child's development.

The IFSP is an agreement reflective of the current needs, wants, and desires of the family in relation to their
child who has special needs. This agreement is intended to be formulated and implemented as a result of a dynamic, collaborative, cooperative team process involving the families and professionals from multiple disciplines and agencies. The core of this system is the family.

A collaborative relationship between families and professionals is an essential component of successful early intervention efforts (Dinnebeil et al., 1996). A collaborative relationship exists when both families and professionals view each other as partners, with both providing expertise and knowledge that will help the family reach its goals. The quality of that relationship may affect the success of early intervention efforts, with high-quality relationships providing the context for improvement in child and family outcomes. Such relationships acknowledge families as capable individuals who provide for their family's needs.

Finally, the numbers of studies that examined issues of family-centered models of service delivery have proliferated since enactment of P.L. 99-457 in 1986 (Perrin, 1994). However, families' and service providers' perceptions of the IFSP process have been examined in only a few studies. Recent studies addressing parent and professional perceptions of early intervention and family-centered approaches concluded that involvement in their children's intervention programs was of primary importance to families; yet, discrepancies were found between what parents and professionals found as ideal participation of families and what was actual
participation (Able-Boone et al., 1990; Bailey et al., 1992) as well as how congruent the perspectives are between those providing and those receiving early intervention services (Sexton et al., 1996). An inadequate knowledge base of family systems theory and family structure was also perceived by parents and professionals as a primary barrier to implementation of a family-centered service delivery model (Able-Boone et al., 1990; Mahoney et al., 1990; Sparling et al., 1992).

This review of the literature indicates recent agreement in the thrust for parent and professional collaboration in early intervention with infants and toddlers. A need exists for family involvement in all aspects of a young child's intervention program. However, questions regarding the efficacy of early intervention services should be asked of families and professionals (Bailey et al., 1998). Further research should determine if families and professionals agree to the appropriateness of the services provided, family's strengths, needs, and outcomes from the IFSP and use their perceptions as one method of evaluating the IFSP for effecting a family-centered practice. In part, the answer to these questions will reflect the evolving nature of policy and practice with regard to the relative resources invested in child and family services. A major policy issue to be determined is the relative importance of child versus family outcomes (Bailey et al., 1998).
Ultimately the field must decide if the results of early intervention constitute a necessary or sufficient basis for determining that the efforts have been justified. Whether they agree with this perspective or not, an expectation of overall efficacy will continue to be held for the field by consumers and policymakers. Thus, it becomes a professional responsibility to determine both desirable and realistic expectations for outcomes for all clients of early intervention, which include both children and families (Bailey et al., 1998).

Chapter III provides an overview of the methods and procedures for the study.
CHAPTER 3

METHODOLOGY

Chapter three describes the methodology used in this study. Included is a description of the approval process, subject selection, method of data collection, research procedures, and system of analyzing the data.

Approval Process

The Special Children's Clinic and the UNLV Department of Special Education cooperated in a study on the experiences of families and service coordinators regarding usefulness of the Individualized Family Service Plan (IFSP) and assumptions made in law regarding required processes for developing and implementing the IFSP. In April, 1998, the researcher and his advisor met with the director and two designees as research co-coordinators at the Special Children's Clinic in Las Vegas, Nevada. The proposed research was approved and an informed consent letter and questionnaire were co-designed by the researcher and Clinic personnel for use with families and service coordinators.
Subjects

A reported 164 families and their children were receiving at least one service from the Special Children's Clinic under Part C (originally Part H) of the Individuals with Disabilities Education Act (IDEA), but not all were eligible for participation as potential subjects. Of 164 families receiving early intervention services, 50 did not pick up the survey packets from the families' communication folder at the Clinic, it appeared thirty were still in the process of completing their first IFSP, and the researcher was told by Clinic personnel that many of the families either would not be able to read and understand a questionnaire or simply would not take the time necessary to complete and return it.

Subject selection criteria included families who a) were receiving early intervention services through the Special Children's Clinic Intervention Programs, b) signed a consent agreement to participate in the study, and c) had completed their first written IFSP.

Only those service coordinators whose families agreed to participate in the study were asked to complete the study questionnaire. Nine of the service coordinators were coordinating services for more than one family and were asked to complete questionnaires on each family who agreed to participate in the study. In addition to those 9, 31 service coordinators were expected to facilitate the development and implementation of the IFSP, under the auspices of the Clinic,
for a total pool of 40 potential service coordinators designing and implementing the IFSP through the Department of Human Resources, Division of Health (DH), Clark County, Nevada.

Twenty six families who have children ages birth to 3 with disabilities and 17 service coordinators who work with twenty six children and families were determined to be eligible for this study. Twenty three (88%) of the family member respondents were mothers. Tables 3.1 and 3.2 show demographic data for the families and service coordinators who participated in the study.

Data Collection

Data were collected for 2 months, from May 6, 1998 to July 10, 1998. The questionnaire consisted of research items or statements organized under the four research assumptions (A through D) and were represented in the questionnaire as follows: Assumption A has research items in Part I; Assumption B in Part II; Assumption C in Part III; and Assumption D in Part IV. See the Questionnaire in Appendix A.

The survey packets for parents and service coordinators contained an introductory letter, consent letters to families and service coordinators, instructions explaining the survey's purpose and the process of completion; a description of Individualized Family Service Plan (IFSP); the survey; personal data form for families and service coordinators, as appropriate to each packet; and a stamped, self-addressed
return envelope. Families and service coordinators who returned the packet constituted the participants. The items on the questionnaire were based on an analysis of the relevant laws, assumptions, and findings or point of view from the literature that identified issues and concerns with the use of the Individualized Family Service Plan (IFSP) and family-centered services.

Questionnaire items were piloted, reviewed, and revised based on survey questionnaire design methodology (Berdie & Anderson, 1974; Rossi, Wright, & Anderson, 1983; Jaeger, 1984; Borg & Gall, 1989). Four groups were selected to participate in pilot tests of the questionnaire. Three university special education faculty members, three early intervention specialists, two service coordinators, and five members of families who had infants or toddlers with disabilities reviewed and completed a formal evaluation of the pilot questionnaire. Pre-field test modifications were made on the basis of the feedback received from the reviewers. A field test of the questionnaire was conducted using three families and three service coordinators as subjects. The purpose of the field test was to remove, revise, or replace any questions that were unclear, ambiguous, culturally and socially biased, or too difficult. Copies of the final questionnaire, cover letter, consent letters, and personal data are in as Appendix A.

The responses from the four groups were analyzed to determine if the four discriminant groups could respond to
each questionnaire item without difficulty within each pilot test situation. The questionnaire was given to the four groups in the pilot phase of the study as a means of modifying and improving the correctness and clarity of each research item. Participants in the four pilot groups agreed that the response items represented a fair sample of the content of each assumption being tested, thus constituting content validity.

**Procedures**

The research process with the Clinic Intervention Programs included a letter describing the study, consent form, and a questionnaire as a packet. Directions in the letter asked families who were willing to participate to sign the consent form and return it with a completed questionnaire to the researcher. The researcher sent the consent form to the Clinic personnel who had coded the forms for a) protection of family privacy, and b) correct identification of the families' service coordinators, who were given a copy of family consent so they would know to complete a questionnaire on that family. The procedures to protect the confidentiality of all participants and the infants and toddlers receiving services included: a) receiving approval from the University Human Subjects Committee and b) identifying participants only through the use of investigation codes used by the co-coordinators at the Clinic.
The packet containing the survey questionnaire, a postage-paid return envelope, and consent forms were put in each family's communication folder at the Clinic for pick up. Return of the consent letter and completed questionnaire represented agreement from families for the student researcher to use their responses in the study and to ask their service coordinators to complete an identical questionnaire.

A copy of the consent form from families with whom the service coordinators worked was sent to the service coordinators who completed a questionnaire for each family, and returned it to the student researcher. With assistance of the Clinic co-coordinators, each of the families was matched to questionnaires from the appropriate service providers. All respondents remained unknown to the researcher. No names were used in any reports of their answers, and their responses to each question were compiled with others and reported as group perceptions.

In the first distribution of research packets, the subjects were requested to complete the questionnaire and return it to the student researcher no later than July 10, 1998. A numerical code had been applied at the Clinic to each questionnaire as well as to each return envelope so a log of respondents could be maintained by a designee at the Clinic. This assisted the co-coordinators in determining who required follow-up contact. For example, respondents were logged in by identification number in a directory of subjects created for
record keeping purposes and maintained only by the co-coordinating personnel at the Clinic. After two months from the date on which packets were distributed, the nonrespondents were sent a reminder letter followed by a telephone call from the Clinic research coordinators. Follow-up phone calls were also made to answer any questions concerning the survey. If these additional families completed the surveys, they also returned them to the student researcher with no identifiers, except the service coordinator code. Data on the family members and service coordinators completing the survey are identified in Tables 3.1 and 3.2.

Respondents were asked to answer 47 Likert scale research items divided into four main research categories (A through D) and six open-ended questions regarding their experiences of the IFSP. In addition, respondents were encouraged to add comments under research items or statements to enable elaboration. Analyses of the data from respondents appear in detail in Chapter 4.

Data Analysis

A 5 point Likert scale format was used for each questionnaire item with numerical weights of 1 for strongly disagree, 2 for disagree, 3 for undecided, 4 for agree, and 5 for strongly agree. The responses were input to the spreadsheet of Quattro computer software for data analysis. The printed Quattro data file was compared to the original
numbers of the questionnaire to check that the data were input correctly.

Four main assumptions were answered by calculating data from 47 research items with 5 point Likert scale. Chi-square tests, correlations, and frequency counts, where appropriate, were conducted to determine a) if families and service coordinators agree on IFSP goal/outcome appropriateness, services provided, and the family's priorities and concerns in the IFSP b) if the IFSP policy and processes effecting family-centered services and helping to validate four basic assumptions in the law.

Criteria for meeting the assumption were: a) the assumption was partially met if greater than 50% of all family and service coordinator respondents to all Likert-scale items under each assumption were "agree" or "strongly agree" and open-ended question responses exceeded a 50% positive match; and b) the assumption was fully met if greater than 75% of all respondents to all Likert-scale answers were "agree" or "strongly agree" and open-ended question responses exceeded a 75% positive match.

A summary of responses are presented and discussed in Chapter 5.
### Table 3.1 Demographic Characteristics of Family Respondents

<table>
<thead>
<tr>
<th>The person who filled out the survey:</th>
<th>Mother</th>
<th>Father</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>23(88%)</td>
<td>1(4%)</td>
<td>2(8%)</td>
</tr>
</tbody>
</table>

**Child's age:**
- Less than 1 year: 4(15%)
- 1 - 2 years: 10(38%)
- 2 - 3 years: 12(46%)

**Year(s) enrolled in early intervention program:**
- Less than 1 year: 17(65%)
- 1 - 2 years: 5(19%)
- 2 - 3 years: 4(15%)

**Year(s) worked with present service coordinator:**
- Less than 1 year: 22(85%)
- 1 - 2 year: 2(8%)
- 2 - 3 year: 2(8%)

**Gender of children:**
- Female: 8(31%)
- Male: 18(69%)

**Education level:**
- High school: 8(31%)
- Partial college: 7(27%)
- College graduate: 7(27%)
- Graduate degree: 4(15%)

**Ethnicity:**
- Caucasian: 17(65%)
- African American: 1(4%)
- Hispanic: 3(12%)
- Asian American: 3(12%)
- Other: 2(8%)

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Table 3.2 Demographic Characteristics of Service Coordinator Respondents

<table>
<thead>
<tr>
<th>Job title as a service coordinator:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child development specialist</td>
<td>14(54%)</td>
</tr>
<tr>
<td>Speech/language pathologist</td>
<td>6(23%)</td>
</tr>
<tr>
<td>Early childhood special education teacher</td>
<td>2(8%)</td>
</tr>
<tr>
<td>Nutritionian</td>
<td>2(8%)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>1(4%)</td>
</tr>
<tr>
<td>Physical therapist</td>
<td>1(4%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of children/families on caseload:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4 - 10</td>
<td>7(27%)</td>
</tr>
<tr>
<td>11 - 20</td>
<td>15(58%)</td>
</tr>
<tr>
<td>21 - 30</td>
<td>4(15%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of years employed as service coordinator in present program:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>4(15%)</td>
</tr>
<tr>
<td>More than 1 year</td>
<td>22(85%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education level:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>College graduate</td>
<td>11(42%)</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>15(58%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>22(85%)</td>
</tr>
<tr>
<td>African American</td>
<td>3(12%)</td>
</tr>
<tr>
<td>Other</td>
<td>1(4%)</td>
</tr>
</tbody>
</table>

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CHAPTER 4

RESULTS

The results of this study are reported for each of the four assumptions and related research items. A questionnaire was used to obtain the level of agreement between the families and service coordinators regarding the development and implementation of the Individualized Family Service Plan (IFSP). The questionnaire was divided into four categories based on the assumptions (A to D) to be tested using 47 Likert-scale type statements, six open-ended questions, and comments of respondents on some questionnaire items.

The law and regulations of IDEA (the Individuals with Disabilities Education Act) make several types of assumptions in governing infant and toddler programming. Four basic assumptions in the law and the IFSP process were investigated in this study.

Assumption A suggests the family can and will participate in identifying specific priorities, concerns,
and goals/outcomes for the IFSP. This assumption was tested using 11 research items and 2 open-ended questions. Assumption B suggests the families and service coordinators can identify and obtain services needed to reach the IFSP goals/outcomes. Five research statements and 2 open-ended questions were designed to determine the level of agreement between the families and service coordinators as a method of testing the validity of this assumption. Assumption C infers that the families and service coordinators select services for listing in the IFSP that address the priorities, concerns, and goals/outcomes of the child and family. Twelve research items and an open-ended question were used to test the respondents' level of agreement and the validity of the assumption. Finally, assumption D suggests that the families and service coordinators can evaluate effectiveness of the development and implementation of the IFSP. Seven research items and an open-ended question tested the two groups' level of agreement and the assumption.

Twenty-six families and 17 service coordinators who served the 26 families returned a total of 52 completed questionnaires. Nine service coordinators were coordinating the IFSP for more than one family and were asked to
complete a questionnaire for each family after receiving signed consent to participate.

A Chi-square analysis and frequency count were applied to each Likert-scale questionnaire item and open-ended questions to determine the level of agreement between the families and service coordinators regarding the development and implementation of the IFSP and to test the validity of the assumption specified in the law. Open-ended questions offered the families and service coordinators an opportunity to address novel topics and provided information not requested elsewhere in the questionnaire. Respondents also were encouraged to make comments elaborating on their responses. Responses to open-ended questions and comments were analyzed and grouped thematically where necessary and presented as verbatim as possible. In addition, correlations were conducted to determine if a relationship existed between the two groups' responses on each item and whether or not a family response matched the service coordinator's response on each research item. Results are presented for research items or statements under the four Assumptions.
Assumption A

Families and service coordinators work together in a manner that enables the family to demonstrate ability to participate in identifying its specific priorities, concerns, and goals/outcomes in the IFSP.

