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Family Perspectives of the Professional-Paraprofessional Partnership Model of Home-Based Early Intervention Service Delivery

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FAMILY PERSPECTIVES OF THE PROFESSIONAL-PARAPROFESSIONAL PARTNERSHIP MODEL OF HOME-BASED EARLY INTERVENTION SERVICE DELIVERY

by

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ABSTRACT

Family Perspectives of the Professional-Paraprofessional Partnership Model of Home-Based Early Intervention Service Delivery

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Current legislation regarding early intervention services has focused on the family unit, rather than the individual child, as the recipient of services. A model of family-centered care has been adopted and as a result, new models for service delivery have been developed. The present study examined family perspectives of the professional-paraprofessional partnership model, and assessed the ecological validity of this model as it relates to the basic principles of family-centered care. Families who participated in an early intervention program that utilized the professional-paraprofessional partnership model were interviewed upon program completion. Families reported receiving a wide range of child and family services, as well as assistance from their home visitor in accessing formal and informal resources within their community. Families recognized and positively responded to visitors who were flexible, supportive, and respectful of their family. A positive

relationship was found between the number of family services received and ratings of the home visitor on variables of flexibility, support, and control. The majority of families described the home visiting service as the most helpful service they received. In addition, there were no differences in the services provided by professional and paraprofessional visitors, as reported by families. Overall, family reports indicated parent satisfaction with the professional-paraprofessional partnership model, and this model was found to meet the proposed family-centered objectives for early intervention services.

(114 pages)

INTRODUCTION AND STATEMENT OF THE PROBLEM

During the past 5 years, the majority of states have begun the implementation of early intervention services for 0 to 3-year-olds who are at-risk for, or who have, a developmental disability. These actions have been taken in accordance with Public Law 99-457, the Education for the Handicapped Act Amendments. The most recent reauthorization of this legislation is through the Individuals with Disabilities Education Act, IDEA.

The purpose of P.L. 99-457, specifically Part H and Part B, was to better address the needs of children with disabilities, age birth to 5. This was in part accomplished through an optional state grant program, Part H. Under Part H, states were to develop a plan to provide services to children age birth through 2, who either experienced or were at-risk for developmental delay (Ballard, Ramirez, & Zantal-Wiener, 1987). Prior to the amendments, states were not required by federal law (Education for the Handicapped Act, P.L. 94-142) to provide services to these children. If states accepted funding from the U.S. Department of Education through the fifth year of planning, then services would become an entitlement for children, covered under the states eligibility requirements.

A crucial element of the new law was the central role of the family. Under Part H, the family took on a pivotal role in program development and implementation (P.L. 99-457, sections 671, 672, & 677). Specifically, the original definition of early intervention was expanded to include family training, counseling, and home visits.

In addition, the use of individual family service plans became a mandated practice for intervention (McIntosh & Parsons, 1986).

The recognition of the central role of the family in services for children with and at-risk for developmental delays has been slowly recognized in the past decade. For example, the Surgeon General's Report of 1987 also focused on the importance of the family. This report emphasized family-centered, community-based, and coordinated care for children with special health needs (Koop, 1987). Specifically, these principles were reflected in the published "Action Steps" for program implementation. The emphasis on supporting the family, present in federal legislation, clearly illustrates the importance of family participation in early intervention.

It has been suggested, however, that the biggest challenge for most early intervention programs has been compliance with the federal mandate for family-focused programs (Sass-Lehrer & Bodner-Johnson, 1989). Challenges in implementing family-focused programs have included programmatic issues such as program design, training, and cultural barriers, as well as demographic concerns such as rural and urban differences in population, services, and resources. This study focuses on one component of this challenging situation--providing family-centered care to families living in rural areas, whose children are at-risk for developmental delay. Due to geographical constraints and a sparse population base, many rural communities have only limited numbers of services and service providers. Such limited resources make the provision of any form of care extremely difficult. Therefore, providing early intervention services that are family-centered,

community-based, and coordinated to families living in rural regions poses a significant problem for most existing state systems.

The lack of a consistent pool of trained professional staff, combined with the relative dearth of services in rural areas, creates significant difficulties for early intervention programs in providing adequate services. The extra component of family-centered practice adds additional stress to an already overburdened system. Models of practice for rural communities that honor the family-centered principles, yet recognize the lack of professional providers and the sparse nature of services, must be developed and tested. This study reports the degree to which one program was able to provide services to children in a rural health district, who were Part H eligible or at-risk for developmental delay, and to give parents and service providers a sense of family-centered care, as part of service delivery. The model that was developed used paraprofessionals to work collaboratively with public health nurses in providing a range of services to the target population. By hiring and training paraprofessionals to provide the necessary intervention services (under the close supervision of public health nurses), programs can increase their number of service providers without severely taxing their limited budgets. An early intervention program in rural southeast Utah tested this solution. A home-based, professional-paraprofessional partnership model was implemented to increase the number of service providers and to promote the provision of family-centered, community-based, and coordinated services in a rural area. The present study was an ecological validation of the professional-

paraprofessional partnership model. Parent perceptions of, and satisfaction with this model of service delivery were examined, in order to determine whether such a model fit the established family-centered, community-based, and coordinated care objectives for early intervention services.

REVIEW OF RELATED LITERATURE

In order to successfully evaluate the ecological validity of the professional-paraprofessional partnership model, a foundation for evaluation must be established. First, the model itself is descriptively defined. Second, a working definition of ecological validity is developed. Third, the basic components of the model and the related literature are examined. The components to be examined include (a) family-centered care, (b) home visiting in early intervention, (c) paraprofessionals in early intervention, and (d) family perceptions of early intervention services.

The Professional-Paraprofessional Partnership Model

A Description of the Model

The professional-paraprofessional partnership model, as developed for this project, is a home-visiting service delivery model that combines the use of paraprofessionals in concert with professionals to provide early intervention services to children ages birth to 3 (Roberts, 1993). The purpose of the model is to provide a cost effective way to increase the quality of service and the number of families served in sparsely populated rural regions (Roberts & Immel, 1992).

Local paraprofessionals are hired from the local community by the service providing agency (i.e., local health department). A professional is teamed with one or more paraprofessionals, and the team then works together to provide the necessary intervention services. The paraprofessional is closely supervised by the

professional nurse. Preservice training is provided for the paraprofessionals, and both team members (professional and paraprofessional) participate in regular inservice training. The training program is community planned and taught. In addition, it is tailored to meet specific needs of the community. The importance of interagency coordination and the utilization of community resources are emphasized throughout the training procedure. Training topics may include, but are not limited to, the following: child development, early intervention legislation, community resources, case management, and the basic components of family-centered, community-based, and coordinated care.

Once trained, paraprofessionals provide direct services to families in the program, under the supervision of the public health nurse. Joint visits (i.e., professional and paraprofessional) are made periodically, and supervision and case consultation occur on a regular basis (e.g., weekly meetings). In addition, the team serves as a case manager for the family. As case manager, the team develops, implements, and maintains an appropriate Individualized Family Service Plan (IFSP) and establishes communication and coordination among the various agencies providing services to the family (Roberts, 1993).

Compliance with Federal Guidelines

The professional-paraprofessional partnership model incorporated guidelines established by the 1987 Surgeon General's report (Koop, 1987). Each of the three objectives, community-based, coordinated, and family-centered care, as named in the report, are represented in the model. The first objective, community-based care, is addressed

through the employment of individuals who reside in, and are familiar with, the local community. The second objective, coordinated care, is accomplished through the use of home visitors as case coordinators. The third and final objective, family-centered care, however, is not as simple to demonstrate. While home visitors receive training in basic elements of family-centered care, and families are involved in the service delivery process, it is difficult to determine whether or not this form of care is actually delivered. Additional evaluation of the professional-paraprofessional partnership model is needed to determine whether it meets the family-centered objective established by the 1987 Surgeon General's report. This was the aim of the present study.

Ecological Validity of the Professional-Paraprofessional Partnership Model

While family-centered care is well supported in policy, little is known about how the concept is best operationalized in practice. Mahoney, O'Sullivan, and Dennembaum (1990b) have suggested "the family-focused agenda of P.L. 99-457 was forged on the basis of solid theoretical rationale, but little, if any empirical support" (p. 145). Results from their national study examining parents' perceptions of early intervention programs do, however, support the underlying assumptions of this agenda. These authors found a significant relationship between the quantity of family-focused activities received and mothers' perceptions of the degree of benefit their family experienced.

The degree to which the model of family-centered care generalizes to practice may also be described in terms of ecological validity. Ecological validity is a relatively new term in the psychological literature that suggests a relationship between laboratory findings and outcomes in other environments. Specifically, it is the degree to which results from a controlled setting, created by the researcher, can be generalized to other settings (Borg & Gall, 1989). As noted above, a set of principles that are well supported in policy have been proposed for family-centered care. However, little is know about how these principles translate into practice. The professional-paraprofessional partnership model was designed for the provision of family-centered early intervention services and was founded on the basic principles of family-centered care. Therefore, the degree to which these principles translate into practice needs to be examined. In order to ecologically validate the "family-centeredness" of the professional-paraprofessional partnership model, the basic components of family-centered care are compared to family reports of actual services received in a program which used this model.

Family-Centered Care

Defining Family-Centered Care

According to Brewer and colleagues (Brewer, McPherson, Magrab, & Hutchins, 1989), family-centered care is the philosophy of service delivery in which the pivotal role of the family is recognized and respected. Programs incorporating this philosophy support families in

their natural care-giving and decision making roles, and view parents and professionals as equal partners.

Dunst, Trivette, Starnes, Hamby, and Gordon (1991) expanded family-centered care from its basic foundation to include specific principles upon which the concept may be based. They proposed six major principles of family-centered care based on more than a dozen family support principles found in the family support program literature (see Table 1). These principles provide a set of standards for assessing the "family-centeredness" of a program (Dunst, Johanson, Trivette, & Hamby, 1991). They include: (a) enhancing a sense of community, (b) mobilizing resources and support, (c) shared responsibility and collaboration, (d) protecting family integrity, (e) strengthening family functioning, and (f) proactive human service practices. These criteria will be used to evaluate the "family-centeredness" of the professional-paraprofessional partnership model.

Why is Family-Centered Care Important?

If a program is to be truly family-centered, providers must attend to the broad needs of the family, and not merely the developmental needs of the child. Researchers have suggested several reasons why family-focused care is essential for successful intervention. First, their appears to be a relationship between family resources and compliance with child interventions. In a number of studies, Dunst and colleagues (Dunst, Leet, & Trivette, 1988; Dunst, Vance, & Cooper, 1986) found that inadequate resources, not related to child development, interfered with the amount of time, energy, and commitment a parent devoted toward child interventions.

Table 1

Dunst's Major Categories and Examples of Family Support Principles

Category/Characteristics	Examples of Principles
Enhancing A Sense of Community: Promoting the coming together of people around shared values and common needs in ways that create mutually beneficial interdependencies.	Interventions should focus on the building of interdependencies between members of the community and the family unit. Interventions should emphasize the common needs and supports of all people and base intervention actions on those commonalities.
Mobilizing Resources and Supports: Building support systems that enhance the flow of resources in ways that assist families with parenting responsibilities.	Interventions should focus on building and strengthening informal support networks for families rather than depend solely on professional support systems. Resources and supports should be made available to families in ways that are flexible, individualized, and responsive to the needs of the entire family unit.
Shared Responsibility and Collaboration: Sharing of ideas and skills by parents and professionals in ways that build and strengthen collaborative arrangements.	Interventions should employ partnerships between parents and professionals as a primary mechanism for supporting and strengthening family functioning. Resources and support mobilization interactions between families and service providers should be based upon mutual respect and sharing of unbiased information.
Protecting Family Integrity: Respecting the family's beliefs and values and protecting the family from intrusion upon its beliefs by outsiders.	Resources and supports should be provided to families in ways that encourage, develop, and maintain healthy, stable relationships among all family members. Interventions should be conducted in ways that accept, value, and protect a family's personal and cultural values and beliefs.
Strengthening Family Functioning: Promoting the capabilities and competencies of families necessary to mobilize resources and perform parenting responsibilities in ways that have empowering consequences.	Interventions should build upon family strengths rather than correct weaknesses or deficits as primary ways of supporting and strengthening family functioning. Resources and supports should be made available to families in ways that maximize the family's control over and decision-making power regarding services they receive.
Proactive Human Service Practices: Adoption of consumer-driven human service delivery models and practices that support and strengthen family functioning.	Service-delivery programs should employ promotion rather than treatment approaches as the framework for strengthening family functioning. Resource and support mobilization should be consumer-driven rather than service provider-driven or professionally prescribed.

Taken from Dunst, Johanson, Trivette, and Hamby, 1991

Second, parental perceptions of the value of an intervention may also be linked to compliance. Kolobe (1981) determined that parental adherence to a child's physical therapy interventions was directly related to the parents' assessment of the importance and value of the intervention.

Third, it has been suggested that parental involvement in intervention services may actually enhance parenting skills through empowerment. Sass-Lehrer and Bodner-Johnson (1989) noted:

> Parent involvement and empowerment as partners in the intervention process are the new goals [of P.L 99-457]. Parents of special needs children will reap the benefits of this new focus as they gradually assume more and more responsibility for their children's growth and development. This in turn, will foster confidence and competence in their parenting abilities. (p. 75)

Finally, failure to address the needs of the entire family may lead to the demise of the intervention. Dunst (1988) suggested that "failure to address the broader-based needs of families will almost certainly diminish the effects of efforts to support and strengthen family functioning" (p. 5).

Home Visiting in Early Intervention

Homes Visiting as it Relates to Family-Centered Care

In order to create an effective family-centered program, families must be included in decisions regarding their child's care. Therefore, various options regarding types of services need to be provided (Dunst, Trivette, & Deal, 1988). While center-based services provide adequate and convenient care for some families, they may be impractical or inaccessible to others. A number of factors, including (a) extreme distance from the center, (b) lack of transportation, (c) lack of child care services for siblings, and (d) the immobility of a sick child, may prevent families from benefiting from center-based services. Home-based services may provide a valuable alternative for these families. Larner and Halpern (1987) suggested that early

intervention programs which utilize lay (i.e., paraprofessional) home visitors frequently reach families who may not otherwise receive services.

In addition to increased versatility and accessibility, home-based early intervention programs may provide more family-centered care than center-based programs. In a national study of mothers' perceptions of early intervention programs, Mahoney et al. (1990b) found that programs with home-based components and programs which utilized IFSPs tended to have a greater family-focused orientation than other programs.

The Success of Home visiting in Early Intervention

Home visiting services have been used successfully in numerous intervention programs, involving a wide variety of services. Such services include respite care (Joyce & Singer, 1983), parental support and information (Dawson, Van Doorninck, & Robinson, 1989; Heins, Nance, & Ferguson, 1987), preventive child care (Oda & Boyd, 1988), prenatal care (Field, Widmayer, Stringer, & Ignatoff, 1980; Olds, Henderson, Tatelbaum, & Chamberlin, 1986; Ross, 1984), mother-child interaction training (Madden, Levenstein, & Levenstein, 1976), and early hospital release of low birthweight infants (Brooten et al., 1986). The positive effects of these home visiting programs include improvement or enhancement of prenatal care, child health care, child birth-weight and length of gestation, cognitive development, child temperament, parent attitudes, emotional relief, and program cost effectiveness.

Reviews of the literature have consistently found small, positive effects for home-based early intervention with at-risk children (Roberts & Wasik, 1990). In addition, various authors (e.g., Bailey et al., 1988) have suggested that using home-based services in early intervention provides an opportunity to enhance families' involvement in their children's services. It appears, however, that the efficacy of home visiting programs may be related to certain program characteristics. In a recent review of the home visiting literature, Olds and Kitzman (1993) suggested a number of program characteristics which may contribute to program efficacy. These characteristics include: (a) comprehensive focus, (b) frequent visits, (c) well-trained professional staff, and (d) service to families who are at elevated risk for poor outcome.

Home Visitors as Case Managers

In P.L. 99-457, Section 677, the importance of the case manager is recognized in the requirements of the Individual Family Service Plan. Researchers have suggested that the case manager role may be most appropriately filled by home visitors. Aaronson (1989) suggested that case managers who make home visits would be better able to successfully complete their duties than case managers who did not. In addition, combining case management duties with home visiting (primary interventionist) duties may help assure that families receive services in a supportive, efficient, and cost effective manner.

Paraprofessionals in Early Intervention

Unfortunately, home-based services can be costly. Due to the individualized nature of this form of service delivery, more service providers are needed than in a traditional center-based program. Specifically, under a home-based model, several individuals are needed to provide services to families previously served by one provider in a center-based program. However, an alternative to the high costs of additional professional service providers is the utilization of paraprofessional service providers. Larner and Halpern (1987) have suggested that early intervention programs which utilize paraprofessional service providers (i.e., home visitors) are cost-effective.