In Assumption A, responses from the families and service coordinators on each research item regarding family priorities, concerns, and goals/outcomes of the IFSP showed statistically significant differences in their level of agreement on 3 of 11 research items (1 item was at $p < .05$ and 2 items were $p < .01$). A frequency of response item analysis showed 85% 'agree' or 'strongly agree', 9% 'undecided', and 6% 'disagree' or 'strongly disagree' on 11 research items designed to test Assumption A. Two open-ended questions were asked respondents to identify a) family priorities and concerns in developing the IFSP, and b) specific IFSP goals/outcomes by priority. The findings are presented in Tables 4.1 through 4.13.

Research Item # 1. The IFSP is developed at a time when the family is ready to set goals/outcomes.

Data in Table 4.1 reveal that the families and service coordinators had no statistically significant difference in their level of agreement with regard to the statement that
the IFSP was developed at a time when the family was ready to set goals/outcomes, $X^2 (3, N=52)=2.92, p > .40$.

**Table 4.1** Family Readiness to Develop IFSP Goals/Outcomes

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>2 (7.7%)</td>
<td>5 (19.2%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>4 (15.4%)</td>
<td>3 (11.5%)</td>
</tr>
<tr>
<td>Agree</td>
<td>12 (46.2%)</td>
<td>14 (53.8%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>8 (30.8%)</td>
<td>4 (15.4%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

**Comments:** Two service coordinators said that "families are asked to complete an IFSP before diagnoses are completed and often before they know what's wrong with their child. Therefore the family needs to know what the IFSP is."

**Research Item #2.** At least one member of the family has equal influence with the service coordinator in developing the IFSP.

Data in Table 4.2 indicate that the families and service coordinators had no statistically significant difference in their responses regarding at least one member of the family having an equal influence with the service coordinator in developing the IFSP, $X^2 (4, N=52)=3.46, p > .40$. 

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Table 4.2 Sharing Equal Influence to Develop the IFSP

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>2 (7.7%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>11 (42.3%)</td>
<td>16 (61.5%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>11 (42.3%)</td>
<td>9 (34.6%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

. Comments: Two service coordinators reported that some parents have even more influence than the service coordinators in developing the IFSP. They mentioned that "it also depends if the parent has the skills and sense of empowerment necessary for the process. In these cases, the family was highly skilled." On the other hand, one family member mentioned that "I, as a parent, am typically ignorant of IFSP procedures. I certainly can not be effective and influence my child's IFSP processes."

Research Item #3. The family's native language or other mode of communication (example: sign language) is used in a) developing the IFSP and b) implementing the IFSP.

Data in Tables 4.3 and 4.4 reveal that the families and service coordinators had no statistically significant differences regarding use of family's native language or other mode of communication to develop the IFSP, $X^2 (3,
N=51) = 2.59, p > .40. (see Table 4.3) and implement the IFSP, $X^2 (4, N=50) = 2.56, p > .60$ (see Table 4.4).

**Table 4.3** Use of Family's Native Language or Other Mode of Communication to Develop the IFSP

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=25)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (3.8%)</td>
<td>2 (7.7%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>4 (15.4%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>8 (30.8%)</td>
<td>11 (42.3%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>12 (46.2%)</td>
<td>12 (46.2%)</td>
</tr>
<tr>
<td>Total</td>
<td>25 (96.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

**Table 4.4** Use of Family's Native Language or Other Mode of Communication to implement the IFSP

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=24)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (3.8%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>3 (11.5%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>8 (30.8%)</td>
<td>11 (42.3%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>11 (42.3%)</td>
<td>13 (50.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>24 (92.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

**Comments:** One service coordinator and 1 family mentioned that the family speaks bilingually at home. They indicated that lack of knowledge of another language or culture could impede the process in developing and implementing the IFSP.
Research Item # 4. The service coordinator assists the family in identifying an accurate list of family priorities and concerns.

Data in Table 4.5 indicate that the families and service coordinators showed no statistically significant difference in their level of agreement on this item, $X^2 (4, N=52)=6.62, p > .10$.

Table 4.5 Service Coordinators Help Families to Identify an Accurate List of Families' Priorities and Concerns

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>0 (0.0%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>11 (42.3%)</td>
<td>17 (65.4%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>14 (53.8%)</td>
<td>7 (26.9%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Comments: One family reported that "my service coordinator is very honest with me in ways to deal with my son's disability-doesn't keep things from me. She is helping me to be positive in all things concerning my child." Another parent appreciated that "they tell me what they think my child's potential is." The same family member also said that interpersonal relationship such as honesty,
trust, and establishing a positive atmosphere were seen as important contributors to working successfully together.

Research Item # 5. The service coordinator gives priority to the goals/outcomes preferred by the family in the IFSP.

Data in Table 4.6 reveal that the families and service coordinators had no statistically significant difference in their level of agreement on this item, $X^2 (4, N=52)=7.64, p > .10$.

Table 4.6 Service Coordinator Gives Priority to the Goals/Outcomes Preferred by the Family in the IFSP

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>2 (7.7%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>0 (0.0%)</td>
<td>2 (7.7%)</td>
</tr>
<tr>
<td>Agree</td>
<td>10 (38.5%)</td>
<td>15 (57.7%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>14 (53.8%)</td>
<td>8 (30.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

. Comments: One family member reported that "I, as a parent, have learned that what was a priority for our family in the beginning is not as vital as other issues that the service coordinator identifies."
Research Item # 6. The family considers the goals/outcomes in the IFSP to be appropriate.

Data in Table 4.7 reveal that the families and service coordinators showed no statistically significant difference in their level of agreement regarding the appropriateness of goals/outcomes in the IFSP, \( X^2 (3, N=52)=6.12, p > .10 \).

**Table 4.7 Appropriateness of IFSP Goals/Outcomes**

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>2 (7.7%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>0 (0.0%)</td>
<td>2 (7.7%)</td>
</tr>
<tr>
<td>Agree</td>
<td>11 (42.3%)</td>
<td>16 (61.5%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>13 (50.0%)</td>
<td>8 (30.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Comments: One service coordinator reported that “if the family doesn’t consider the goals/outcomes in the IFSP to be appropriate, the service coordinators will fail to make them aware that they need to feel [sic] goals/outcomes are appropriate.”
Research Item # 7. IFSP goals/outcomes were developed to meet the priorities and concerns of the a) child b) parents and c) all family members.

Data in Table 4.8 reveal that the families and service coordinators showed no statistically significant difference in their level of agreement regarding priorities and concerns to the Child component of this item, \( X^2 (2, N=52) = 4.27, p > .10 \).

**Table 4.8 IFSP Goals/Outcomes Meet the Priorities and Concerns for the Child**

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>2 (7.9%)</td>
<td>2 (7.7%)</td>
</tr>
<tr>
<td>Agree</td>
<td>6 (23.1%)</td>
<td>13 (50.0%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>18 (69.2%)</td>
<td>11 (42.3%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

However, Table 4.9 data show that a statistically significant difference was found between the families and service coordinators in their degree of agreement in developing IFSP goals/outcomes to meet the priorities and concerns of parents, \( X^2 (4, N=52) = 10.66, p < .05 \).
Table 4.9 IFSP Goals/Outcomes Meet the Priorities and Concerns for the Parents

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>2 (7.9%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>2 (7.9%)</td>
<td>3 (11.5%)</td>
</tr>
<tr>
<td>Agree</td>
<td>6 (23.1%)</td>
<td>16 (61.5%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>15 (58.7%)</td>
<td>7 (26.9%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Table 4.10 also shows that a statistically significant difference was found between the families and service coordinators in their responses about IFSP goals/outcomes developed to meet the priorities and concerns of all family members, \( \chi^2 (4, N=52)=18.20, p < .01 \).

Table 4.10 IFSP Goals/Outcomes Meet the Priorities and Concerns for All Family Members

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>3 (11.5%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>3 (11.5%)</td>
<td>8 (30.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>4 (15.4%)</td>
<td>14 (53.8%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>15 (58.7%)</td>
<td>4 (15.4%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

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Research Item # 10. When the IFSP is reviewed, the IFSP goals/outcomes are being met.

Table 4.11 indicates that a statistically significant difference was found between the families and service coordinators in their degree of agreement on this item, $X^2 (3, N=52)=14.39, p < .01$.

Table 4.11 IFSP Goals/Outcomes were being Met at the Time of IFSP Review

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (3.8%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>2 (7.9%)</td>
<td>3 (11.5%)</td>
</tr>
<tr>
<td>Agree</td>
<td>10 (38.5%)</td>
<td>21 (80.8%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>13 (50.0%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Comments: One service coordinator reported that “activities are designed to work toward goals/outcomes and stimulate child’s overall development. Home programs are provided for families to follow through at home to work towards goals.” Another service coordinator also reported that “therapy is given to help work on goals/outcomes and suggestions for family to follow through at home to work on goals/outcomes.” One family mentioned that most of the IFSP goals/outcomes were not met, but were ongoing.
In open-ended item #8, the families and service coordinators were asked to list the most critical priorities and concerns of families listed in the IFSP. The families and service coordinators (n=52) listed seven priorities and concerns. The most critical priorities and concerns listed by families and service coordinators by frequency of response are reported in Table 4.12.

**Table 4.12** Most Critical Priorities and Concerns of Families Listed in the IFSP

<table>
<thead>
<tr>
<th>Most Critical Priorities &amp; Concerns in the IFSP</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
<th>Total (N=52)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech and language</td>
<td>12</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td>Fine and gross motor</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Socialization</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Overall development</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Independence</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Health and nutrition</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Sufficient therapists</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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In open-ended item #9, the families and service coordinators were asked to list specific IFSP goals/outcomes by priority. Their responses appear in Table 4.13.

**Table 4.13 Specific IFSP Goals/Outcomes by Priority**

<table>
<thead>
<tr>
<th>Specific IFSP Goals/Outcomes by Priority</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
<th>Total (N=52)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing language</td>
<td>6</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>Developing motor skills</td>
<td>8</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Interacting with others</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Improving nutrition</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Attending group activity</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Following directions</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Decreasing misbehaviors</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

The number of family and service coordinator commonalities among responses to each research item support the validity of Assumption A that families can and do participate in identifying priorities, concerns, and goals/outcomes for the IFSP.
Assumption B

Families and service coordinators can identify services needed to reach the IFSP goals/outcomes and see that those services are provided.

In Assumption B, responses for the two groups regarding IFSP goals/outcomes related to services provided to the child and family showed a statistically significant difference in their level of agreement on 1 of 5 research items. A frequency of response item analysis showed 81% 'agree' or 'strongly agree’, 10% 'undecided’, and 9% ‘disagree’ or ‘strongly disagree’ on 5 research items. Two open-ended questions were used to identify a) services needed but not provided for the child and family, and b) any barriers that prevent families from getting services. The findings are presented in Tables 4.14 through 4.20.

Research Item #1. The service coordinator uses the IFSP goals/outcomes in determining the services to be provided for the a) child and b) family.

Data in Tables 4.14 and 4.15 reveal that no statistically significant differences were found between the families and service coordinators in their level of agreement on this item regarding the child, \( X^2 (4, n=52) = 3.34, p > .50 \). (see Table 4.14) and the family, \( X^2 (4, \)
N=51)=3.03, p > .50 (see Table 4.15). One (3.8%) family did not respond to this item.

Table 4.14 Use of the IFSP Goals/Outcomes to Determine the Services to be Provided for the Child

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>1 (3.8%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>11 (42.3%)</td>
<td>15 (57.7%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>13 (50.0%)</td>
<td>9 (34.6%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Table 4.15 Use of the IFSP Goals/Outcomes to Determine the Services to be Provided for the Family

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=25)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>2 (7.9%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>3 (11.5%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>10 (38.5%)</td>
<td>14 (53.8%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>9 (34.6%)</td>
<td>10 (38.5%)</td>
</tr>
<tr>
<td>Total</td>
<td>25 (96.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>
Research Item # 2. The service coordinator gives the family an opportunity to choose the services desired.

Data in Table 4.16 reveal that a statistically significant difference was found between the families and service coordinators in responding to this statement, $X^2 (4, N=52)=11.50, p < .05$.

Table 4.16 Service Coordinator Gives Family an Opportunity to Choose Services

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>2 (7.9%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>2 (7.9%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>5 (19.2%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>7 (26.9%)</td>
<td>16 (61.5%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>12 (46.2%)</td>
<td>7 (26.9%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Comments: One family member reported that "the family sometimes doesn't know what services are available and what they mean for the child and family."

Research Item # 3. Some services on the IFSP were not provided to the a) child and b) family.

Data in Tables 4.17 and 4.18 reveal that no statistically significant differences were found between the families and service coordinators in their level of agreement on this item for the child, $X^2 (4, N=52)=9.07, p >
.05 (see Table 4.17) and the family, $X^2 (4, N=52)=8.41, p > .05$ (see Table 4.18).

**Table 4.17** Services on the IFSP not Provided to the Child

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>14 (53.8%)</td>
<td>11 (42.3%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>3 (11.5%)</td>
<td>11 (42.3%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>4 (15.4%)</td>
<td>3 (11.5%)</td>
</tr>
<tr>
<td>Agree</td>
<td>1 (3.8%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>4 (15.4%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

**Table 4.18** Services on the IFSP not Provided to the Family

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>14 (53.8%)</td>
<td>11 (42.3%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>3 (11.5%)</td>
<td>11 (42.3%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>4 (15.4%)</td>
<td>3 (11.5%)</td>
</tr>
<tr>
<td>Agree</td>
<td>2 (7.7%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>3 (11.5%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Comments: One service coordinator reported that "if some services on the IFSP are not provided, information given to parents to seek services in the community is needed, if available." Another service coordinator mentioned that home visits would be helpful, particularly during meal time to help child tolerate textures.
In open-ended item # 4, the families and service coordinators were asked to describe services needed but not provided. The frequency of identified components was counted and analyzed by groups (families and service coordinators, and total for the two groups).

Fourteen (54%) of 26 families reported that seven services were needed but not provided as presented in Table 4.19. Table 4.19 shows that 24 (94%) service coordinator questionnaires had responses saying that no services needed were not provided for the child and family. Only inclusive classroom and transportation (n=1 for each item) were mentioned by the two service coordinators as services not provided.