Additional Benefits of Paraprofessionals

In addition to cost-effectiveness, several authors (Gottlieb, 1985; Honig & Lally, 1982; Larner & Halpern, 1987) have suggested supplementary benefits of using paraprofessional home visitors in early intervention services. Such benefits include: (a) increased acceptance of the service provider by families, (b) cultural familiarity, (c) "peer-like" relationships which allow for maximum flexibility, (d) increased accessibility, (e) a compromise between formal and informal support services, and (f) the extension of limited service resources.

Efficacy of Paraprofessionals

Paraprofessional service providers have been shown to be effective in several mental health service areas. Corcoran (1985)

found that counseling subjects were more willing to seek treatment from paraprofessional than professional therapists. In addition, no differences were found between professional and paraprofessional therapists in degree of treatment success or in subject perceptions of expertness, attractiveness, and trustworthiness. Some researchers have even suggested that clients treated by paraprofessional therapists show greater improvement than those treated by professionals (Hattie, Sharpley, & Rogers, 1984). Still others suggest that paraprofessional and professional therapists are equally effective (Berman & Norton, 1985).

Paraprofessional service providers have also been effectively employed in early intervention programs. Numerous authors (Dawson et al., 1989; Field et al., 1980; Heins et al., 1987; Joyce & Singer, 1983; Powell & Grantham-McGregor, 1989; Sandow, Clarke, Cox, & Stewart, 1981) have studied the efficacy of programs using paraprofessional home visitors in early intervention, and have concluded that such programs are indeed effective.

Family Perceptions of Early Intervention Services

The Importance of Family Perceptions in Evaluation of Early Intervention Programs

While parent input in the initial stages of the intervention process (e.g., goal development, service planning) has been actively encouraged, mechanisms for parent feedback regarding their actual experience are rarely reported (Upshur, 1991). It has been suggested that parent satisfaction may be as important as objective measures of change for promoting a sense of well-being among families (Gallagher,

1990; Kaiser & Hammeter, 1989). In addition, Smith (1986) argued that multiple sources of evaluation, including parent satisfaction, provide valuable information to program planners and policy makers. Finally, by obtaining information from parents regarding their experience with received services, we may determine to what degree the proposed service model was actually delivered (Belsky, 1986; Upshur, 1991). Mahoney, O'Sullivan, and Dennembaum (1990a) proposed that "programs can ascertain that they are truly providing family-focused services only if the parents themselves perceive that they are receiving the kinds of services that family-focused intervention entails" (p. 12).

In addition, family satisfaction with early intervention services may have an impact on compliance with intervention programs. The importance of consumer satisfaction research has been noted in the medical field because of the correlation between patient satisfaction and future behavior (i.e., seeking medical advice, complying with recommendations, maintaining continuity of care) (Marquis, Davies, & Ware, 1983; Patrick, Scrivens, & Charlton, 1983; Zastowny, Roghmann, & Hengst, 1983). Therefore, obtaining parent satisfaction information would be especially important for the evaluation of new models of service delivery.

Family Perceptions of Early Intervention Programs

Several researchers have evaluated family perceptions of various early intervention programs. Specific areas of evaluation have included parent satisfaction, program helpfulness, and services received.

Parent satisfaction. In a study of mothers' and fathers' perceived benefits of early intervention, Upshur (1991) found that overall, both mothers and fathers rated their first year of early intervention services as positive. Similarly, Johnson and El-Hato (1990) conducted interviews with mothers participating in a home-based early intervention program and found great satisfaction with the program. However, family satisfaction appeared primarily due to the support provided by the home visitors, rather than the progress made by their children.

Perceived helpfulness. While parental responses to most early intervention programs have been quite positive, some variability exists with regard to the services parents considered to be most helpful. Upshur (1991) found that not all service components were ranked as equally helpful. Specifically, parents considered learning new techniques for working with their child as most beneficial, and saw motor development, behavior, communication, cognition, and self-help, respectively, as the greatest areas of child benefit. The majority of parents also rated home visits as being very helpful. Upshur suggested that "...much can be learned by soliciting feedback about specific aspects of services" (p. 355).

Able-Boone, Sandall, Loughry, and Frederick (1990) interviewed parents to assess their perceptions of infant and family services as proposed in P. L. 99-457. Parents stressed a need for information about their child's condition and available resources, and for professionals to both relay information to the family and to allow the family to become their own decision makers.

The amount of family-focused intervention services a family receives may also have an impact on perceived helpfulness and efficacy. Mahoney et al. (1990b) found a significant relationship between mothers' perceptions of the effectiveness of intervention services and the amount of family-focused services they received.

Services most often received. It appears that information provision and system involvement may be the most common interventions perceived by parents. As discussed earlier, Mahoney et al. (1990b) conducted a national study of mothers' perceptions of family-focused early intervention and found that the most common services were providing parents with information about their child and helping parents become involved in the early intervention system. The least commonly provided services were resource assistance and personal-family assistance. Discrepancies between the types of services desired and services received were greatest for service utilization and identification of community resources.

Family Perceptions of Paraprofessional Service Providers

Despite the apparent endorsement of paraprofessionals in early intervention programs, literature regarding family perceptions of such programs is relatively sparse. Joyce and Singer (1983) sent early intervention program participants questionnaires assessing the quality and effectiveness of services. From this information they concluded that (a) families whose children were recently found to have a disability reported receiving more benefits from respite-care services; (b) families felt respite-care services were successful in providing

emotional relief, by allowing parents to participate in outside activities; and (c) many families believed that respite-care services helped them avoid institutionalization of their children.

Sandow et al. (1981) administered an attitude questionnaire to study program participants' reactions to services. They concluded that family perceptions of intervention services were related to the diagnostic status of their child. Families of children with IQs in the moderately retarded range based program success on intellectual and social improvements. However, families of children with IQs in the profoundly retarded range measured program success in terms of the personal support they received and the degree to which the "burden of care" was lifted. These findings suggest that families' means of measuring program success vary with the individual needs of the family and target child.

Dawson et al. (1989) used case histories in describing family perceptions of paraprofessional care. The majority of mothers gave high ratings to their relationship with their paraprofessional home visitor. In addition, many stated that the visitor cared about them as a person and provided them with useful information. Families' reactions to home-based intervention services provided by paraprofessionals have generally been positive. However, the needs of families receiving these services vary greatly. It appears that families' satisfaction with intervention programs varies according to the fit between the services provided and the family's unique needs. Specifically, the more tailored intervention services are to a

family's needs, the more satisfied the family is with the services they receive.

PURPOSE AND PROCEDURES

The general purpose of this study was to increase the present understanding of families' perceptions of the professional-paraprofessional partnership model of home-based early intervention service delivery. Families who participated in a program which used this model should report receiving services that were family-centered in nature. The purpose of this study was to assess the actual outcome of such a program, in terms of parents' perceptions of services received, in order to evaluate the ecological validity of this theoretical model. Ecological validity was evaluated in terms of the match between families' reports of services received and the basic principles of family centered care, as defined by Dunst, Trivette, et al. (1991) (refer to Table 1).

There were several objectives to this study:

1a. To describe parents' reported perceptions of the services they received for their family and for their child in a program utilizing the professional-paraprofessional partnership model.

1b. To determine if parent reports of services received for their child and for their family vary systematically by group, between families with a paraprofessional service provider and families with a professional service provider.

2a. To describe parents' perceptions of their relationship with their primary service provider in a program utilizing the professional-paraprofessional partnership model.

2b. To determine if differences exist in parents' mean ratings of flexibility, control, respect, and support between parent/professional relationships and parent/paraprofessional relationships.

3. To determine the relationship between parent reports of the number of family services received and ratings of flexibility, respect, control, and support in the parent/service provider relationship.

Hypotheses

It was hypothesized that:

1a. Families with a paraprofessional service provider will report receiving an equal number of child and family services, as families with a professional service provider.

1b. Families with a paraprofessional service provider will report receiving an equal number of suggested formal resources from their visitor, as families with a professional service provider.

1c. Families with a paraprofessional service provider will report receiving an equal number of suggested informal resources from their visitor, as families with a professional service provider.

2. Families with a paraprofessional service provider will report equal levels of flexibility, respect, control and support in their relationship with their primary service provider, as families with a professional service provider.

3. Families reporting higher numbers of family services received will rate the relationship with their primary service provider higher on variables of flexibility, respect, control, and support, than families reporting lower numbers of family services received.

Procedures

Source of Data

The data for this study were obtained from a research project, coordinated by the Early Intervention Research Institute, investigating the effects of the professional-paraprofessional partnership model of home-based early intervention services (Roberts, 1990). The project was the local component of a more encompassing project titled "National and Local Models of Paraprofessional Training and Service Delivery for Families of Children with Special Health Needs." The project ran from October of 1989 through September of 1992 and was funded by the U.S. Bureau of Maternal and Child Health. The primary goal of the local project was to develop a model of home-visiting service delivery that would address the problem faced by many states, of having insufficient numbers of trained personnel to deliver early intervention services to families in very rural areas (Roberts, 1993). The model used for this project was the professional-paraprofessional partnership model, which was discussed earlier.

The project was conceived through joint planning by the Early Intervention Research Institute and the Utah State Department of Health, and the Southeast Utah District Health Department was chosen as the project site. Children who entered the Southeast Utah District Health Department's Infant Development Program after May of 1990 were randomly assigned to either an experimental (paraprofessional/ professional service provider team) or control group (professional service provider). Because 100% of the paraprofessionals' time was dedicated to home visiting, while only a portion of the professionals'

time was allotted for this activity, a weighted assignment (2 to 1) was used in order to provide home visiting services to more families. Children enrolled in the IDP program prior to the study were not included. Children assigned to the experimental group received weekly home visits by a paraprofessional visitor under the supervision of the IDP nurse, who also visited the family with the paraprofessional every 6 to 8 weeks. Children assigned to the control group received a monthly visit from the IDP nurse.

Collection of Data

Upon completion of the program, each family was asked to participate in a family interview. The purpose of this interview was to obtain direct feedback from the families regarding their experience and satisfaction with the services they received. In addition, the interview provided closure to the families and supplied them with an opportunity to ask any remaining questions. Attempts were made to contact all families who had participated in the project. All families were telephoned to schedule an appointment for an interview. If attempts to reach the family by phone were unsuccessful, written correspondence was sent.

An adapted version of the Family Interview Survey of Family Support Services (Dunst, Trivette, et al., 1991) was administered to each available family, in their home, by a graduate assistant. Three graduate assistants were trained to administer the interview prior to data collection. Training consisted of an explanation of the interview format, guidelines for administration, examination of the interview by the graduate assistant, and a practice administration of

the interview. Graduate assistants were provided feedback after the mock administration.

Population and Sample

The target population for this study was families of children age 0 to 3, identified as at-risk for developmental delay, residing in rural geographical areas, and receiving home-based early intervention services. The accessible population was families residing in one of four counties (Grand, Emery, Carbon, or San Juan) in southeastern Utah, with children age 0 to 3 who had been identified as at-risk for developmental delay, and who participated in the Southeast Utah Health Department's Infant Development Program (IDP). This section of Utah is categorized as rural to frontier and has an ethnic mix which is predominantly Caucasian, with some Native Americans and Hispanics. The accessible population was a fairly homogenous group consisting predominantly of low socioeconomic status (i.e., median annual income of $15,000), Caucasian families, many of whom belong to the Church of Jesus Christ of Latter-day Saints. The homogeneity of this group may affect the generalizability of this study.

The sample consisted of 68 families who participated in the Southeast Utah Health Department IDP program, from May of 1990 to March of 1992 and who were available and agreed to participate in a family interview. The primary referral source for the IDP program was tertiary care hospitals within the state of Utah. Selection for participation in the IDP program was based on the Utah state criterion for at-risk status. Additional referral sources included Social Services, WIC clinics, local physicians, and members of the local

community. Children were not excluded on the basis of condition. All children referred to the IDP program, for whom parental consent was obtained, were included in the study.

Design

The study utilized a posttest-only control-group design. Group assignment was previously determined by the procedures followed in the original program. Families' responses to interview items were examined, and then compared, by group, to determine if significant differences existed. It should be noted that each group received home visits on different frequency schedules. The actual frequency of services provided by a home visitor was not assessed in the interview. Rather, questions were asked regarding the range of different kinds of services families received. Because the study took place in rural communities, and the number of potential services and resources were extremely limited, it was assumed that families from both groups would receive a similar range of services and resources, regardless of frequency of visits.

These data were used in a series of analyses, all produced by an SPSSX-PC computer package. Analyses included a series of one-way ANOVAs, a MANOVA, effect sizes (ES), and several Pearson Product Moment Correlations. Several tables were also constructed to display descriptive information for the variables assessed by the interview. The first analysis was a series of one-way ANOVAs, in which group assignment was the independent variable, while mean number of child services, family services, visitor-suggested formal resources, and visitor-suggested informal resources were the dependent variables.

The second analysis was a MANOVA, in which group assignment was the independent variable and mean service provider ratings of flexibility, respect, control, and support were the dependent variables. Due to the large difference in size between the two groups (46 vs 22), effect sizes (to be abbreviated "ES") were also computed for each variable in the first two analyses. This was accomplished using the formula of standard mean differences (i.e., the mean score of the control group on the dependent variable was subtracted from the experimental group mean and divided by the control group standard deviation). In addition, it has been suggested that effect sizes may be used to help clarify the "practical significance" of test results (Borg & Gall, 1989). For this study, an effect size of .33 or greater was considered to be of "practical significance." In the final analysis, Pearson Product Moment Correlations were conducted between the number of family services reported and service provider ratings of the flexibility, respect, control, and support.

Data and Instrumentation

Interview Development

The family interview used in the study was a revised version of the Family Interview Survey of Family Support Services. This interview was originally developed by Dunst, Trivette, et al. (1991) for the evaluation of family support initiatives involving persons with disabilities, to assess the degree to which family-centered principles were involved. Permission to use and revise the interview was gained from the original author during a telephone conversation.

Each question on the original interview was reworded to apply to the services provided in the professional-paraprofessional partnership program. The interview contained open-ended questions regarding services received (e.g., What types of services or resources has the visitor provided to your child and family?), formal and informal sources of support (e.g., What types of services or resources has the visitor helped you obtain from other agencies or programs?), characteristics of the parent-service provider relationship (e.g., How would you describe your working relationship with your visitor?), examples of and reactions to service provision (e.g., Of all the services you have received, which have been the most helpful to your family and why?), and recommendations for future providers (e.g., How do you think service providers can be more responsive to the needs of at-risk children and their families?).

The revised survey was piloted with four parents of children with disabilities to assess whether the questions elicited the desired information. At the end of the pilot interview, parents were asked to supply feedback regarding ambiguous or awkwardly worded questions. Alterations were made based on the feedback obtained from these parents. Each interview was accompanied by a set of instructions to inform the interviewer of proper procedures. Instructions included information regarding consent and testing procedures, recording written responses, providing examples, time constraints, and recording threats to validity. Because the purpose of the interview was to obtain feedback from all families who participated in the program, interviewers were instructed to explain unfamiliar terms and rephrase

items, when necessary, to facilitate understanding by the family member. If questions were rephrased, the interviewer was instructed to note this information in the "complications" section of the interview. In addition, interviewers were instructed to record any other complications that occurred during the interview. For example, some families were unable to answer questions or to complete the interview because of language barriers, minimal contact with their service provider, or distractions during the interview. Such interviews were judged as having questionable validity and were not coded (5 of the 73 interviews were not coded).

Recording the Data

Data were recorded in two forms. Oral consent was obtained from each family prior to the onset of the interview, and the interviewee's responses were audio taped and recorded in written format by the interviewer. Upon completion of the interview, each audio tape was transcribed. The transcribed form was used for coding interview responses. The written version provided back-up data for each interview and also contained notes from the interviewer regarding rephrased questions, complications, and threats to validity.

Coding the Data

Once all interviews had been completed, a coding system was developed by the author to systematically code the responses to each interview question (see Appendix A). The coding system was designed to assess several variables, including: (a) types of child and family services received; (b) visitor-assisted formal and informal resources;

(c) independently obtained formal and informal resources; (d) degree of perceived flexibility, respect, control, and support in the parent-provider relationship; (e) helpfulness of services; and (f) practice recommendations.

Coding dictionary and conventions. The coding system included a coding dictionary and conventions, which were used to standardize the coding procedure. The coding dictionary consisted of a list of 85 variable names (e.g., SITEID), a description and possible codes for each variable name (e.g., Site ID; 01=Carbon, 02=Emery, 03=Grand, 04=San Juan), and the number of columns in the data set each variable would span (e.g., columns 3-4). This format was used to facilitate data entry into SPSSX-PC.