**Table 4.19 Services Needed but not Provided**

<table>
<thead>
<tr>
<th>Services</th>
<th>Family (N=14)</th>
<th>Service Coordinator (N=2)</th>
<th>Total (N=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusive classrooms</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Speech &amp; language</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Home visits</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Sufficient therapists</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Transportation</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Parent training</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>ASL*</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>No response</td>
<td>12</td>
<td>24</td>
<td>36</td>
</tr>
</tbody>
</table>

* ASL: American Sign Language
In open-ended item # 5, the families and service coordinators were asked to list any barriers that prevent families from getting services needed. The barriers listed by families and service coordinators were analyzed by number and frequency. The families and service coordinators \((n=26)\) identified six barriers that prevented families from getting services and are presented in Table 4.20. Table 4.20 also shows that 13 (50%) families and 13 (50%) service coordinators did not respond to this item.

**Table 4.20 Barriers that Prevent Families from Getting Services**

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Family ((N=13))</th>
<th>Service Coordinator ((N=13))</th>
<th>Total ((N=26))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of programs &amp; facilities</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Lack of information</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Limited time of service provider</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Lack of money</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Lack of administrative cooperation</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Lack of parent training</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>No response</td>
<td>13</td>
<td>13</td>
<td>26</td>
</tr>
</tbody>
</table>

The number of family and service coordinator commonalities among responses to each research item support the validity of Assumption B that families and service coordinators can identify services for the IFSP goals/outcomes and see that those services are provided.
Assumption C

Families and service coordinators select services for listing in the IFSP that address the priorities, concerns, and goals/outcomes of the child and family.

In Assumption C, responses of the two groups on each research item concerning services provided and their relation to the priorities, concerns, and goals/outcomes of the child and family in the IFSP showed statistically significant differences in their level of agreement on 6 of 24 research items (5 items were at $p < .05$ and 1 item was $p < .01$). A frequency of response item analysis showed 81% 'agree' or 'strongly agree', 10% 'undecided', and 9% 'disagree' or 'strongly disagree' on 24 research items. Respondents rated their level of agreement on 24 research items to determine if the families and service coordinators selected services for listing in the IFSP that addressed the priorities, concerns, and goals/outcomes of the child and family. An open-ended question was used to ask respondents to identify the services respondents considered to be most effective in meeting the priorities and concerns of the child and family. The findings are presented in Tables 4.21 through 4.46.
Research Item # 1. The family is provided with understandable information related to priorities and concerns of the a) child and b) family.

Tables 4.21 and 4.22 showed no statistically significant differences were found between the families and service coordinators in their level of agreement on this item for the child, $X^2 (3, N=52)=3.48, p > .30$ (see Table 4.21) and the family, $X^2 (4, N=50)=8.71, p > .05$ (see Table 4.22). Table 4.22 indicates that 2 (7.9%) families did not respond to the Family component of this item.

Table 4.21 Providing Understandable Information to the Family on Priorities and Concerns about the Child

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>1 (3.8%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>11 (42.3%)</td>
<td>17 (65.4%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>13 (50.0%)</td>
<td>8 (30.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>
Table 4.22 Providing Understandable Information to the Family on Priorities and Concerns about the Family

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=24)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>2 (7.9%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>0 (0.0%)</td>
<td>2 (7.9%)</td>
</tr>
<tr>
<td>Agree</td>
<td>9 (34.6%)</td>
<td>17 (65.4%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>12 (46.2%)</td>
<td>7 (26.9%)</td>
</tr>
<tr>
<td>Total</td>
<td>24 (93.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Comments: One service coordinator reported that “the family is provided with understandable information more through discussion than by use of the IFSP.” One family member reported that “I am concerned that my child’s health problem will affect her motor skill development and later intensify her speech and language problems. She sticks her tongue out rather than keeping it in her mouth, and is not yet chewing well. But I am not quite sure that I am provided with enough information related to the concerns of my child.”

Research Item # 2. The family members are treated as team members in determining the services provided for the a) child and b) family.

No statistically significant differences were found between the two groups in their level of agreement on this
item for the child, $X^2 (4, \ N=52) = 4.78, p > .30$ (see Table 4.23) and the family, $X^2 (4, \ N=50) = 7.10, p > .10$ (see Table 4.24). Table 4.24 indicates that 2 (7.9%) families did not respond to the item.

**Table 4.23** Families are Treated as Team Members to Determine the Services Provided for the Child

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Agree</td>
<td>10 (38.5%)</td>
<td>16 (61.5%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>13 (50.0%)</td>
<td>10 (38.5%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

**Table 4.24** Families are Treated as Team Members to Determine the Services Provided for the Family

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=24)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>2 (7.9%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>2 (7.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Agree</td>
<td>8 (30.8%)</td>
<td>15 (57.7%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>11 (42.3%)</td>
<td>11 (42.3%)</td>
</tr>
<tr>
<td>Total</td>
<td>24 (93.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>
Comments: One family member reported that "I, as a parent of child with disability, can only agree or disagree to what they offer - not what my child really might need."

Research Item # 3. At least one family member has influence equal to that of the service coordinator in determining which services will be received.

Data in Table 4.25 reveal that no statistically significant difference was found between the families and service coordinators in their level of agreement on this item, $X^2 (3, N=52) = 6.47, p > .05$.

Table 4.25 Family Member has Influence Equal to Service Coordinator in Determining Services to be Received

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>2 (7.7%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Agree</td>
<td>9 (34.6%)</td>
<td>16 (61.5%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>15 (57.7%)</td>
<td>9 (34.6%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Research Item # 4. The family and service coordinator agree that the services provided are the services needed for the a) child and b) family.

No statistically significant differences were found between the families and service coordinators in their
level of agreement on this item for the child, $X^2 (3, N=52) = 6.67$, $P > .05$ (see Table 4.26) and the family, $X^2 (4, N=51) = 5.65$, $P > .20$ (see Table 4.27). In item # 4 b), 1 (3.8%) family did not respond to the item.

**Table 4.26** Services Provided were Services Needed for the Child

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>2 (7.7%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Agree</td>
<td>8 (30.8%)</td>
<td>16 (61.5%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>15 (57.7%)</td>
<td>10 (38.5%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

**Table 4.27** Services Provided were Services Needed for the Family

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=25)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>2 (7.7%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>5 (19.2%)</td>
<td>4 (15.4%)</td>
</tr>
<tr>
<td>Agree</td>
<td>7 (26.9%)</td>
<td>14 (53.8%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>10 (38.5%)</td>
<td>8 (30.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>25 (96.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Comments: One service coordinator reported that "if it's a service that seems unreasonable, there can be a discussion on it, but you try to address all concerns, and
provide what services are available and can be provided. There are times we may offer a service and the family declines services, because they feel it's not needed."

Research Item #5. **Children receiving services have opportunities to interact with children who do not require special services.**

Data in Table 4.28 reveal that the families and service coordinators showed a statistically significant difference in their level of agreement on interaction of the child being served with children not requiring special services, $X^2 (1, N=33)=8.25, p < .05$. A Fisher’s Exact Test for 2 x 2 table was used due to the small number of expected frequency.

**Table 4.28 Child Interaction with Children not Requiring Special Services**

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=11)</th>
<th>Service Coordinator (N=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>6 (54.5%)</td>
<td>21 (95.5%)</td>
</tr>
<tr>
<td>Agree</td>
<td>5 (45.5%)</td>
<td>1 (4.5%)</td>
</tr>
<tr>
<td>Total</td>
<td>11 (100.0%)</td>
<td>22 (100.0%)</td>
</tr>
</tbody>
</table>

*Comments:* One service coordinator reported that "we don’t have typically developing children participating in the clinic program. They are even asked to stay out of the playground." Three families mentioned they don’t have inclusive classrooms or programs.
Research Item #6. The agency had enough money to obtain or continue the services required to meet the priorities and concerns of the a) child and b) family.

Data in Tables 4.29 and 4.30 reveal that the families and service coordinators showed no statistically significant differences in their level of agreement on this item for the child, $X^2 (4, N=52)=2.90, p > .50$ (see Table 4.29) and the family, $X^2 (4, N=51)=1.95, p > .70$ (see Table 4.30). One (3.8%) family member did not respond to the Family component of this item.

Table 4.29 Funding of Services Met the Priorities and Concerns of the Child

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>5 (19.2%)</td>
<td>3 (11.5%)</td>
</tr>
<tr>
<td>Agree</td>
<td>8 (30.8%)</td>
<td>13 (50.0%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>11 (42.3%)</td>
<td>9 (34.6%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>
Table 4.30 Funding of Services Met the Priorities and Concerns of the Family

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=25)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>5 (19.2%)</td>
<td>4 (15.4%)</td>
</tr>
<tr>
<td>Agree</td>
<td>8 (30.8%)</td>
<td>12 (46.2%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>10 (38.5%)</td>
<td>9 (34.6%)</td>
</tr>
<tr>
<td>Total</td>
<td>25 (96.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Comments: One service coordinator reported that "there was money to obtain and continue services. It may be not [sic] for the frequency of some services such as physical therapy (PT), occupational therapy (OT), or other therapies."

Research Item # 7. The services are provided in a manner that effectively meets the priorities and concerns of the a) child and b) family.

Statistically significant differences were found between the families and service coordinators in their level of agreement as to whether or not the services were provided in a manner that effectively met the priorities and concerns of the child, $X^2 (3, N=52)=8.17, p < .05$ (see Table 4.31) and the family, $X^2 (3, N=51)=9.02, p < .05$ (see
Table 4.32). One (3.8%) family did not respond to the
Family component of this item.

Table 4.31 Effectiveness of Services Provided Met the
Priorities and Concerns of the Child

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>2 (7.7%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>1 (3.8%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>9 (34.6%)</td>
<td>19 (73.1%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>14 (53.8%)</td>
<td>5 (19.2%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Table 4.32 Effectiveness of Services Provided Met the
Priorities and Concerns of the Family

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=25)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>3 (11.5%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>1 (3.8%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>7 (26.9%)</td>
<td>18 (69.2%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>14 (53.8%)</td>
<td>6 (23.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>25 (96.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Comments: One service coordinator reported that
scheduling of therapy services has not been effectively
managed. One family member said "I, as a parent of child
with Down Syndrome, am interested in getting to know some
other parents of other children with Down Syndrome to better understand my child and plan for her future."

Research Item # 8. The family was placed on a waiting list before receiving services.

Data in Table 4.33 reveal that the families and service coordinators differed to a statistically significant level in responding to whether or not the family was placed on a waiting list before receiving services, \( X^2 (4, N=51) = 16.63, p < .01 \). One (3.8%) family did not respond to this item.

Table 4.33 Family was Placed on a Waiting List before Receiving Services

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=25)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>10 (38.5%)</td>
<td>3 (11.5%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>3 (11.5%)</td>
<td>4 (15.4%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>1 (3.8%)</td>
<td>3 (11.5%)</td>
</tr>
<tr>
<td>Agree</td>
<td>3 (11.5%)</td>
<td>14 (53.8%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>8 (30.8%)</td>
<td>2 (7.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>25 (96.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Comments: One service coordinator mentioned that children with visual impairment do not wait if the visual diagnosis is known at the onset.

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Research Item # 9. Use of an IFSP helps to coordinate services provided for the a) child and b) family.

Data in Table 4.34 reveal that the families and service coordinators had a statistically significant difference in their level of agreement on item # 9 a), $X^2 (4, N=52)=10.43, p < .05$.

Table 4.34 An IFSP Helps to Coordinate Services Provided for the Child

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>2 (7.7%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>10 (38.5%)</td>
<td>20 (76.9%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>13 (50.0%)</td>
<td>4 (15.4%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

However, no statistically significant difference was found between the families and service coordinators in responding that use of an IFSP helped to coordinate services provided for the family, $X^2 (4, N=51)=9.42, p > .05$ (see Table 4.35). One (3.8%) family did not respond to this item regarding the Family.
Table 4.35 An IFSP Helps to Coordinate Services Provided for the Family

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=25)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (3.8%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>3 (11.5%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>9 (34.6%)</td>
<td>20 (76.9%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>11 (42.3%)</td>
<td>4 (15.4%)</td>
</tr>
<tr>
<td>Total</td>
<td>25 (96.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Research Item # 10. IFSP meeting is scheduled when it is convenient for the a) family and b) service coordinator.

Data in Tables 4.36 and 4.37 reveal that the families and service coordinators showed no statistically significant differences in their level of agreement on this item for the family, \( X^2 (3, N=52) = 6.25, P > .05 \) (see Table 4.36) and the service coordinator, \( X^2 (3, N=52) = 7.55, P > .05 \) (see Table 4.37).
Table 4.36 Scheduling IFSP Meetings at the Convenience of the Family

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>3 (11.5%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Agree</td>
<td>8 (30.8%)</td>
<td>14 (53.8%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>15 (57.7%)</td>
<td>11 (42.3%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Table 4.37 Scheduling IFSP Meetings at the Convenience of the Service Coordinator

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>3 (11.5%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>5 (19.2%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>9 (34.6%)</td>
<td>14 (53.8%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>12 (46.2%)</td>
<td>8 (30.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Comments: One service coordinator reported that "we try to make it convenient for the family. There are times if it is not during working hours. We try to accommodate the family if possible (after work, or lunch time)." One family mentioned that evening hours should be available so working spouses can participate to the meeting.
Research Item #11. The IFSP is reviewed at least every six months.

A statistically significant difference was found between the families and service coordinators on their response to the question about the IFSP being reviewed at least every six months, but the value is small, as shown by the degrees of freedom, \( X^2 (2, \ N=52)=6.82, \ p < .05 \) (see Table 4.38).

**Table 4.38 IFSP is Reviewed at least Every Six Months**

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>6 (23.1%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Agree</td>
<td>9 (34.6%)</td>
<td>11 (42.3%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>11 (42.3%)</td>
<td>15 (57.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Research Item #12. Use of the IFSP is effective in identifying a) family strengths (priorities) b) family needs (concerns) c) family goals/outcomes d) child priorities and concerns e) child services and f) family services.

No statistically significant differences were found between the families and service coordinators in their level of agreement on this item, a) \( X^2 (4, \ N=52)=6.44, \ p > \)
.10 (see Table 4.39); b) $X^2 (3, N=52)=6.77, p > .05$ (see Table 4.40); c) $X^2 (4, N=52)=5.53, p > .20$ (see Table 4.41); d) $X^2 (2, N=52)=3.09, p > .20$ (see Table 4.42); e) $X^2 (3, N=52)=6.00, p > .10$ (see Table 4.43); and f) $X^2 (4, N=52)=6.72, p > .10$ (see Table 4.44).