The dictionary was organized in a way that corresponded to the organization of the interview. Variable names began with the first two or three letters of the corresponding interview section, and the dictionary was divided by subheadings that corresponded to the interview subheadings. This organization system was used to facilitate accurate coding.

The coding conventions contained the basic rules for coding the family interview data. The following was explained in the document: (a) instructions for filling out the coding sheet (i.e., the form on which data were coded), (b) how to code missing data, (c) how to read variable names, (d) how to report coding problems, and (e) specific information for coding each variable. Below is a brief explanation of how the variables examined in this study (i.e., number of child and family services, number of visitor suggested formal and informal

resources, ratings of the parent/provider relationship, and helpfulness of services and recommendations) were coded.

Child and family services. Each interviewee was asked about the types of services the home visitor had provided to his/her child and family. Family responses from all interviews were then reviewed and divided into categories (i.e., 14 child service categories and 6 family service categories) based on common themes among the responses. For example, reports of visitors working with the child on sitting, crawling, walking, and grasping all had a motor theme and therefore a motor development category was formed. Child categories included services such as social development, general development, monitoring, emotional support, and outside referrals, while family categories included information sharing, emotional support, and outside referrals. Each category was then given a variable name and defined in the coding conventions. Examples of codable responses were listed for each variable. The coder was instructed to code whether or not a given service was reported during the course of each interview.

Formal and informal resources. Families were asked questions regarding the types of formal and informal resources that the visitor had helped them obtain and the types of resources they had obtained independently. When families reported informal resources, they were asked who provided the support (e.g., family, neighbors, friends, church). Again, responses from all interviews were reviewed and then divided into general categories based on common response themes. Categories consisted of both visitor assisted and independently obtained formal resources (e.g., developmental, financial, medical),

and informal resources (e.g., daycare, emotional support, general help). Categories were given variable names, which were defined in the coding conventions. Examples of codable responses were listed in the conventions for each variable. For each interview, the coder determined whether or not a given service was reported.

Parent/provider relationship. Questions regarding characteristics of the parent/provider relationship were also included in the interview. Specific questions addressing examples of flexibility, respect, control, and support (important factors in family-centered care) were asked. Each of these variables was then assigned a rating, ranging from 1 (very negative) to 5 (very positive), by an independent rater. The rater was blind to subject assignment, and based her ratings on the variable description and sample responses (representing each rating level) provided in the coding conventions.

Helpfulness of services and recommendations. Finally, families were asked questions regarding the types of services that were most helpful and the kinds of recommendations they would make to future service providers. Again, responses from all interviews were reviewed and a generalized response list for each variable was compiled from this information. These lists included 7 possible response codes for helpful services, and 16 possible codes for recommendations. Examples of codable responses were listed for each variable.

Testing the system. An expert in early intervention research (Dr. Richard N. Roberts) reviewed the coding system and judged the information it generated to be representative of the interview questions. The coding system was then piloted on several randomly

selected interviews and revisions were made to problematic variable descriptions and coding instructions.

An undergraduate research assistant, blind to subject assignment, was trained to use the coding system. The system was piloted and 93% interrater reliability (between the undergraduate and the author) was attained. A minimum interrater reliability was set at 85%, and 10% of the interviews were shadow scored. In addition, Kappa coefficients (Cohen, 1960) were computed for two randomly selected variables (i.e., family service-emotional support [.72] and independent informal resource-day care [1.00]), and both indicated a high level of interrater agreement.

RESULTS

The primary objective of this study was to describe parents' perceptions of the professional-paraprofessional partnership model in relation to the services they received and their relationship with their primary service provider. An additional objective of the study was to determine if differences existed between groups (i.e., professional primary provider vs paraprofessional primary provider) in these two areas. Because the existence of such differences would be an important factor in the interpretation of the interview results, these data are presented first.

Parent Reports of Services Received

The first formal objective of the study was to describe parents' reported perceptions of services received and determine if these reports varied systematically by group. Descriptive data for services received are presented by group in Table 2. It was hypothesized that families with paraprofessionals as primary service providers would report an equal number of child and family-oriented services, visitor-suggested formal resources, and visitor-suggested informal resources, as families with professionals as primary service providers. A series of one-way ANOVAs was used to test the hypotheses, and all were supported. No significant differences were found in the number of child (p = .493; ES = -.048) and family (p = .681; ES = .093) services, or in the number of visitor-suggested formal (p = .752; ES = -.083) and informal (p = .981; ES = .007)

Table 2

A Group Comparison of Descriptive Data for Family Reports of Services Received

Variable	Mean	Standard Deviation	Range	Minimum Maximum	p value	ES
Child Services						
Total	4.015	2.175	11	0-11	.493	-.048
Paraprofessional	3.978	2.113	9	0-9		
Professional	4.091	2.348	10	1-11		
Family Services						
Total	.897	1.081	5	0-5	.681	.093
Paraprofessional	.935	.998	3	0-3		
Professional	.818	1.259	5	0-3		
Visitor-Assisted Formal Resources						
Total	1.350	1.004	4	0-4	.752	-.083
Paraprofessional	1.326	1.012	4	0-4		
Professional	1.409	1.008	3	0-3		
Visitor-Assisted Informal Resources						
Total	.288	.489	2	0-2	.981	.007
Paraprofessional	.289	.506	2	0-2		
Professional	.286	.463	1	0-1		

resources. Because no group differences were found for services received, the response frequencies for all interview variables are presented for the entire sample and are not broken down by group. Services received are examined in terms of (a) child and family services, (b) formal and informal resources, and (c) perceptions of services.

Child and Family Services

The response frequencies of services received are provided in Table 3. More than two-thirds of the families participating in the project reported receiving outside referrals (for their child) from

Table 3

Response Frequencies of Child and Family Services Received

Variable	Responses	Number of Responses & Percentage of Sample
Child Services	Outside Referrals	(46) 68%
	Information Sharing	(32) 47%
	Motor Development	(32) 47%
	General Development	(23) 34%
	Monitoring	(20) 29%
	Medical Care	(14) 21%
	Language Development	(14) 21%
	Adaptive Development	(9) 13%
	Emotional Support	(9) 13%
	Assessment	(6) 9%
	Cognitive Development	(5) 7%
	Social Development	(3) 4%
	Behavior Problems	(2) 3%
Family Services	Outside Referrals	(17) 25%
	Emotional Support	(16) 24%
	Information Sharing	(11) 16%
	General Helping	(11) 16%
	Monitoring	(5) 7%
	Pregnancy Counseling	(1) 1%

their service provider. In addition, nearly one-half of families reported receiving information from their service provider. With regard to specific child development services, a large portion of families (approximately one-half) reported receiving motor development, followed in frequency by general development services. Outside referrals for other family members and emotional support were the most commonly reported family services. Overall, child services were reported more frequently than family services.

Formal and Informal Resources

The frequencies of reported formal and informal resources, obtained both independently and with visitor assistance, are presented in Table 4. Overall, the most frequently reported formal resources

Table 4

Response Frequencies of Formal and Informal Resources as Reported by Families

Variable	Responses	Number of Responses & Percentage of Sample
Visitor-Assisted Resources		
Formal	Medical	(27) 40%
	Financial	(24) 35%
	Developmental	(15) 22%
	Parent Support	(11) 16%
	Educational	(8) 12%
	Day Care	(7) 10%
Informal	General Help	(9) 13%
	Day Care	(6) 8%
	Emotional Support	(3) 4%
	Necessities	(1) 1%
Independently Obtained Resources		
Formal	Financial	(35) 51%
	Medical	(9) 13%
	Developmental	(5) 7%
	Educational	(3) 4%
	Parent Support	(2) 3%
	Day Care	(1) 1%
Informal	Day Care	(38) 56%
	General Help	(11) 16%
	Emotional Support	(10) 15%
	Necessities	(6) 8%
	Financial Assistance	(5) 7%
	Medical	(3) 4%

were financial and medical, while the most common informal resources were day care and general help. Families reported visitor assistance more frequently than independent access for all formal resources (i.e., medical, developmental, parent support, education, and day care), except financial. Conversely, all informal resources were more often obtained independently, than with visitor assistance.

Family Perceptions of Services Received

The frequencies of parents' reported perceptions of services received are provided in Table 5. Over one-third of families reported the home visitor service as the most helpful service they had received.

Table 5

Response Frequencies of Families Reported Perceptions of Services

Variable	Responses	Number of Responses & Percentage of Sample
Most Helpful Service	Home Visitor Service	(28) 41%
	Financial Services	(17) 25%
	Medical Services	(6) 8%
	Developmental Services	(5) 7%
	Other	(5) 7%
	Day Care Services	(2) 3%
	Parent Support Services	(1) 1%
Reason Service was Most Helpful	Knowledge/Information	(23) 34%
	Financial Assistance	(15) 22%
	Other	(10) 15%
	Emotional Support	(8) 12%
	Contacts/Referrals	(3) 4%
Recommendations for Future Service Providers	Visitor as Model	(43) 63%
	Greater Awareness	(12) 18%
	Involve More Families	(6) 8%
	Advertise Services	(4) 6%
	More Visits	(4) 6%

When asked why a service was most helpful, the reason most often given was that it provided the family with knowledge or information. All families who participated in the interview were asked to provide recommendations for future service providers. Approximately two-thirds of all families interviewed suggested that other providers should use their home visitor as a model of excellent service delivery.

Parent Ratings of the Parent/Provider Relationship

The second formal objective of the study was to determine if parents' reported perceptions of the parent/provider relationship varied systematically by group on variables of flexibility, respect, control, and support. A group comparison of descriptive data for ratings of the service provider relationship is provided in Table 6.

Table 6

A Group Comparison of Descriptive Data for Family Ratings of the Parent/Provider Relationship

Variable	Mean	Standard Deviation	Range	Minimum-Maximum	*p* value	ES
Flexibility						
Total	3.875	.724	3	2-5	.815	.056
Paraprofessional	3.889	.682	3	2-5		
Professional	3.842	.834	3	2-5		
Respect						
Total	4.016	.826	3	2-5	.223	.009
Paraprofessional	3.933	.837	3	2-5		
Professional	4.211	.787	2	3-5		
Control						
Total	3.922	.878	3	2-5	.042	-.353
Paraprofessional	3.778	.927	3	2-5		
Professional	4.263	.653	2	3-5		
Support						
Total	4.109	.737	2	3-5	.977	-.743
Paraprofessional	4.111	.775	2	3-5		
Professional	4.105	.658	2	3-5		

It was hypothesized that families with a paraprofessional service provider would report equal levels of flexibility, respect, control,

and support in their relationship with their service provider, as families with a professional service provider. A MANOVA was used to test this hypothesis. Although the results of the MANOVA (F = .091) were not significant at the p = .05 level, effect sizes for two of the individual variables (i.e., respect and control) were suggestive of differences that are practically significant. For this reason, individual ANOVAs were computed for each variable; however, caution was used when interpreting these findings. The hypothesis was supported for variables of flexibility (p = .815; ES = .056), support (p = .977; ES = .009), and respect (p = .223; ES = -.353); note, however, that the effect size for this variable is indicative of a difference that may be practically significant, but not for the variable of control. Families' ratings of professional service providers were significantly higher on the variable of control (p = .042; ES = -.743) than their ratings of paraprofessional service providers.

Family Services and Ratings of the Parent/Provider Relationship

The third formal objective of the study was to determine the relationship between parent reports of family services and ratings of the parent/provider relationship. It was hypothesized that families reporting higher numbers of family services would rate the relationship with their primary service provider higher on variables of flexibility, respect, control, and support, than families reporting lower numbers of family services. A series of Pearson Product Moment

Correlations was used to test this hypothesis. The hypothesis was supported for all variables except respect (r = .182; p = .150). Families' receiving higher numbers of family services rated their service provider significantly higher on variables of flexibility (r = .273; p = .029), control (r = .281; p = .025), and support (r = .337; p =.007).

DISCUSSION

This study examined parent perceptions of the professional-paraprofessional partnership model of home-based early intervention service delivery. This task was accomplished by evaluating information obtained in structured interviews with families who participated in a program that utilized this model. It was hypothesized that families with paraprofessional service providers would report an equal number of child and family-oriented services, as well as visitor-suggested formal and informal resources. This hypothesis was supported. In addition, it was hypothesized that families with paraprofessional service providers would report equal levels of flexibility, respect, control, and support in their relationship with their service provider, as families with professional service providers. This hypothesis was supported only for variables of flexibility and support. Families with professional service providers rated their provider significantly higher on variables of respect and control, than families with paraprofessional service providers.

Finally, it was hypothesized that families reporting a higher number of family services would have higher service provider ratings on variables of flexibility, respect, control, and support. A significant positive correlation was found between the number of reported family services received and service provider ratings of flexibility, control, and support. The hypothesis was not supported for the respect variable.

Because no systematic differences between the two groups were found in terms of services received, these results are discussed for the entire sample. Following this discussion is an examination of the differences between the two groups on parent/provider relationship variables, and the relationship between family services received and parent/provider relationship ratings. Finally, family perspectives of the professional-paraprofessional partnership model are examined in terms of the use of paraprofessionals, and the philosophy of family-centered care.

Services Received

Child and Family Services

Each family was asked questions regarding the services their home visitor provided for their child and for their family. Parents named outside referrals (68%), information sharing (47%), and motor development (47%) as the services most frequently received for their child. These results coincide with the results of a national survey in which Mahoney et al. (1990b) found (a) providing parents with information about their child, and (b) helping parents to become involved in the formal systems of care to be the most commonly reported early intervention services.

In the past, information sharing and referrals for additional services have been found to be important to parents participating in early intervention. Able-Boone and colleagues (1990) conducted an evaluation of parents' perspectives of the family services proposed in P.L. 99-457. These authors found that parents emphasized a need to

become knowledgeable about their child's disability and about available services. In addition, parents stressed the importance of professionals sharing information. Similarly, in their national survey of home visiting programs, Roberts and Wasik (1990) found information delivery to be in the top five services rated as being of primary importance to families. Other authors (Quine & Pahl, 1986) have suggested that providing parents with information about their child's disability may be closely related to parent satisfaction with services.

With respect to general family services received, the most frequently named services included outside referrals (25%) and emotional support (24%). Past research has illustrated the importance of emotional support in service provision. In interviews with parents receiving early intervention services, Calhoun, Calhoun, and Rose (1989) found that parents reported emotional support as a definite benefit of early intervention services. In addition, Roberts and Wasik (1990) (as mentioned earlier) found emotional support to be of primary importance to families in the home visiting programs they surveyed.

Formal and Informal Resources

Families were also asked questions regarding their formal and informal resources. Formal resources included agencies, organizations, and professional services, whereas informal resources were friends, family, neighbors, etc. Families were asked to differentiate between the formal and informal resources that the visitor helped them obtain, and those resources they obtained

independently. Families reported visitor assistance more frequently than independent access for all formal resources (i.e., developmental, education, parent support, medical, and day care) except financial. Conversely, families reported independent access more often than visitor assistance to all informal resources. This finding suggests that families can adequately access informal resources without assistance, but seem to value assistance from a caring individual who helps them through the formal systems of care.

Mahoney et al. (1990b) found that the greatest discrepancy between the types of services desired by parents and the types of services received existed for services related to utilizing the system and identifying community resources. The fact that many families in the current project reported receiving such services provides evidence to support the family-centered nature of the professional-paraprofessional partnership model.

Overall, medical (40%) and financial (35%) services were the most frequently reported formal resources, while day care (65%) was the most common informal resource. Other common informal resources included general help (29%) and emotional support (19%). Families reported that informal support was typically provided by family members, as opposed to friends, neighbors, community, or church members.

Overall Response to the Project

Families were also asked questions regarding the services they found most helpful and the recommendations they would make to future service providers. Families frequently listed home visiting (41%) as

the most helpful service they received. When asked why a particular service was helpful, the reason most often given was that it provided the family with valuable information and knowledge. These results are consistent with Upshur's (1991) findings that parents rated early intervention services as "quite helpful," and the majority found home visits to be "very helpful." In addition, parents reported that learning techniques to work with their child was the most beneficial aspect of the services they received.

In terms of recommendations for future service providers, the majority of families (63%) suggested that other service providers model the behavior of their home visitor. During the interview, parents often made comments about the exemplary behavior of their service provider, in comparison to other providers. For example, one parent stated, "If they were all like her, the world would be in better shape," while another noted, "She was flexible enough and willing enough to work along with us, unlike some other people might have been." Other common recommendations included (a) increased awareness of family situations and issues, (b) involving more families in the project, and (c) advertising available services.