### Table 4.39 Effective Use of the IFSP to Identify Family Priorities

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>2 (7.7%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>2 (7.7%)</td>
<td>7 (26.9%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>5 (19.2%)</td>
<td>7 (26.9%)</td>
</tr>
<tr>
<td>Agree</td>
<td>8 (30.8%)</td>
<td>8 (30.8%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>9 (34.6%)</td>
<td>3 (11.5%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

### Table 4.40 Effective Use of the IFSP to Identify Family Concerns

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>3 (11.5%)</td>
<td>2 (7.7%)</td>
</tr>
<tr>
<td>Agree</td>
<td>8 (30.8%)</td>
<td>17 (65.4%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>14 (53.8%)</td>
<td>7 (26.9%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>
Table 4.41 Effective Use of the IFSP to Identify Family Goals/Outcomes

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>2 (7.7%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>2 (7.7%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>12 (46.2%)</td>
<td>18 (69.2%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>10 (38.5%)</td>
<td>6 (23.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Table 4.42 Effective Use of the IFSP to Identify Child Priorities and Concerns

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>3 (11.5%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Agree</td>
<td>11 (42.3%)</td>
<td>17 (65.4%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>12 (46.2%)</td>
<td>8 (30.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>
Table 4.43 Effective Use of the IFSP to Identify Child Services

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Agree</td>
<td>12 (46.2%)</td>
<td>20 (76.9%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>12 (46.2%)</td>
<td>6 (23.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Table 4.44 Effective Use of the IFSP to Identify Family Services

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>2 (7.7%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>2 (7.7%)</td>
<td>3 (11.5%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>2 (7.7%)</td>
<td>5 (19.2%)</td>
</tr>
<tr>
<td>Agree</td>
<td>10 (38.5%)</td>
<td>14 (53.8%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>10 (38.5%)</td>
<td>4 (15.4%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

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In open-ended item # 13, the families and service coordinators were asked to list most effective services in meeting the priorities and concerns of the a) child and b) family. The frequency of services identified was analyzed by groups (families and service coordinators, and total for the two groups).

The families and service coordinators (n=44) found eight most effective services in meeting the priorities and concerns of the child. Related services (n=21) was identified as the most commonly expressed response. The second most commonly expressed response was provision of inclusive classroom (n=11). The next service identified as the most effective was more play-based program (n=5). Other services identified by both groups appear in Table 4.45. Three (12%) of 26 families and 5 (19%) of 26 service coordinators did not respond to this item (see Table 4.45).

The families and service coordinators (n=46) also identified eight services to be most effective in meeting the needs of the family. Like item # 13 a), related services (n=15) was identified as the most important services to be considered in meeting the needs of the family. The second most commonly expressed response was provision of parent involvement (n=12). Other services identified by the two groups are presented in Table 4.46.
Four (15%) of 26 families and 2 (8%) of 26 service coordinators did not answer this question.

**Table 4.45 Most Effective Services to Meet the Priorities and Concerns of the Child**

<table>
<thead>
<tr>
<th>Services</th>
<th>Family (N=23)</th>
<th>Service Coordinator (N=21)</th>
<th>Total (N=44)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related services</td>
<td>11</td>
<td>10</td>
<td>21</td>
</tr>
<tr>
<td>Inclusive classrooms</td>
<td>4</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>More-play based</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>More-home based</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Behavior modification</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Parent involvement</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Funding of programs</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>A variety of evaluation methods</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>No response</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
</tbody>
</table>

**Table 4.46 Most Effective Services to Meet the Priorities and Concerns of the Family**

<table>
<thead>
<tr>
<th>Services</th>
<th>Family (N=22)</th>
<th>Service Coordinator (N=24)</th>
<th>Total (N=46)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related services</td>
<td>8</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Parent involvement</td>
<td>4</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Inclusive classrooms</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>More-home based</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Funding of programs</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>More-play based</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Behavior modification</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>A variety of evaluation methods</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No response</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>
The number of family and service coordinator commonalities among responses to each research item support the validity of Assumption C that families and service coordinators can select services for listing in the IFSP that address the priorities, concerns, and goals/outcomes of the child and family.
Assumption D

Families and service coordinators can evaluate effectiveness of the development and implementation of the IFSP.

In Assumption D, responses from the families and service coordinators on each research item regarding effectiveness of the development and implementation of the IFSP showed statistically significant differences in their level of agreement on 6 of 7 research items (3 items were at $p < .05$, 2 items were $p < .01$, and 1 item was $p < .001$). A frequency of response item analysis showed 70% 'agree' or 'strongly agree', 18% 'undecided', and 12% 'disagree' or 'strongly disagree' on 7 research items. An open-ended question was asked to identify the most critical improvements needed, if any, in a) developing the IFSP and b) implementing the IFSP. The findings are presented in Tables 4.47 through 4.56.

Research Item # 1. The types of professionals needed to provide the services required by the IFSP are made available to the a) child and b) family.

A statistically significant difference was found between the families and service coordinators in their level of agreement on the types of professionals available
to provide the services required by the IFSP to the child, $X^2(4, N=52)=11.28, p < .05$ (see Table 4.47).

However, no statistically significant difference was found between both groups in their level of agreement on availability of the types of professionals required by the IFSP to provide services for the family, $X^2(4, N=52)=2.73, p > .60$ (see Table 4.48).

**Table 4.47** Availability of Professionals Required by the IFSP to Provide Services for the Child

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>2 (7.7%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>2 (7.7%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Agree</td>
<td>8 (30.8%)</td>
<td>19 (73.1%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>13 (50.0%)</td>
<td>7 (26.9%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

**Table 4.48** Availability of Professionals Required by the IFSP to Provide Services for the Family

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>1 (3.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (3.8%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>5 (19.2%)</td>
<td>4 (15.4%)</td>
</tr>
<tr>
<td>Agree</td>
<td>9 (34.6%)</td>
<td>14 (53.8%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>10 (38.5%)</td>
<td>7 (26.9%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>
. Comments: One service coordinator mentioned that more physical therapists are needed. One family member said that the clinic needed a deaf education specialist and program. Another family mentioned that children with speech problems needed more specialized education.

Research Item # 2. **Professionals developing and implementing the IFSP are qualified.**

A statistically significant difference was found between the families and service coordinators in the degree of agreement on qualifications of professionals developing and implementing the IFSP, $X^2(2, N=52)=7.55, p < .05$ (see Table 4.49).

**Table 4.49 Professionals Developing and Implementing the IFSP were Qualified**

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>0 (0.0%)</td>
<td>2 (7.7%)</td>
</tr>
<tr>
<td>Agree</td>
<td>11 (42.3%)</td>
<td>18 (69.2%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>15 (57.7%)</td>
<td>6 (23.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>
Research Item # 3. **Use of the IFSP should be continued.**

A statistically significant difference was found between the families and service coordinators in the degree of agreement on continuing to use the IFSP, $X^2 (3, \ N=52)=19.36, \ p < .001$ (see Table 4.50).

**Table 4.50 Continue Using of the IFSP**

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0 (0.0%)</td>
<td>1 (3.8%)</td>
</tr>
<tr>
<td>Undecided</td>
<td>1 (3.8%)</td>
<td>5 (19.2%)</td>
</tr>
<tr>
<td>Agree</td>
<td>8 (30.8%)</td>
<td>18 (69.2%)</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>17 (65.4%)</td>
<td>2 (7.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>26 (100.0%)</td>
<td>26 (100.0%)</td>
</tr>
</tbody>
</table>

Research Item # 4. **Changes and/or improvements are needed in the process of a) developing the IFSP b) implementing the IFSP.**

The families and service coordinators showed statistically significant differences in their level of agreement on changes/improvements being needed in developing the IFSP, $X^2 (1, \ N=37)=8.40, \ p < .01$ (see Tables 4.51) and implementing the IFSP, $X^2 (1, \ N=40)=5.41, \ p < .05$ (see Table 4.52). A Fisher's Exact Test for a 2 x 2 table.
was used due to the occurrence of small numbers of expected frequencies.

**Table 4.51** Changes/Improvements Needed in Developing the IFSP

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=20)</th>
<th>Service Coordinator (N=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>13 (65.0%)</td>
<td>3 (17.6%)</td>
</tr>
<tr>
<td>Agree</td>
<td>7 (35.0%)</td>
<td>14 (82.4%)</td>
</tr>
<tr>
<td>Total</td>
<td>20 (100.0%)</td>
<td>17 (100.0%)</td>
</tr>
</tbody>
</table>

**Table 4.52** Changes/Improvements Needed in Implementing the IFSP

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=21)</th>
<th>Service Coordinator (N=19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>12 (57.1%)</td>
<td>4 (21.1%)</td>
</tr>
<tr>
<td>Agree</td>
<td>9 (42.9%)</td>
<td>15 (78.9%)</td>
</tr>
<tr>
<td>Total</td>
<td>21 (100.0%)</td>
<td>19 (100.0%)</td>
</tr>
</tbody>
</table>

**Comments**: One service coordinator reported that the process of developing and implementing the IFSP should be simplified so families can initiate parts of it. Another service coordinator responded “we need to have goals in place immediately-usually as basis goal [sic] with parent input then become more specific as we get to know the child.” One family member also said that “parents should be educated about services and given control so they can decide for themselves what they want for the child.”
Research Item # 5. Families and children would receive services, even if the IFSP requirements were dropped.

Data in Table 4.53 reveal that the families and service coordinators showed a statistically significant difference in their responses as to whether or not the families and children would receive services even if the IFSP requirements were dropped. A Fisher's Exact Test for a 2 x 2 table was used due to the occurrence of small number of expected frequency. A statistically significant difference was found between the two groups on this item, $X^2 (1, N=36)=7.63, p < .01$. Fourteen (54%) of 26 families and 22 (85%) of 26 service coordinators responded to this item.

Table 4.53 Families and Children Would Receive Services Even If IFSP Requirements were Dropped

<table>
<thead>
<tr>
<th>Degree of Agreement</th>
<th>Family (N=14)</th>
<th>Service Coordinator (N=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>7 (50.0%)</td>
<td>2 (9.1%)</td>
</tr>
<tr>
<td>Agree</td>
<td>7 (50.0%)</td>
<td>20 (90.9%)</td>
</tr>
<tr>
<td>Total</td>
<td>14 (100.0%)</td>
<td>22 (100.0%)</td>
</tr>
</tbody>
</table>
In open-ended item # 6, the families and service coordinators were asked to list the most critical improvements needed in a) developing the IFSP and b) implementing the IFSP.

Of 52 families and service coordinators, 20 (77%) of 26 families and 13 (50%) of 26 service coordinators did not respond to the item regarding critical improvements needed to develop the IFSP. Those responding identified seven critical improvements needed in developing the IFSP as presented in Table 4.54, which shows slight differences exist between the families and service coordinators.

Of 52 families and service coordinators, 22 (85%) of 26 families and 15 (58%) of 26 service coordinators did not respond to the item asking them to list the most critical improvements needed in implementing the IFSP, but respondents identified six critical improvements that were needed (see Table 4.55).
<table>
<thead>
<tr>
<th>Improvements Needed</th>
<th>Family (N=6)</th>
<th>Service Coordinator (N=13)</th>
<th>Total (N=19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>More family-centered</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>More programs &amp; therapists</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>More information</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>More time &amp; energy</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>More natural environment</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Eliminating unnecessary section of the IFSP</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>More home visits</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No response</td>
<td>20</td>
<td>13</td>
<td>33</td>
</tr>
</tbody>
</table>

**Table 4.55** Critical Improvements Needed to Implement the IFSP

<table>
<thead>
<tr>
<th>Improvements Needed</th>
<th>Family (N=4)</th>
<th>Service Coordinator (N=11)</th>
<th>Total (N=15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>More programs &amp; therapists</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>More family-centered</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>More information</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Eliminating unnecessary section of the IFSP</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>More time &amp; energy</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>More natural environment</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No response</td>
<td>22</td>
<td>15</td>
<td>37</td>
</tr>
</tbody>
</table>
In open-ended item #7, the families and service coordinators (n=52) were asked to choose the persons (family, service coordinator, both family and service coordinator, and other) having the most influence in developing the IFSP. Thirty-six (69%) of 52 respondents indicated that both the family and service coordinator have the most influence in developing the IFSP (see Table 4.56).

**Table 4.56 Persons Having the Most Influence in Developing the IFSP**

<table>
<thead>
<tr>
<th>Persons</th>
<th>Family (N=26)</th>
<th>Service Coordinator (N=25)</th>
<th>Total (N=52)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Service Coordinator</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Both</td>
<td>19</td>
<td>17</td>
<td>36</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>

**Summary of Chi-Square Analyses**

Tables 4.57 through 4.60 summarize the results of the level of agreement between the family and service coordinator ratings on 47 research items divided into four categories (Assumption A through D) regarding the development and implementation of the IFSP. A Chi-square analysis was conducted to determine if statistically significance differences existed in their levels of agreement on each research item.
<table>
<thead>
<tr>
<th>Items</th>
<th>Chi-Square($X^2$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The IFSP is developed at a time when the family is ready to set goals/outcomes</td>
<td>NS</td>
</tr>
<tr>
<td>At least one member of the family has an equal influence with the service coordinator in developing the IFSP</td>
<td>NS</td>
</tr>
<tr>
<td>The family's native language or mode of communication (Ex: sign language) is used in:</td>
<td></td>
</tr>
<tr>
<td>a) developing the IFSP</td>
<td>NS</td>
</tr>
<tr>
<td>b) implementing the IFSP</td>
<td>NS</td>
</tr>
<tr>
<td>The service coordinator assists the family in identifying an accurate list of family priorities and concerns</td>
<td>NS</td>
</tr>
<tr>
<td>The service coordinator gives priority to the goals/outcomes preferred by the family in the IFSP</td>
<td>NS</td>
</tr>
<tr>
<td>The family considers the goals/outcomes in the IFSP to be appropriate</td>
<td>NS</td>
</tr>
<tr>
<td>IFSP goals/outcomes were developed to meet the priorities and concerns of the:</td>
<td>S**</td>
</tr>
<tr>
<td>a) child</td>
<td>NS</td>
</tr>
<tr>
<td>b) parents</td>
<td>S**</td>
</tr>
<tr>
<td>c) all family members</td>
<td>S**</td>
</tr>
<tr>
<td>When the IFSP is reviewed, IFSP goals/outcomes are being met</td>
<td>S*</td>
</tr>
</tbody>
</table>

S: Significant (* p < .05 ** p < .01)  
NS: Not Significant
Table 4.58 Responses to Questions on IFSP Goals/Outcomes Related to Services Provided to the Child and Family

<table>
<thead>
<tr>
<th>Items</th>
<th>Chi-Square($X^2$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The service coordinator uses the IFSP goals/</td>
<td></td>
</tr>
<tr>
<td>outcomes in determining the services to</td>
<td></td>
</tr>
<tr>
<td>be provided for the:</td>
<td></td>
</tr>
<tr>
<td>a) child</td>
<td>NS</td>
</tr>
<tr>
<td>b) family</td>
<td>NS</td>
</tr>
<tr>
<td>The service coordinator gives the family an opportunity</td>
<td></td>
</tr>
<tr>
<td>to choose the services desired</td>
<td>S*</td>
</tr>
<tr>
<td>Some services on the IFSP were not provided to the:</td>
<td></td>
</tr>
<tr>
<td>a) child</td>
<td>NS</td>
</tr>
<tr>
<td>b) family</td>
<td>NS</td>
</tr>
</tbody>
</table>

S: Significant (*p < .05)

NS: Not Significant
Table 4.59 Responses to Questions on Services Provided and Strengths (Priorities), Needs (Concerns), and Goals/Outcomes of the Child and Family in the IFSP

<table>
<thead>
<tr>
<th>Items</th>
<th>Chi-Square($X^2$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The family is provided with understandable information related to the priorities and concerns of the:</td>
<td>NS</td>
</tr>
<tr>
<td>a) child</td>
<td>NS</td>
</tr>
<tr>
<td>b) family</td>
<td>NS</td>
</tr>
<tr>
<td>The family members are treated as team members in determining the services provided for the:</td>
<td>NS</td>
</tr>
<tr>
<td>a) child</td>
<td>NS</td>
</tr>
<tr>
<td>b) family</td>
<td>NS</td>
</tr>
<tr>
<td>At least one family member has influence equal to that of the service coordinator in determining which services will be received</td>
<td>NS</td>
</tr>
<tr>
<td>The family and service coordinator agree that the services provided are the services needed for the:</td>
<td>NS</td>
</tr>
<tr>
<td>a) child</td>
<td>NS</td>
</tr>
<tr>
<td>b) family</td>
<td>NS</td>
</tr>
<tr>
<td>Children receiving services have opportunities to interact with children who do not require special services</td>
<td>S*</td>
</tr>
<tr>
<td>The agency had enough money to obtain or continue the services required to meet the priorities and concerns of the:</td>
<td>NS</td>
</tr>
<tr>
<td>a) child</td>
<td>NS</td>
</tr>
<tr>
<td>b) family</td>
<td>NS</td>
</tr>
<tr>
<td>The services are provided in a manner that effectively meets the priorities and concerns of the:</td>
<td>S*</td>
</tr>
<tr>
<td>a) child</td>
<td>S*</td>
</tr>
<tr>
<td>b) family</td>
<td>S*</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Items</th>
<th>Chi-Square ($X^2$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The family was placed on a waiting list before receiving services</td>
<td>$S^{**}$</td>
</tr>
<tr>
<td>Use of an IFSP helps to coordinate services provided for the:</td>
<td></td>
</tr>
<tr>
<td>a) child</td>
<td>$S^*$</td>
</tr>
<tr>
<td>b) family</td>
<td>NS</td>
</tr>
<tr>
<td>IFSP meetings are scheduled when convenient for the:</td>
<td></td>
</tr>
<tr>
<td>a) family</td>
<td>NS</td>
</tr>
<tr>
<td>b) service coordinator</td>
<td>NS</td>
</tr>
<tr>
<td>The IFSP is reviewed at least every six months</td>
<td>$S^*$</td>
</tr>
<tr>
<td>Use of the IFSP is effective in identifying:</td>
<td></td>
</tr>
<tr>
<td>a) family strengths (priorities)</td>
<td>NS</td>
</tr>
<tr>
<td>b) family needs (concerns)</td>
<td>NS</td>
</tr>
<tr>
<td>c) family goals/outcomes</td>
<td>NS</td>
</tr>
<tr>
<td>d) child priorities and concerns</td>
<td>NS</td>
</tr>
<tr>
<td>e) child services</td>
<td>NS</td>
</tr>
<tr>
<td>f) family services</td>
<td>NS</td>
</tr>
</tbody>
</table>

$S$: Significant ($* p < .05$ $** p < .01$)

NS: Not Significant
Table 4.60 Responses to Questions on Changes/Improvements Needed in Developing and Implementing the IFSP

<table>
<thead>
<tr>
<th>Items</th>
<th>Chi-Square($X^2$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The types of professionals needed to provide the services required by the IFSP are made available to the:</td>
<td></td>
</tr>
<tr>
<td>a) child</td>
<td>S*</td>
</tr>
<tr>
<td>b) family</td>
<td>NS</td>
</tr>
<tr>
<td>Professionals developing and implementing the IFSP are qualified</td>
<td>S*</td>
</tr>
<tr>
<td>Use of the IFSP should be continued</td>
<td>S***</td>
</tr>
<tr>
<td>Changes and/or improvements are needed in the process of:</td>
<td></td>
</tr>
<tr>
<td>a) developing the IFSP</td>
<td>S**</td>
</tr>
<tr>
<td>b) implementing the IFSP</td>
<td>S*</td>
</tr>
<tr>
<td>Families and children would receive services, even if the IFSP requirements were dropped</td>
<td>S**</td>
</tr>
</tbody>
</table>

S: Significant (*p < .05 **p < .01 ***p < .001)
NS: Not Significant

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The student researcher matched service coordinators to each family they served, collapsed the Likert-scale rating of "strongly disagree and disagree" as well as "strongly agree and agree", thus forming two polarized sets of responses, in addition to "undecided", which was dropped for this analysis. The percentage of agreement and disagreement was computed on the 47 research items (See the Survey Instrument in Appendix A to refer to the full sentence of each questionnaire item). Assumption A research item responses are reported under Part I from the questionnaire. Assumption B research item responses are reported under Part II and Assumption C research item responses are shown under part III from the questionnaire. Finally, Assumption D research item responses are reported under Part IV from the questionnaire. Results of the analysis are as below:

**Tables in Part I**

1. (4.1) 14 (54%) of the 26 families agreed with their service coordinator on Part I, item 1) regarding family readiness to develop IFSP goals/outcomes.
2. (4.2) 23 (88%) of the 26 families agreed with their service coordinator on Part I, item 2) regarding sharing equal influence to develop the IFSP.
(4.3) 17 (68%) of the 25 families agreed with their service coordinator on Part I, item 3a) regarding use of family’s native language or other mode of communication to develop the IFSP.

(4.4) 17 (71%) of the 24 families agreed with their service coordinator on Part I, item 3b) regarding use of family’s native language or other mode of communication to implement the IFSP.

(4.5) 23 (88%) of the 26 families agreed with their service coordinator on Part I, item 4) that service coordinators help families identify an accurate list of families’ priorities and concerns.

(4.6) 21 (81%) of the 26 families agreed with their service coordinator on Part I, item 5) that the service coordinator gives the priority to the goals/outcomes preferred by the family in the IFSP.

(4.7) 22 (85%) of the 26 families agreed with their service coordinator on Part I, item 6) regarding appropriateness of IFSP goals/outcomes.
Tables

(4.8) 22 (85%) of the 26 families agreed with their service coordinator on Part I, item 7a) that IFSP goal/outcomes were developed to meet the priorities and concerns for the child.

(4.9) 20 (77%) of the 26 families agreed with their service coordinator on Part I, item 7b) that IFSP goal/outcomes were developed to meet the priorities and concerns for the parents.

(4.10) 17 (65%) of the 26 families agreed with their service coordinator on Part I, item 7c) that IFSP goal/outcomes were developed to meet the priorities and concerns of all family members.

(4.11) 19 (73%) of the 26 families agreed with their service coordinator on Part I, item 10) that IFSP goals/outcomes were being met at the time of IFSP review.

Tables in Part II

(4.14) 22 (85%) of the 26 families agreed with their service coordinator on Part II, item 1a) regarding use of the IFSP goals to determine the services to be provided for the child.
Tables

(4.15) 19 (76%) of the 25 families agreed with their service coordinator on Part II, item 1b) regarding use of the IFSP goals to determine the services to be provided for the family.

(4.16) 19 (73%) of the 26 families agreed with their service coordinator on Part II, item 2) that the service coordinator gives the family an opportunity to choose services desired.

(4.17) 17 (65%) of the 26 families agreed with their service coordinator on Part II, item 3a) regarding services on the IFSP not provided to the child.

(4.18) 17 (65%) of the 26 families agreed with their service coordinator on Part II, item 3b) regarding services on the IFSP not provided to the family.

Tables in Part III

(4.21) 23 (88%) of the 26 families agreed with their service coordinator on Part III, item 1a) regarding providing understandable information to the family on priorities and concerns about the child.
Tables

(4.22) 19 (79%) of the 24 families agreed with their service coordinator on Part III, item 1b) regarding providing understandable information to the family on priorities and concerns about the family.

(4.23) 23 (88%) of the 26 families agreed with their service coordinator on Part III, item 2a) regarding family treated as team members to determine the service provided for the child.

(4.24) 19 (79%) of the 24 families agreed with their service coordinator on Part III, item 2b) regarding family treated as team members to determine the service provided for the family.

(4.25) 23 (88%) of the 26 families agreed with their service coordinator on Part III, item 3) that family member has influence equal to service coordinator in determining services to be received.

(4.26) 23 (88%) of the 26 families agreed with their service coordinator on Part III, item 4a) regarding services provided were services needed for the child.
Tables

(4.27) 16 (64%) of the 25 families agreed with their service coordinator on Part III, item 4b) regarding services provided were services needed for the family.

(4.28) 7 (28%) of the 25 families agreed with their service coordinator on Part III, item 5) regarding their child's interaction with children not receiving special services.

(4.29) 15 (58%) of the 26 families agreed with their service coordinator on Part III, item 6a) regarding funding of services to meet the needs of the child.

(4.30) 13 (52%) of the 25 families agreed with their service coordinator on Part III, item 6b) regarding funding of services to meet the needs of the family.

(4.31) 21 (81%) of the 26 families agreed with their service coordinator on Part III, item 7a) regarding effectiveness of services provided to meet the priorities and concerns of the child.
Tables

(4.32) 19 (76%) of the 25 families agreed with their service coordinator on Part III, item 7b) regarding effectiveness of services provided to meet the priorities and concerns of the family.

(4.33) 14 (56%) of the 25 families agreed with their service coordinator on Part III, item 8) that family was placed on a waiting list before receiving services.

(4.34) 23 (88%) of the 26 families agreed with their service coordinator on Part III, item 9a) that an IFSP helped coordinate services provided for the child.

(4.35) 20 (80%) of the 25 families agreed with their service coordinator on Part III, item 9b) that an IFSP helped coordinate services provided for the family.

(4.36) 22 (85%) of the 26 families agreed with their service coordinator on Part III, item 10a) regarding scheduling IFSP meeting at the convenience of the family.
Tables

(4.37) 17 (65%) of the 26 families agreed with their service coordinator on Part III, item 10b) regarding scheduling IFSP meeting at the convenience of the service coordinator.

(4.38) 20 (77%) of the 26 families agreed with their service coordinator on Part III, item 11) regarding reviewing the IFSP at least every six months.

(4.39) 11 (42%) of the 26 families agreed with their service coordinator on Part III, item 12a) regarding effective use of the IFSP to identify family priorities.

(4.40) 20 (77%) of the 26 families agreed with their service coordinator on Part III, item 12b) regarding effective use of the IFSP to identify family concerns.

(4.41) 20 (77%) of the 26 families agreed with their service coordinator on Part III, item 12c) regarding effective use of the IFSP to identify family goals/outcomes.
Tables

(4.42) 22 (85%) of the 26 families agreed with their service coordinator on Part III, item 12d) regarding effective use of the IFSP to identify child priorities and concerns.

(4.43) 24 (92%) of the 26 families agreed with their service coordinator on Part III, item 12e) regarding effective use of the IFSP to identify child services.

(4.44) 12 (46%) of the 26 families agreed with their service coordinator on Part III, item 12f) regarding effective use of the IFSP to identify family services.

Tables in Part IV

(4.47) 21 (81%) of the 26 families agreed with their service coordinator on Part IV, item 1a) regarding availability of professionals required by the IFSP to provide services for the child.

(4.48) 15 (58%) of the 26 families agreed with their service coordinator on Part IV, item 1b) regarding availability of professionals required by the IFSP to provide services for the family.
Tables

(4.49) 24 (92%) of the 26 families agreed with their service coordinator on Part IV, item 2) that professionals developing and implementing the IFSP were qualified.

(4.50) 19 (73%) of the 26 families agreed with their service coordinator on Part IV, item 3) that use of the IFSP should be continued.

(4.51) 6 (23%) of the 26 families agreed with their service coordinator on Part IV, item 4a) regarding changes and improvements needed in developing the IFSP.

(4.52) 7 (27%) of the 26 families agreed with their service coordinator on Part IV, item 4b) regarding changes and improvements needed in implementing the IFSP.

(4.53) 6 (23%) of the 26 families agreed with their service coordinator on Part IV, item 5) regarding receiving services in case of dropping the IFSP requirements.
In another analysis, the responses of each family were matched to the responses of their service coordinator.

(1) Family 1 agreed with their service coordinator on 32 (68%) of the 47 items (Tables 4.1 through 4.53);

(2) Family 2 agreed with their service coordinator on 38 (81%) of the 47 items;

(3) Family 3 agreed with their service coordinator on 36 (77%) of the 47 items;

(4) Family 4 agreed with their service coordinator on 30 (64%) of the 47 items;

(5) Family 5 agreed with their service coordinator on 42 (89%) of the 47 items;

(6) Family 6 agreed with their service coordinator on 29 (62%) of the 47 items;

(7) Family 7 agreed with their service coordinator on 29 (62%) of the 47 items;

(8) Family 8 agreed with their service coordinator on 40 (85%) of the 47 items;

(9) Family 9 agreed with their service coordinator on 25 (53%) of the 47 items;

(10) Family 10 agreed with their service coordinator on 10 (21%) of the 47 items;
(11) Family 11 agreed with their service coordinator on 16 (34%) of the 47 items;
(12) Family 12 agreed with their service coordinator on 42 (89%) of the 47 items;
(13) Family 13 agreed with their service coordinator on 40 (85%) of the 47 items;
(14) Family 14 agreed with their service coordinator on 30 (64%) of the 47 items;
(15) Family 15 agreed with their service coordinator on 26 (55%) of the 47 items;
(16) Family 16 agreed with their service coordinator on 37 (79%) of the 47 items;
(17) Family 17 agreed with their service coordinator on 21 (47%) of the 47 items;
(18) Family 18 agreed with their service coordinator on 41 (87%) of the 47 items;
(19) Family 19 agreed with their service coordinator on 36 (77%) of the 47 items;
(20) Family 20 agreed with their service coordinator on 31 (66%) of the 47 items;
(21) Family 21 agreed with their service coordinator on 37 (79%) of the 47 items;
(22) Family 22 agreed with their service coordinator on 37 (79%) of the 47 items;
(23) Family 23 agreed with their service coordinator on 40 (85%) of the 47 items; 
(24) Family 24 agreed with their service coordinator on 40 (85%) of the 47 items; 
(25) Family 25 agreed with their service coordinator on 40 (85%) of the 47 items; and 
(26) Family 26 agreed with their service coordinator on 28 (60%) of the 47 items. 
Agreement between the families and service coordinators was 70%. Less than 50% agreement between a family and their service coordinator occurred in 3 cases.
Pearson Correlation Coefficients were computed only for descriptive purposes because the data do not meet the assumptions that they came from bivariate normal distribution and are ordered categorical variables. Negative correlations also were found on 9 of 47 items on: Part I, item 3a; Part I, item 3b; Part III, item 2a; Part III, item 2b; Part III, item 9b; Part III, item 12e; Part III, item 12f; Part IV, item 3; and Part IV, item 5 (See Appendix A).