Overall, the professional-paraprofessional partnership model seemed to be well accepted by families in the project. The services provided by the paraprofessionals were seen as compatible to those provided by professionals, in terms of the types of services provided and the helpfulness of those services. The general response to the program was very positive. Many families expressed disappointment upon its conclusion. One parent made the following comment, "She's

been really good....I know there are a lot of kids who have really bad problems and I think it would be very comforting for those parents to have someone coming down and helping them. I thought it was a wonderful program."

Service Provider Ratings

While the author found no differences in services provided by professional and paraprofessional home visitors, this was not true for the parent/provider relationship. While parents reported paraprofessionals as equally flexible and supportive as professionals, they reported them to be less respectful of the family's beliefs and values and less apt to allow the family control of services being received.

This discrepancy in ratings of respect and control between professional and paraprofessional service providers may be partially explained by a problem that was noted during training and supervision regarding boundaries (Roberts, 1993). Many of the paraprofessionals experienced difficulty setting boundaries with the families. Specifically, these individuals had difficulty differentiating between services that were appropriate to provide (e.g., providing a contact name and telephone number for a support service) and those that were not (e.g., buying and delivering coal to the family). As a result, they may have "overstepped their bounds" in an attempt to be helpful. As discussed earlier, boundary issues were a component of the training that the paraprofessionals received. It appears, however, that additional training in this area was needed. Therefore, future

implementations of this model should include more extensive training related to boundary issues.

It should be noted, however, that the mean ratings of all relationship variables for paraprofessionals ranged from neutral to positive. This indicates that although the paraprofessionals were not as respectful, and did not allow the family as much control as the professionals, as a group, they did not receive negative ratings on either variable.

Aside from these discrepancies, support appears to be a key factor in the parent/provider relationship. Numerous families commented on the value and importance of having a person to contact when they needed support. Summers et al. (1990) solicited mothers' views of needs and expected outcomes of early intervention services. Mothers stressed informality, emotional sensitivity, and friendship as most important qualities. Similarly, Upshur (1991) found a correlation between the overall rating of program helpfulness and a decrease in parent stress.

Family Services and the Parent/Provider Relationship

A significant positive correlation was found between the number of family services received and ratings of the parent/provider relationship on variables of flexibility, control, and support. In essence, families rated their provider more positively when they received more family services. This is similar to a finding by Mahoney et al. (1990b) that the more family intervention services

mothers reported receiving, the more they perceived the intervention services as benefiting their family.

Although a positive correlation was found between the number of family services received and service provider ratings of flexibility, control, and support, this was not true for ratings of respect. Perhaps this discrepancy in ratings is due to differences in the constructs that were rated. While variables of flexibility, control, and support can be easily assessed on the basis of overt behaviors, it is difficult to assess respect in this manner. For example, families listed the following behaviors as contributing to flexibility: (a) setting appointment times, (b) providing visits at different places, and (c) rescheduling appointments. Similarly, families seemed to assess a visitor's level of support in terms of these behaviors: (a) listening to concerns, (b) providing supportive statements, and (c) calling to check on the family. In addition, families reported specific instances where they were given options or asked to make choices about the services they received as contributing to their assessment of control. However, families' reports of respect were not typically described in terms of overt actions. Instead, families primarily reported respect in terms of feelings they had towards the visitor.

Therefore, while family-based services contribute to the family-centeredness of the relationship and may enhance relationship ratings of flexibility, control, and support, they do not seem to affect ratings of respect. However, additional studies are needed to confirm this finding.

Families' Perspectives of the Professional-Paraprofessional Partnership Model

In conceptualizing the findings of the study and evaluating the ecological validity of the professional-paraprofessional partnership model, two key questions must be answered. First, were families responsive to the use of paraprofessional service providers? And second, based on the findings from the family interview, did the project meet the established family-centered goals? The answers to these questions are discussed in the sections that follow.

The Use of Paraprofessionals

An important question that must be considered in evaluating any project that uses paraprofessionals in lieu of professionals is whether or not differences exist in the services received. In the present study, no significant differences were found between the services reportedly provided by professionals and those reportedly provided by paraprofessionals. This finding supports several authors' conclusions (Dawson et al., 1989; Field et al., 1980; Heins et al., 1987; Joyce & Singer, 1983; Powell & Grantham-McGregor, 1989; Sandow et al., 1981) that programs using paraprofessional home visitors in early intervention are indeed effective. In addition, these findings add to our limited understanding of family perceptions of such programs.

Fulfillment of Project Goals

To review, a primary goal for the project was to enhance the quality of care families received, in order to reflect the family-

centered principles set forth by P.L. 99-457 and the 1987 Surgeon General's Report (Koop, 1987). To determine if the quality of care received reflected these principles, the degree with which family reports of services received coincided with the basic principles of family-centered care was examined. These principles, as outlined by Dunst, Trivette, et al. (1991) (see Table 1), are now systematically compared with the basic structure of the professional-paraprofessional partnership model, the results of the family interview, and comments from families who participated in the program.

Enhancing a sense of community. The 1987 Surgeon General's Report (Koop) emphasized the importance of community-based services. Dunst, Trivette, et al. (1991) further suggested that to meet family-centered criteria, such services must also build interdependencies between community members and the family unit. The professional-paraprofessional partnership model meets both of these criteria. The basic structure of the model requires community-based services. The project was implemented in a preexisting community facility, and local paraprofessionals residing in that community were employed.

In addition, families participating in the project reported receiving suggestions for accessing formal community resources. These resources included medical, financial, developmental, educational, day care, and support services.

Mobilizing resources and supports. Building support services for families is a critical feature of family-centered care. Service providers must help families to build informal support networks and, at the same time, provide services which are flexible and responsive

to the families needs. Families in the project reported receiving suggestions for accessing informal sources of support. Sources included friends, family, neighbors, and other church or community members. Families also reported positive levels of flexibility in their relationship with their service provider. One parent made the following comment about her family's service provider: "She let me work on things in my own time, my own pace with him--she never really pushed me to do anything."

Shared responsibility and collaboration. Dunst emphasized the importance of partnerships between the parents and the service provider. He further suggested that mutual respect and the sharing of unbiased information are crucial elements of such a partnership. Families in the project reported high levels of control in their relationship with their service provider. For example, one parent stated, "It made me feel good that she would listen to the things that I thought he needed to work on, you know, instead of just working around what she was planning." Another noted, "There was a lot of teamwork and it was great as far as helping us."

Protecting family integrity. Respecting and accepting the family's beliefs and values are critical to family-centered care. Families in the project reported positive levels of respect in their relationship with their service provider. The respect and acceptance felt by these families is best illustrated in the following comments:

> "She never pushed one way or the other, I felt respected."
>
> "It made me feel good, like we weren't alone."
>
> "We're really close to her, she's more like family than anything...like having a sister around."

Strengthening family functioning. In family-centered care, service provision is focused on promoting capabilities and competencies, rather than correcting weaknesses. Families in the project reported feeling supported and empowered by their visitors. Parent comments included, "I felt good about the whole relationship. She gave me some confidence and made me feel like I was being a real supportive mom," and "It was great, it was encouraging, it was good to get feedback that I was doing okay as a mom."

Proactive human service practices. Recent legislation regarding early intervention services (P.L. 99-457, sections 671, 672, & 677) cites the family unit as the recipient of services, and not merely the child. In addition, Dunst suggested a consumer-driven service delivery model, which supports and strengthens family functioning. Families participating in the project reported receiving a large range of family-based services, in addition to standard child-based services. Furthermore, the home visiting component of the professional-paraprofessional partnership model allowed the family maximum convenience and accessibility to services.

Limitations

This study contained several limitations which must be considered in the interpretation of the findings. First, the nature of the sample used in this study may limit the generalizability of the results. Specifically, past research has indicated that subjects in rural areas may perceive services as more helpful than other subjects. In a national study of perceptions of pediatricians' helpfulness, O'Sullivan, Mahoney, and Robinson (1992) found that mothers living in

rural areas perceived pediatricians as more helpful than did mothers living in suburban areas. Because the subjects participating in this study all resided in a rural, intermountain area, their responses to intervention may be especially positive. Therefore, the findings of this study may be limited to families living in rural areas. In addition, subjects in this study were drawn from rural southeastern Utah, and the specific characteristics of this population (as described earlier) may vary from other rural populations, and further limit the generalizability of the results.

Second, because some families who participated in the program were not available for interview, the results of this study may not fully represent the views of all parents participating in this program. Reasons families were not interviewed included (a) moving out of area, (b) not responding to correspondence, or (c) refusing to participate. The families who agreed to participate in the family interview may differ from those families who did not agree to participate.