In Part I, item 3a, there was a low negative correlation between the two groups regarding the use of family’s native language or other mode of communication to develop the IFSP (-.37).

In Part I, item 3b, there was a low negative correlation between the two groups regarding use of family’s native language or other mode of communication to implement the IFSP (-.37).

In Part III, item 2a, there was a moderate negative correlation between the two groups regarding the family treated as team members to determine the services provided for the child (-.54).

In Part III, item 2b, there was a low negative correlation between the two groups regarding the family
treated as team members to determine the services provided for the family (-.44).

In Part III, item 9b, there was a low negative correlation between the two groups as to whether use of an IFSP helps coordinate services provided for the family (-.46).

In Part III, item 12e, there was a moderate negative correlation between the two groups regarding effective use of the IFSP to identify child services (-.62).

In Part III, item 12f, there was a low negative correlation between the two groups regarding effective use of the IFSP to identify family services (-.50).

In Part IV, item 3, there was a low negative correlation between the two groups as to whether use of the IFSP should be continued (-.43).

Finally, in Part IV, item 5, there was a low negative correlation between the two groups regarding receiving services in case of dropping the IFSP requirements (-.35).

The findings from the data reported in this Chapter are summarized and discussed in Chapter 5.
This study was designed to test four basic assumptions in the Individuals with Disabilities Education Act (IDEA) concerning development and implementation of the Individualized Family Service Plan (IFSP) by surveying families and service coordinators on their experiences in development and implementation of the IFSP. This research provided data regarding specific aspects of the IFSP processes of planning services for infants and toddlers at-risk for and with disabilities and their families. The requirements in the law mandate an IFSP for all children and families receiving early intervention services, thus articulating the principle that infants and toddlers with special needs will be served within the context of their families.

Overall, both families and service coordinators tended to show positive and consistent levels of agreement on 47 Likert-scale research items regarding development and
implementation of the IFSP. The basic assumptions in the law about families and service coordinators regarding the family as a participant in processes of the IFSP appeared to be met for the vast majority of the families. They reported the IFSP processes to be effective and supported its continued use. The average percentage of agreement of each family with their service coordinator was 72 percent. Implications of the data are discussed under each of the four assumptions.

**Assumption A.** Families and service coordinators work together in a manner that enables the family to demonstrate ability to participate in identifying its specific priorities, concerns, and goals/outcomes in the IFSP.

The assumption investigated in this statement appears to be met because the families, with the service coordinators, demonstrated their participation in identifying specific priorities, concerns, and goals/outcomes in the IFSP.

Eight Likert-scale research items with two items containing sub categories (a total of 11 questions) as well as two open-ended questions tested the levels of agreement and answers of families and service coordinators.

Part C of Public Law 105-17 requires early interventionists to develop an Individualized Family
Service Plan (IFSP). In creating the plan, professionals are required to assess family resources, priorities, and concerns or factors that should be considered in determining goals and activities. The plan also should include expected outcomes for families. A service coordinator was assigned to assist the family's efforts to gain access to coordinate services. The majority of families and service coordinators (85%) agreed on 11 research items indicating that the family demonstrated an ability to participate in identifying specific priorities, concerns, and goals/outcomes. The families and service coordinators tended to agree on 11 research items indicating that: 1) the IFSP was developed at a time when the family was ready to set goals/outcomes (73%); 2) at least one member of the family had an equal influence with the service coordinator in developing the IFSP (90%); 3 and 4) the family's native language or other mode of communication was used in developing the IFSP (83%) and implementing the IFSP (83%); 5) the service coordinator assisted the family in identifying an accurate list of family priorities and concerns (94%); 6) the service coordinator gave priority to the goals/outcomes preferred by the family in the IFSP (90%); 7) the service coordinator considered the goals/outcomes in the IFSP to be appropriate
(92%); 8, 9, and 10) IFSP goals/outcomes were developed to meet the priorities and concerns of the child (92%), parent (85%) and all family members (77%); and 11) by the time the IFSP was reviewed, the IFSP goals/outcomes were being met (87%).

Although statistically significant differences were found, the families and service coordinators either agreed or strongly agreed to statements that IFSP goals/outcomes were developed to meet the priorities and concerns of a) parents and b) family members. However, their responses indicated that by the time the first IFSP was reviewed, the IFSP goals/outcomes were not met but were being met.

Some families and service coordinators commented that: a) sometimes families are asked to complete an IFSP before diagnoses are completed. Therefore, the family should know what the IFSP is; b) the family needs to acquire skills and sense of empowerment necessary for the development of the IFSP; c) positive relationships such as honesty and trust between the families and service coordinators are a major factor for the IFSP process in early intervention programs.

The requirements for content of the IFSP plan indicate that a statement of the child’s present level of development, family priorities and concerns, major outcomes expected, specific services planned, natural environments
provided, initiation and duration of services, the responsible service coordinator, and the steps to be taken for transition to preschool or other services must be included. The law requires all of this information to be presented in family's native language or other mode of communication with which the family is most comfortable. Interpreters should be available as needed to ensure the family’s active participation. In this study, 20 (80%) of 25 families and 23 (88%) of 26 service coordinators agreed or strongly agreed that the family’s native language or other mode of communication was used in developing the IFSP, and 19 (79%) of 24 families and 24 (92%) of 26 service coordinators agreed or strongly agreed that the family’s native language or other mode of communication was used in implementing the IFSP. Perhaps the high level of agreement occurs because the majority of families and service coordinators communicated in English, which appears to have been the majority native language. The small number of bilingual families also agreed to this provision being met.

The law requires early intervention programs to give the family a chance to include in the IFSP a statement of the priorities, concerns, and resources the family has and may need in order to help the child grow and develop. The
service coordinator and other team members should help the family identify the priorities, concerns, and resources and decide which are the most important. Although resource identification was considered to be beyond the scope of this study, 25 (96%) of 26 families and 24 (92%) of 26 service coordinators agreed or strongly agreed that the service coordinator assisted the family in identifying an accurate list of family priorities and concerns, thus validating assumption A.

The law requires that strategies or activities to accomplish the outcomes should be a part of the IFSP. They provide more specific information about how the team plans to provide the intervention. The service coordinator should also give priority to the goals/outcomes preferred by the family in the IFSP. In this study, 24 (92%) of 26 families and 23 (88%) of 26 service coordinators answered that the service coordinator gave priority to the goals/outcomes preferred by the family in the IFSP, thus validating assumption A.

As a part of the IFSP, the team should set criteria or standards to measure if goals/outcomes have been reached. Criteria should be practical and easy to judge. The team as a whole should review each outcome to assess whether the outcome has been completed.
Because outcomes reflect the family’s priorities and concerns, the family should help decide when work toward the outcome is no longer needed. If, at any time, the family believe that one or more of the outcomes in the IFSP need to be changed or if the family want to add an outcome, the family may discuss this with the service coordinator. In this study, 23 (88%) of 26 families and 22 (85%) of 26 service coordinators agreed or strongly agreed that IFSP goals/outcomes were being met at the time of IFSP review, thus validating assumption A.

The families and service coordinators appear to support the importance of active family involvement in the IFSP processes as advocated in the model described by Bailey, Buysse, Smith, and Elam (1992). A few families and service coordinators, in several comment sections on the questionnaire, also emphasized the importance of personal relationships in developing the IFSP. This finding is consistent with results from a study by Dunst and Paget (1991), which concluded that honesty, trust, and commitment are the critical components in building effective parent-professional partnerships in early intervention programs.

The parental emphasis on information to meet the child’s needs also was shown in the study. This finding is consistent with a study conducted by Summers et al. (1990)
who found that meeting informational needs was emphasized by the families of younger children, while building family-professional relationship skills and meeting needs for general family well-being were emphasized more often by the families of older children.

Responses to open-ended questions revealed that the families and service coordinators listed seven priorities and concerns from the IFSP, including speech and language development, fine and gross motor skill development, socialization, overall development for the child, health and nutrition, more independence, and sufficient therapists.

In listing the more critical IFSP goals/outcomes, the families and service coordinators listed four specific goals/outcomes that matched their priorities and concerns of developing language; developing fine and gross motor skills; communicating or interacting with others; and improving eating habits and nutrition. However, their priorities and concerns did not include three additional goals/outcomes that were identified, which were attending group activities; following directions; and decreasing misbehaviors.

Regarding family priorities and concerns in developing the IFSP in open-ended questions, most answers from
families and service coordinators tended to emphasize only services to the child (DeGangi, Royeen, & Wietlisbach, 1992) even if the IFSP is to be a family-centered program. The data also show that the priority listings of IFSP goals/outcomes tended to center on the child much more often than on the family. Few family goals were identified by families and service coordinators.

Because most family priorities, concerns, and goals/outcomes were child-focused, it appears that the emphasis on family goals, identification and use of family priorities, and the specificity and complexity of identifying family goals/outcomes in much of the literature was not supported in this study. Rather, this finding is consistent with recent research conducted by Bailey, McWilliam, Darkes, Hebbeler, Simeonsson, Spiker, & Wagner (1998) that found satisfaction with child service was a critical outcome because families typically rated services for the child as being of highest priority. Also, selecting outcome measures, it appears clear that service coordinators should take care to ensure that the family goals/outcomes are known and accomplished. If this process does not occur, the IFSP is likely to have little meaning as a family-centered document.
The lack of emphasis on family goals is also consistent with a study conducted by Bailey et al. (1990) supporting the view of the child as the central focus within the family even when involved family members are the primary decision-makers. It appears that families generally have established their own relationships, daily routines and particular place in the environment, thus representing the greatest potential influence in the child's life.

**Assumption B. Families and service coordinators can identify services needed to reach the IFSP goals/outcomes and see that those services are provided.**

The assumption investigated in this statement was supported because the families and service coordinators did identify services needed to meet the IFSP goals and agreed that those services were provided.

Three research items with five possible responses and two open-ended questions sought to determine the level of agreement between the families and service coordinators regarding IFSP goals/outcomes related to services provided to the child and family. The combined responses reveal high commonalities that demonstrate the validity of Assumption B.

Public Law 105-17 (Part C) requires that a statement of the major outcomes expected to be achieved for the
infant or toddler and the family be specified. The law also requires that the IFSP be in writing and contain information that will clarify services for the child and family who are to receive such services.

The majority of families and service coordinators (81%) agreed that the services identified as being needed to reach IFSP goals/outcomes and the services listed in the IFSP were provided. The families and service coordinators tended to agree on all 5 research items indicating that the service coordinator used the IFSP goals/outcomes in determining the services to be provided for the child (92%) and family (83%); the service coordinator gave the family an opportunity to choose the services desired (81%); and some services on the IFSP were provided to the child (75%) and family (75%).

The law requires early intervention services should be based on the child's and family's priorities and concerns and the service coordinator or other members of the team should decide which of the services are appropriate for the child and family. The entire team works together to decide what services are best for the child and family to reach IFSP goals/outcomes. The family will be the primary decision-maker on the team. The other members of the team will provide the family with information and resources to
help the family choose services desired. In this study, 19 (73%) of 26 families and 23 (88%) of 26 service coordinators agreed or strongly agreed that the service coordinator gave the family an opportunity to choose the services desired.

Five (19%) of 26 families and one (4%) of 26 service coordinators stated that some services on the IFSP were not provided to the child and also 5 (19%) of 26 families and one (4%) of 26 service coordinators agreed or strongly agreed that a few services were not provided to the family. However, most families and service coordinators tended to agree that most services on the IFSP were provided to the child (75%) and family (75%), thus both partially validating the assumption. The assumption cannot be supported fully because, in an open-ended question, fourteen (54%) of 26 families reported that seven services were needed but not provided. For those families, the services identified as not being provided included; inclusive classroom; speech and language; home visits; sufficient therapists; transportation; parent training; and American Sign Language (ASL). Conversely, most of the service coordinators (n=24) reported services needed were provided for the child and family. Only the inclusive classroom; and transportation were mentioned as services
not provided. The most critical service identified as needed but not provided was the inclusive classroom for both groups. It seems clear from this study that a need exists for more opportunities for inclusion. Some researchers of integrated settings have shown that they are beneficial for social and other behavioral outcomes, compared to segregated settings (Buysse & Bailey, 1993). In general, most of the families and service coordinators believed that services specified on the IFSP were provided for the child and family. However, this was one of the two areas of the study that generated the most discrepancy in responses between families and service coordinators.

Findings from this analysis indicate that most families may feel positive about their individual service coordinator, but some negativism toward the service system. This result is consistent with a study conducted by McWilliam, Lang, Vandiviere, Angell, Collins, and Underdown (1995) who found that, although family and professional relationships were the most positive experiences in early intervention services, these same families reported having to struggle for services. Despite these struggles, early intervention may be one of the most positive experiences that families of children with special needs will encounter. To assure that families receive services
specified in the IFSP, IFSP teams who work to develop the IFSP plan should include information about each service required in the content of the plan.

Enabling and empowering families is another issue stressed in the literature so they may become their child's informed decision-maker. Study results showed that 19 (73%) of the families and 23 (88%) service coordinators indicated that the family should have an opportunity to choose the services desired for the child and family. This response tends to confirm the family enablement and empowerment model advocated by Dunst, Trivette, and Deal (1988). This family-centered approach to early intervention did allow families in this study to identify their needs even though they listed, mostly, those of their child. Further, it appears from responses in this study that, with support, the families were capable of identifying their priorities, concerns, and preferred goals/outcomes pertaining to services provided. Dinnebeil, Hale, and Rule (1996) also concluded that such relationships between parents and professionals were necessary and were the basis of all early intervention services provided to infants and toddlers with special needs, as well as their families. It appears to be important that the IFSP be shared by families
and service coordinators to enable and empower families as they invite early intervention programs into their lives.

Regarding any barriers that prevent families from getting services, half of the families and service coordinators (n=26) identified six barriers that included lack of programs and facilities; lack of information; limited time of service provider; lack of administrative cooperation; lack of money; and lack of parent training. Thirteen (50%) of the families and 13 (50%) service coordinators did not respond to this item. Even though a few barriers were listed, the researcher found that most of the families and service coordinators believe that few barriers prevent families from getting most services needed at the Clinic.

Only one family indicated barriers in receiving services when the child turned 3. They reported it seemed that the transition from C to Part B services was problematic. The Clinic should be able to identify and remove barriers that prevent families from receiving services or cause them to be on waiting lists.
Assumption C. Families and service coordinators select services for listing in the IFSP that address the priorities, concerns, and goals/outcomes of the child and family.

The law requires a statement of family priorities, concerns, goals/outcomes, and specific early intervention services to meet the unique needs of the infant or toddler and the family. The assumption being examined is that families and service coordinators will select services identified in the IFSP that address the priorities, concerns, and goals/outcomes of the child and family. Based on the responses of research items, the assumption investigated in this statement appears to be valid because the families and service coordinators contended that they selected services for listing in the IFSP that addressed the priorities, concerns, and goals/outcomes of the child and family.

Twelve research items with 24 possible responses sought to determine the level of agreement between families and service coordinators indicating if services provided were directly related to the priorities, needs, and goals/outcomes of the child and family in the IFSP. An open-ended question was used to find the most effective services that each group identified as meeting the
priorities and concerns of the child and family. The combined responses and commonalities were used to test the validity of Assumption C.

The majority of families and service coordinators (81%) appear to concur that the services provided addressed the priorities, concerns, and goals/outcomes of the child and family that were identified in the IFSP. Specifically, the families and service coordinators tended to agree on 21 of 24 research items indicating that the family was provided with understandable information related to priorities and concerns of the child (94%) and family (87%); the family members were treated as team members in determining the services for the child (94%) and family (87%); at least one family member had influence equal to that of the service coordinator to obtain services (94%); the services provided were the services needed for the child (94%) and family (75%); the agency had enough money to obtain or continue the services to meet the priorities and concerns of the child (79%) and family (75%); the services were provided in a manner that effectively met the priorities and concerns of the child (90%) and family (87%); use of an IFSP helped to coordinate services provided for the child (90%) and family (85%); IFSP meetings were scheduled when it was convenient for the
family (92%) and service coordinator (88%); the IFSP was reviewed at least every six months (88%); the use of the IFSP was effective in identifying family concerns (88%), family goals/outcomes (89%), child priorities and concerns (97%), child services (96%), and family services 73%). The majority of families and service coordinators tended to agree that they participated in selecting services in the IFSP that addressed priorities, concerns, and goals of the child and family. Unmet needs were expressed regarding inclusive classroom services, being placed on a waiting list before receiving services, and less than effective use of the IFSP to identify family priorities (See Appendix A).

Although statistically significant differences were found on 6 of 24 research items, the families and service coordinators either agreed or strongly agreed that the services were provided in a manner that effectively met the priorities and concerns of the child and family; an IFSP helped to coordinate services provided for the child; and the IFSP was reviewed at least every six months.

The law requires early intervention programs to provide the family with understandable information related to the priorities and concerns of the child and family. Information the family chooses to share will be used to help the team develop the IFSP. By providing understandable
information related to the family's priorities and concerns, the other members of the team can work with the family to plan the most appropriate program for the child and family. Some ideas and information will be shared in informal conversation with the service coordinator. The service coordinator may ask the family specific questions or may give the family a form with a list of priorities, concerns, and resources. In this study, 24 of 26 families (92%) and 25 of 26 service coordinators (96%) agreed or strongly agreed that the family was provided with understandable information related to the priorities and concerns of the child and also 21 of 24 families (88%) and 24 of 26 service coordinators agreed or strongly agreed to the Family component of this item, thus both validating assumption C.

Another assumption in the law is that family members present at the IFSP meeting will participate and be respected members of the team. The entire team members should work together to determine what services are the most appropriate for the child and family. The family will be the primary decision-maker on the team. The data in this study support the assumption inherent in the law that the family members will be treated as team members in determining the services needed for the child and family.
This finding is consistent with a study conducted by McCollum and Maude (1993) that stressed parent's rights to be active participants or consumers in their child's educational programs. Parents essentially should cooperate in writing their child's individualized education plan, share ideas for targeted goals, and give consent to evaluation and placement.

On the IFSP, services provided are summarized to provide an easy-to-read description of who will do what, when, and where. These descriptions, which are required in the law, are helpful reminders to the family and service coordinator. However, service selections need to be flexible; they can be changed to meet the priorities and concerns of the child and family. In this study, 23 (88%) of 26 families and 26 (100%) of 26 service coordinators agreed or strongly agreed that the services provided were the services needed for the child, and also 17 (68%) of 25 families and 22 (85%) of 26 service coordinators agreed or strongly agreed to the Family component of this item, thus both further helping to validate assumption C.

Regarding child interaction with children not requiring special services, service coordinators differed significantly in their responses in regard to children receiving services having opportunity to interact with
children without disabilities. Twenty-one (96%) of 22 service coordinators believed that integrated settings were not provided for their children. On the other hand, five (46%) of 11 families responded that children had opportunity to interact with children who do not require special needs. This result is consistent with previous research conducted by Peck, Carson, and Helmstetter (1992) that found many agreements and disagreements reported by parents and teachers regarding the opportunity for children with disabilities in early childhood programs. Also this finding of disagreement creates concerns because of its uncertainty. Studies of inclusive programs at the early childhood level indicate that desirable outcomes cannot be presumed, but are related directly to the quality of services and process of inclusion (Peck et al., 1978; Jenkins, Odom, & Speltz, 1989). Perhaps the Clinic can address the respondents' concerns that inclusive services for children with and without disabilities should be provided.

Regarding effectiveness of service provided to meet the priorities and concerns of the child and family, most of the families and service coordinators (88%) agreed on this item, in spite of some statistically significant
differences between the two groups in their level of agreement in this information.

Regarding families being on a waiting list before receiving services, nearly half the families (42%) reported having been placed on a waiting list before obtaining services. This result appears consistent with findings of Able-Boone et al. (1990, 1992); and McWilliam et al. (1995) that gaining access to desired service was a struggle for some families. However, it could not be determined clearly from the responses of the families whether or not they experienced a waiting period. For example, some families (50%) indicated not having to wait for the service but their service coordinators (62%) said they had to wait for services to begin.

Families and service coordinators also answered differently in responding that use of an IFSP helped to coordinate services provided for the child and family. Both groups agreed or strongly agreed that use of an IFSP assisted in the coordination of services provided for the child and family, but differed significantly in their level of agreement, which showed that the child was the primary recipient of services. This result could reflect the fact that the purpose of the state-funded Clinic has been more oriented to providing programs and services for children.
than families. Until the enactment of Public Law 99-457, the Clinic primarily was responsible for offering child services from birth through age 5.

The law requires the IFSP meeting should be developed within 45 days of the child’s referral for early intervention services. The meeting should not be held, however, until the family has had the opportunity to share the family’s priorities and concerns and until all of the necessary assessment information has been gathered. The meeting should be scheduled at a time and place identified by the family and service coordinator as convenient and comfortable. Before the meeting, it may be helpful to think about the outcomes or services for the child and family. In this study, 23 (88%) of 26 families and 25 (96%) of 26 service coordinators agreed or strongly agreed that the IFSP meeting was scheduled when convenient.

The law also requires that the IFSP should be reviewed every 6 months to make changes as the child’s and family’s priorities and concerns change. In a response as to whether the IFSP is reviewed at least six months, most of families and service coordinators (88%) agreed or strongly concurred with this requirement.

Families and service coordinators were asked to list the most effective services in meeting the priorities and
concerns of the child and family. Both families and service coordinators (n=43) identified the same eight services as being the most effective in meeting the priorities and concerns of the child and family. Both groups identified related services in general as well as occupational therapy and physical therapy as the most effective services in meeting the priorities and concerns of both child and family. They indicated the inclusive classroom was the second most effective service in meeting the priorities and concerns of the child. Parent involvement was the second most effective service in meeting the priorities and concerns of the family. Families, especially, felt they needed more-play based services; more-home based activities; behavior modification; funding of programs; and a variety of evaluation methods.

With regard to the most effective services needed in meeting the priorities and concerns of the child and family, it is recommended that is needed to gain greater understanding of the types, intensity, and frequency of those services provided for the families and children as a method of informing the service system which services are in greatest demand but short supply.
Assumption D. Families and service coordinators can evaluate effectiveness of the development and implementation of the IFSP.

The assumption investigated in this statement appears to be valid because the families and service coordinators tended to evaluate effectiveness of the development and implementation of the IFSP as being positive.

Five research items with 7 possible responses were used to determine the level of agreement on changes and improvements needed regarding the development and implementation of the IFSP. An open-ended question was used to identify most critical improvements needed in developing and implementing the IFSP. The combined responses and commonalities were used to test the validity of Assumption D.

Families and service coordinators showed the greatest number of statistically significant differences in this section of the study in their level of agreement on 6 of 7 research items regarding their conclusions about developing and implementing the IFSP. However, this result should not be interpreted to mean the families and service coordinators disagreed or strongly disagreed with any of the following statements: a) the types of professionals needed to provide the services required by the IFSP were
made available to the child; b) professionals developing and implementing the IFSP were qualified; c) use of the IFSP should be continued; d) changes/improvements were needed in the process of developing and implementing the IFSP; and e) families and children received services, even if the IFSP requirements were dropped.

Overall, both the families and service coordinators (78%) tended to agree that families and service coordinators showed an ability to evaluate effectiveness of the development and implementation of the IFSP. They agreed that a) the types of professionals needed to provide the services required by the IFSP were made available to the child (90%) and family (77%). Twenty-six (100%) of 26 families and 24 (92%) of 26 service coordinators indicated that professionals developing and implementing the IFSP were qualified and 25 (96%) of 26 families and 20 (77%) of 26 service coordinators answered that the use of the IFSP should be continued. Responses also indicated that more service coordinators (81%) than families (39%) agreed that some changes and improvements were needed in the process of developing and implementing the IFSP. Although 20 (91%) of 22 service coordinators agreed that the families would receive services, even if the IFSP requirements were dropped, only 7 (50%) of 14 families agreed on this item.
An open-ended question was asked to identify the most critical changes/improvements needed in developing and implementing the IFSP. Many families and service coordinators did not respond to this question. Based on the predominantly positive responses of both groups to previous questions about the IFSP processes, one might infer that the non-respondents had no recommendations for improvements.

Seven improvements were reported by a few families and service coordinators as being needed to develop and implement the IFSP. They cited more family-centered services; more programs and therapists; more information for the services; more time and energy; more natural environments; eliminating unnecessary sections of the IFSP; and more home-visits. One family member identified more home-visits as a critical improvement needed to develop the IFSP.

Although negative correlations were found on 9 of 47 items, the findings could be misinterpreted or misleading. When the responses on these items for the families and service coordinators were subjected to detailed item analyses, the negative correlations were between the responses of 'agree' and 'strongly agree', therefore...
indicating that the two groups did not disagree on any of these 9 items.

Conclusions

This study surveyed families and service coordinators regarding development and implementation of the IFSP. Results showed few significant disagreements between the two groups in responding to research items regarding the IFSP processes. The following may be concluded, with some caution, based on the responses of the families and service coordinators.

1. Families and service coordinators tended to indicate that the family demonstrated an ability to participate in identifying its specific priorities, concerns, and goals/outcomes of the IFSP. In retrospect, however, the questionnaire needed to be designed differently to elicit more detailed information on the specific outcomes for children and families.

2. Families and service coordinators supported the prospect that services identified as being needed to reach the IFSP goals/outcomes were provided.

3. Families and service coordinators generally indicated that the services provided addressed the
priorities, concerns, and goals/outcomes of the child and family that were identified in the IFSP.

4. A few families, but more service coordinators, tended to agree that changes and improvements were needed in the process of developing and implementing the IFSP.

5. Families and service coordinators clearly stated that the family members were treated as team members in developing and implementing the IFSP.

6. Families and service coordinators tended to disagree that children receiving services had opportunities to interact with children without disabilities.

7. Families and service coordinators believe that the IFSP process should be continued.

Recommendations

Results from this study suggest that additional research is needed to enhance understanding of the IFSP process.

1. Studies similar to this with larger sample sizes should be conducted to determine if these findings tend to be representative of families and service coordinators participating in the IFSP process and need to obtain
data to document the accuracy of perceptions, as well as determine actual outcomes from the process.

2. Research should be conducted to address the respondents' concerns in this study that inclusive programs for children with and without special needs should be provided. However, the specific expectations of the families and service coordinators should be determined and evaluated as outcomes of the inclusive experience.

3. Further research is needed to assess IFSP effectiveness with specific cultural groups and their priorities, concerns, and goals/outcomes, including any language barriers that could prevent their full participation in the IFSP processes.

4. More research is necessary to gain greater understanding of the types, intensity, and frequency of services provided for the families and children.

5. Further research is necessary to determine the types of counseling and training services needed by families and the types of informative materials that would be most important for families about early intervention programs.

6. Further research is needed to study the barriers that prevent families from getting services without being on waiting lists.
The conclusions and recommendations above were derived from the study findings.

Summary

Although the Individualized Family Service Plan (IFSP) is just one component of the statewide systems of early intervention proposed by Part C of IDEA, it is a core that mandates the family's central role as partners with professionals in identifying appropriate services for the infants and toddlers at risk for and with disabilities and their families. The service coordinator is responsible for assisting the family in identifying specific priorities, concerns, and goals/outcomes of the IFSP. This family-centered process for developing the IFSP represents a significant change in the orientation and perceptions of professionals in working with families.

The researcher believes that surveying family and service coordinator perceptions is an effective way of providing useful information for those who plan and implement early intervention programs.

This study determined that families and service coordinators can cooperate to develop and implement an IFSP to meet the family's priorities and concerns, and they indicate being able to evaluate effectiveness of services
as well as whether or not the IFSP helped to create the family-centered services. This study also tested and validated four assumptions in the law and literature related to the IFSP requirements in the law.

Finally, it is hoped that information obtained through this study will be helpful to researchers and interventionists who wish to implement early childhood programs that use an IFSP policy and processes.
Appendix A

Informed Consent Form

Dear Family Member(s),

The Special Children's Clinic and the UNLV Department of Special Education are cooperating in a study on the experiences of families and service coordinators regarding usefulness of the Individualized Family Service Plan (IFSP).

You are being asked to be a participant in this study because you and your child have received, or are receiving services, based on an IFSP and are in a position to help evaluate its use. We need to determine if the IFSP process is an effective way of accurately identifying family priorities/concerns/needs and obtaining effective services based on those priorities, concerns, or needs.

Your responses to a brief questionnaire are extremely important and needed to help improve family and early childhood service programs in this country. Your individual answers to the questions will remain strictly confidential and will not be shared with your service coordinator(s). No names will be used in any reports. Your answers to each question will be compiled with others and reported as a group.

A pre-addressed, stamped envelope is enclosed for your convenience in returning this letter with your signature at the bottom and the enclosed questionnaire when you have completed it but no later than May 29, 1998. Service coordinators, also, are being asked to participate in the study.

If you have any questions regarding the study, please contact Ms. Maryann Casale or Ms. Paula Crawford at the Special Children's Clinic (702-486-7670), Dr. William C. Healey (895-3205), or Mr. Byoung-In Lee (895-1111) at UNLV.

Dr. Healey and Mr. Lee will use information from the study for the purpose of recommending improvements in IFSP policies and practices, as necessary, and for Mr. Lee's doctoral dissertation. If you have any questions about the rights of people participating in research studies, please call Dr. Healey or Mr. Lee or contact the UNLV Office of Sponsored Programs at 895-1357.

Thank you for your time and assistance. Please do not forget to sign this letter in the proper place below, and return it with the enclosed questionnaire by the deadline.

Sincerely,

Byoung-In Lee, Department of Special Education at UNLV

Family Consent

I have read and understand all of the above information. All my questions have been answered to my satisfaction and I agree to participate in this study.

Signature of family member completing questionnaire: __________________
Print Name: __________________. Child's Name: __________________
Dear Service Coordinator(s),

The Special Children’s Clinic and the UNLV Department of Special Education are cooperating in a study on the experiences of families and service coordinators regarding usefulness of the Individualized Family Service Plan (IFSP).

You are being asked to be a participant in this study because you are coordinating or have coordinated IFSP plans for families and children. We need to determine if you perceive the IFSP process to be an effective way of accurately identifying family priorities/concerns/needs and obtaining effective services based on those priorities, concerns, or needs.

We are asking you to complete a brief questionnaire for several families you serve after they agree to participate in this study. You will be given the names of your families/children who are participating. Your responses are extremely important to help improve early childhood service programs. A copy of the family's signed consent form will be on file at the Special Children’s Clinic and available for your review. Please complete a questionnaire for each family, write their name and the child’s name on the first page of the questionnaire, and return all of the questionnaires to Mr. Byoung-In Lee no later than June 12, 1998.

Your individual answers will remain strictly confidential. They will not be shared with Clinic personnel or the families. Responses will be compiled and grouped with no names used in any reports.

A pre-addressed, stamped envelope is enclosed for your convenience in returning all of the questionnaires completed. If you have any questions regarding the study, please contact Ms. Maryann Casale or Ms. Paula Crawford at the Special Children's Clinic (702-486-7670), Dr. William C. Healey (895-3205), or Mr. Byoung-In Lee (895-1111) at UNLV.

Dr. Healey and Mr. Lee will use information from the study for the purpose of recommending improvements in IFSP policies and practices, as necessary, and for Mr. Lee's doctoral dissertation. If you have any questions about the rights of people participating in research studies, please call Dr. Healey or Mr. Lee or contact the UNLV Office of Sponsored Programs at 895-1357.

Thank you for your time and assistance. Please do not forget to return the questionnaires by the deadline.

Sincerely,

Byoung-In Lee, Department of Special Education at UNLV
Questionnaire on the Individualized Family Service Plan (IFSP)

INSTRUCTIONS
This is a brief questionnaire regarding your experiences. Your responses are extremely important and needed to help improve family and early childhood service programs. Please read each item on the questionnaire and circle the number that indicates your perception of current goals/outcomes from the Individualized Family Service Plan (IFSP). Questionnaire items are divided into four parts (Part I through IV). If you strongly disagree, circle 1; if you disagree, circle 2; if you neither agree nor disagree, circle 3; if you agree, circle 4; if you strongly agree, circle 5. Next, please provide specific answers to the open-ended questions at the end of each section of the questionnaire.

Part I: Family Strengths (Priorities), Needs (Concerns), and Goals/Outcomes of the IFSP

1. Strongly Disagree
2. Disagree
3. Undecided
4. Agree
5. Strongly Agree

1. The IFSP is developed at a time when the family is ready to set goals/outcomes. ................................................................. 1 2 3 4 5
   Comments (if any): ____________________________________________________________.

2. At least one member of the family has an equal influence with the service coordinator in developing the IFSP. ................................................................. 1 2 3 4 5
   Comments (if any): ____________________________________________________________.

3. The family's native language or other mode of communication (example: sign language) is used in:
   a) developing the IFSP ................................................................. 1 2 3 4 5
   b) implementing the IFSP ................................................................. 1 2 3 4 5
   Comments (if any): ____________________________________________________________.
4. The service coordinator assists the family in identifying an accurate list of family priorities and concerns (needs). .................................................. 1 2 3 4 5
   Comments (if any): ..................................................................................................................

5. The service coordinator gives priority to the goals/outcomes of the family in the IFSP. .................................................. 1 2 3 4 5
   Comments (if any): ..................................................................................................................

6. The family considers the goals/outcomes in the IFSP to be appropriate. .................................................. 1 2 3 4 5
   Comments (if any): ..................................................................................................................

7. IFSP goals/outcomes were developed to meet the priorities and concerns (needs) of:
a) child ............................................................................................................. 1 2 3 4 5
b) parents ........................................................................................................ 1 2 3 4 5
c) all family members .................................................................................. 1 2 3 4 5
   Comments (if any): ..................................................................................................................

8. Please list the family priorities and concerns (needs) in the IFSP in developing the IFSP goals/outcomes:
   Priorities and Concerns
   a) 
   b) 
   c)

9. Please list three specific IFSP goals/outcomes by priority.
   Goals/Outcomes
   a) 
   b) 
   c)

10. When the IFSP is reviewed, IFSP goals/outcomes are being met. .................................................. 1 2 3 4 5
    Comments (if any): ..................................................................................................................
Part II: IFSP Goals/Outcomes and Services Provided to the Child and Family.

1. The service coordinator uses the IFSP goals/outcomes in determining the services to be provided for the:
   a) child .................................................................1 2 3 4 5
   b) family ...............................................................1 2 3 4 5
   Comments (if any): ____________________________________________

2. The service coordinator gives the family an opportunity to choose the services desired. .................................................................1 2 3 4 5
   Comments (if any): ____________________________________________

3. Some services on the IFSP were not provided to the:
   a) child .................................................................1 2 3 4 5
   b) family ...............................................................1 2 3 4 5
   Comments (if any): ____________________________________________

4. Please list or describe those services needed but not provided.
   a)
   b)
   c)

5. Please list or describe any barriers that prevent families from getting services.
   a)
   b)
   c)
   d)
Part III: Services Provided and Strengths (Priorities), Needs (Concerns), and Goals/Outcomes of the Child and Family in the IFSP

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The family is provided with understandable information related to the priorities and concerns (needs) of the:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b) family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Comments (if any):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>The family members are treated as team members in determining the services provided for the:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b) family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Comments (if any):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>At least one family member has influence equal to that of the service coordinator in determining which services will be received.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Comments (if any):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The family and service coordinator most often agree that the services provided are the services needed for the:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b) family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Comments (if any):</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
5. Children receiving services have opportunities to interact with children who do not require special services. ................................................................. 1 2 3 4 5

   Comments (if any): __________________________________________________________________________

6. The agency had enough money to obtain or continue the services required to meet the priorities and concerns (needs) of the:
   a) child ............................................................................................................. 1 2 3 4 5
   b) family ........................................................................................................... 1 2 3 4 5

   Comments (if any): __________________________________________________________________________

7. The services are provided in a manner that effectively meets the priorities and concerns (needs) of the:
   a) child ............................................................................................................. 1 2 3 4 5
   b) family ........................................................................................................... 1 2 3 4 5

   Comments (if any): __________________________________________________________________________

8. The family was placed on a waiting list before receiving services. .................................................. 1 2 3 4 5
   (Note) If a waiting period was required, please indicate the amount of the time: ____________.

   Comments (if any): __________________________________________________________________________

9. Use of an IFSP helps to coordinate services provided for the:
   a) child ............................................................................................................. 1 2 3 4 5
   b) family ........................................................................................................... 1 2 3 4 5

   Comments (if any): __________________________________________________________________________
10. IFSP meetings are scheduled when it is convenient for the:
   a) family ........................................................................................................... 1 2 3 4 5
   b) service coordinator ................................................................................. 1 2 3 4 5
   Comments (if any): ________________________________________________________

11. The IFSP is reviewed at least every six months. ................................. 1 2 3 4 5
   Comments (if any): ________________________________________________________

12. Use of the IFSP is effective in identifying:
   a) family priorities .......................................................................................... 1 2 3 4 5
   b) family concerns .......................................................................................... 1 2 3 4 5
   c) family goals(outcomes) ............................................................................... 1 2 3 4 5
   d) child priorities and concerns (needs) .......................................................... 1 2 3 4 5
   e) child services .............................................................................................. 1 2 3 4 5
   f) family services ............................................................................................ 1 2 3 4 5
   Comments (if any): ________________________________________________________

13. Please list services you consider to be most effective in meeting the priorities and concerns (needs) of the:

   Child
   a) 
   b) 
   c)  

   Family
   a) 
   b) 
   c)
Part IV: Changes/Improvements Needed in Developing and Implementing the IFSP.

1. The types of professionals needed to provide the services required by the IFSP are made available to the:
   a) child ............................................................................................................ 1 2 3 4 5
   b) family ........................................................................................................ 1 2 3 4 5
   • Comments (if any): _______________________________________________________

2. Professionals developing and implementing the IFSP are qualified. .................................. 1 2 3 4 5
   • Comments (if any): _______________________________________________________

3. Use of the IFSP should be continued. ................................................................. 1 2 3 4 5
   • Comments (if any): _______________________________________________________

4. Changes and/or improvements are needed in the process of:
   a) developing the IFSP ..................................................................................... 1 2 3 4 5
   b) implementing the IFSP ................................................................................. 1 2 3 4 5
   • Comments (if any): _______________________________________________________

5. Families and children would receive services, even if the IFSP requirements were dropped. ........................................................................................................... 1 2 3 4 5
   • Comments (if any): _______________________________________________________

6. Please list the most critical improvements needed, if any, in developing and/or implementing the IFSP:
   Developing the IFSP  Implementing the IFSP
   a) ..................................................................................................................  a) 
   b) ..................................................................................................................  b) 
   c) ..................................................................................................................  c) 

7. The persons having the most influence in developing the IFSP should be:
   (a) family ___ (b) service coordinator ___ (c) both family and service coordinator ___ (d) other ___ : Please specify: ________________________________
Personal Data (Family)

Please check or specify the correct answers below.

1. Who filled out the survey?
   (a) Mother ___ (b) Father ___ (c) Both parents ___
   (d) Mother and another adult ___
   (e) Father and another adult ___
   (f) Other ___: Please specify: ________________________

2. The child's age is: ___ month(s)

3. Number of months of the child enrolled in early intervention program: ___

4. Number of months of the child assigned to the present service coordinator: ___

5. Gender of the child: (1) female ___ (2) male ___

6. Your educational background
   Less than high school ___ High school graduate ___
   Partial college/specialized training ___ College graduate ___
   Graduate degree ___ Other ___: Please specify: ________________

7. Your ethnic background
   Caucasian ___ African American ___ Hispanic ___ Asian American ___
   Other ___: Please specify: ________________________

8. Please check below your desire to receive a copy of the results:
   (1) Yes ___ (2) No ___
   If "yes", please give your name and complete address:
   Name and Address: __________________________________________
                     __________________________________________
Personal Data (Service Coordinator)

Please check or specify the correct answers below.

1. What is your job title as a service coordinator?
   a) Audiologist ___ b) Child Development Specialist ___
   c) Early Childhood Special Education Teacher ___
   d) Nurse ___ e) Nutritionist ___ f) Occupational Therapist ___
   g) Pediatrician ___ h) Psychologist ___ i) Physical Therapist ___
   j) Social Worker ___ k) Speech/Language Pathologist ___
   l) Other ___: Please specify: _______________________

2. Number of children/families for whom you are a service coordinator: ___

3. Age range of children served: _________________________________

4. Length of time employed as a service coordinator:
   a) less than one year ___ b) one year ___ c) more than one year ___

5. Gender of children served and number:
   Gender                     Number
   a) female ___ a) ___
   b) male ___ b) ___

6. Your educational background
   Less than high school ___ High school graduate ___
   Partial college/specialized training ___ College graduate ___
   Graduate degree ___ Other ___: Please specify: _________________

7. Your ethnic background
   Caucasian ___ African American ___ Hispanic ___ Asian American ___
   Other ___: Please specify: _________________

8. Please check below your desire to receive a copy of the results:
   (1) Yes ___ (2) No ___
   If "yes", please give your name and complete address.
   Name and address: _____________________________________________
   _____________________________________________

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Appendix B

IFSP Requirements

(1) **Assessment and Program Development.** A statewide system, as described in Sec. 1433 of IDEA, shall provide, at a minimum, for each infant or toddler with a disability, and the infant's or toddler's family, to receive:

   (a) a multidisciplinary assessment of the unique strengths and needs of the infant or toddler and the identification of services appropriate to meet such needs;

   (b) a family-directed assessment of the resources, priorities, and concerns of the family and the identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of the infant or toddler; and

   (c) a written individualized family service plan developed by a multidisciplinary team, including the parents, as required by subsection (e).

(2) **Periodic Review.** The Individualized Family Service Plan shall be evaluated once a year and the family shall be provided a review of the plan at 6-month intervals (or more often where appropriate based on infant or toddler and family needs).

(3) **Promptness after Assessment.** The Individualized Family Service Plan shall be developed within a reasonable time after the assessment required by subsection (a) (1) is completed. With the parents' consent, early intervention services may commence prior to the completion of the assessment.
(4) **Content of Plan.** The Individualized Family Service Plan shall be in writing and contain:

(a) a statement of the infant's or toddler's present levels of physical development, cognitive development, communication development, social or emotional development, and adaptive development, based on objective criteria;

(b) a statement of the family's resources, priorities, and concerns relating to enhancing the development of the family's infant or toddler with a disability;

(c) a statement of the major outcomes expected to be achieved for the infant or toddler and the family, and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcome is being made and whether modifications or revisions of the outcomes or services are necessary;

(d) a statement of specific early intervention services necessary to meet the unique needs of the infant or toddler and the family, including the frequency, intensity, and method of delivering services;

(e) a statement of the natural environments in which early intervention services shall appropriately be provided, including a justification of the extent, if any, to which the services will not be provided in a natural environment;

(f) the projected dates for information of services and the anticipated duration of the services;

(g) the identification of service coordinator from the profession most immediately relevant to the infant's or toddler's
or family's needs (or who is otherwise qualified to carry out all applicable responsibilities under this part) who will be responsible for the implementation of the plan and coordination with other agencies and persons; and

(h) the steps to be taken to support the transition of the toddler with a disability to preschool or other appropriate services.

(5) **Parental Consent.** The contents of the individualized family service plan shall be fully explained to the parents and informed written consent from the parents shall be obtained prior to the provision of early intervention services described in such plan. If the parents do not provide consent with respect to a particular early intervention service, then the early intervention services to which consent is obtained shall be provided.
REFERENCES


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Dissertation Title: Family and Service Coordinator
Agreements in the Development and Implementation of the
Individualized Family Service Plan (IFSP)

Dissertation Examination Committee:
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Committee Member, Dr. Thomas Pierce, Ph.D.
Committee Member, Dr. John Filler, Ph.D.
Graduate Faculty Representative, Dr. Eunsook Hong, Ph.D.