Third, this study included families of children who were at-risk for developmental delay, in addition to families of children with disabilities, and therefore the results may not generalize to programs involving only families of children with disabilities. In their review of the efficacy literature, Olds and Kitzman (1993) found that home visiting programs which served families who were at an elevated risk for poor outcome were more likely to demonstrate success. They suggest that in order for services to be effective, the family must believe there is a need for them to be visited and that the visitor

has something to offer. Families of children who are at mild risk for delay may not perceive such a need.

Fourth, while families who received services from the professional/paraprofessional team were only asked questions about the paraprofessional, their responses may have inadvertently reflected services provided by the team. Therefore, the findings that no significant differences existed in the services provided by professionals and paraprofessionals may not generalize to studies using paraprofessionals without a professional partner.

Fifth, a post hoc measure was used to determine whether services received by families represented the principles of family-centered care. In interviews, families were asked after-the-fact what kinds of services they received, and their reports were then compared to the basic principles of family-centered care. Direct observation and rating of services being received may have provided a more accurate assessment. In addition, families may have received services which were family-centered in nature, but may not have reported them as such.

Summary

The current legislation regarding early intervention has focused on the family unit as the context in which services must be provided. In addition, a model of family-centered care has been adopted to promote the implementation of such services. For this reason, family perceptions of services received are an important focus for program evaluation. This study evaluated families' reported perceptions of the professional-paraprofessional partnership model of early

intervention service delivery. The purpose of study was to assess the ecological validity of the professional-paraprofessional partnership model in order to determine if the theoretical components of the model were consistent with the actual environmental impact.

Results indicated that no significant differences existed between the services provided by professionals and paraprofessionals. Families reported receiving both child and family-based services, in addition to assistance in accessing formal and informal sources of support. Families also named the home visiting service as the most helpful service they received and recommended that future service providers model after their home visitors. Overall, information and awareness appear to be key factors for rural families receiving early intervention services. These families recognize and positively respond to services which are responsive to their unique needs, and to service providers who are flexible, supportive, and respectful, and who allow the family to maintain control of their child's services. In addition, these families seemed to value having a caring individual to help them through the formal systems of care.

Additional studies of the professional-paraprofessional partnership model are needed to confirm these findings and further evaluate the environmental impact of this model. However, based on the findings of this study, the professional-paraprofessional partnership model does appear to meet the proposed family-centered, community-based, and coordinated objectives for early intervention services. In addition, family reports indicate overall parent satisfaction with the model. In conclusion, the professional-

paraprofessional partnership model may provide a valuable alternative method of providing family-centered early intervention services to families in rural areas.

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APPENDICES

Appendix A

Family Interview Survey of Family Support Principles

Interviewer Instructions

1. Tell the nurse or home visitor (if present) that they will need to leave before the interview begins.

2. Explain to the parent that we will tape record the interview and why.

3. Ask the parent "who came to visit you" to get the name of the nurse or home-visitor.

4. If the family has more than one child in the program, administer one interview and use both children's names in the (child name) space.

5. State the ID # at the beginning of the tape.

6. Write down the bulk of the answer on the interview form, record a -- for no response.

7. You may re-word the question if the parent does not understand it in the present form. If you do, place a star in the left hand margin by the question number.

8. The parent may request an example of what you are asking for, you may provide one, but please record the example you give on the interview form.

9. Keep the parent on task -- this interview can take no more than one hour (completion time is approximately 35 minutes).

10. Please take two minutes at the end of the interview to write down any distractions, difficulties, or problem questions you encountered.

ID # _____

Family Interview Survey of Family Support Services

Carl J. Dunst, Ph.D., Director
Carol M. Trivette, Ph.D., Associate Director

** Revised by Amy Sanford Walters and Richard N. Roberts for the National and Local Models of Paraprofessional Training and Service Delivery for Families of Children with Special Health Needs

IDENTIFYING INFORMATION (Please Print)

Interviewer's Name _____ Date of Interview _____

Beginning Time _____ Ending Time _____ Length of Interview ____

Interviewee's Name _____

Name of Service Provider _____

INTRODUCTION

For the last year or so your family has been involved in a program with the health department, designed to help you work with (Child's name) and obtain any necessary services. I would like to ask you some questions about the services and resources your family received and your feelings about how these resources and services were provided.

I will be tape recording our conversation because the information you are providing is very important to us and we don't want to miss anything.

_____

Interview Observations or Complications:

FAMILY RESOURCES AND SERVICES

First I would like to ask you some questions about the type of resources and services that your family and (child's name) have used during the past year?

1. What types of services or resources has (visitor's name) provided to:
   (child's name) -

   Family -

2. How were these services paid for? (e.g. personal funds, insurance, medicare, etc.)

3. What types of services or resources has (visitor's name) helped you obtain from **other programs or agencies**?

4. Did she help you obtain financial assistance for these services?

5. Did you obtain any of these services and resources with out (visitor's name) assistance.

6. What other types of assistance has (visitor's name) helped you obtain from other people like relatives, friends and neighbors, the church, day care providers, etc.? Please give examples for those that apply.

7. What types of assistance have you obtained **on your own** from these people? Please give examples.

8. Of all the services that you have received for (child's name), which have been most helpful to your family? Why ?

9. Which services or resources have been least helpful? Why?

FAMILY SUPPORT PRINCIPLES

Now I would like you to describe some of the ways in which the (visitor's name) has worked with (child's name) and your family.

ENHANCING A SENSE OF COMMUNITY

1. How has (visitor's name) helped your family participate in community activities?

MOBILIZING RESOURCES AND SUPPORT

2. How have the **services** (visitor's name) provided been flexible and responsive to your family's unique needs?

SHARED RESPONSIBILITY AND COLLABORATION

3. How would you describe the working relationship you have with (visitor's name)?

4. Please describe how your family and (visitor's name) have worked together to get services for (child's name) and your family?

PROTECTING FAMILY INTEGRITY

5. How does (visitor's name) show respect for your family's personal beliefs and values about what is best for (child's name)?

6. How do the services that (visitor's name) provides make the relationships among your family members better? Explain.

STRENGTHENING FAMILY FUNCTIONING

7. In what ways do you feel you have some say (control) in deciding ***what*** services and resources (child's name) and your family receive from the (visitor's name)?

   In what ways do you feel you have some say (control) in deciding ***when*** and ***where*** these services will be provided?

HUMAN SERVICE PRACTICES

8. Does (visitor's name) work with you on what ***you*** feel are your family's needs and concerns or does she tell you what concerns she thinks need to be addressed?

9. Does (visitor's name) give you new information or teach you new skills so that you can get your own needs met, or does she focus on preventing and treating problems? Explain.

COMPARATIVE CASE MATERIAL

Now I would like you to describe some situations that reflect the ways in which (visitor's name) has worked with you and how these situations have made you feel. For each question I will ask for an **example** of a situation you felt good about and one you did not.

1. Describe a situation where **(visitor's name)** was ***flexible and responsive*** to (child's name) needs or your family's needs?

   How did this make you feel?

   Not flexible or responsive?

   How did this make you feel?

2. Describe a situation where you or your family and the (visitor's name) successfully ***worked together*** as a "team" to get a service or resource?

   How did this make you feel?

   Could not successfully work together?

   How did this make you feel?

3. Please describe a situation in which (visitor's name) ***respected your personal values or beliefs*** when working with your family?

   How did this make you feel?

Imposed her own values and beliefs?

How did this make you feel?

4. Please describe a situation in which you felt (visitor's name) allowed you to have a ***lot of control*** over decisions about services (child's name) and your family received?

How did this make you feel?

Little or no control over decisions

How did this make you feel?

5. Please describe a situation where (visitor's name) identified and ***responded*** to (child's name) or your family's ***unique needs***?

How did this make you feel?

Was not responsive to your needs?

How did this make you feel?

POLICY/PRACTICE RECOMMENDATIONS

1. How do you think service providers can be more responsive to the needs of at-risk children and their families?

2. Do you have any other suggestions or recommendations concerning the services (visitor's name) provided?

Appendix B

Family Interview Coding System

FAMILY INTERVIEW CODING DICTIONARY

Variable	Description	Columns
1. CARD18	Card #	1-2
2. SITEID18	Site ID # 01 = Carbon 02 = Emery 03 = Grand 04 = San Juan	3-4
3. SUBID18	Subject ID #	5-7
4. INTV	Interviewer 1 = Todd 2 = Kim 3 = Amy 4 = Chris	8
5. DATE	Date of interview columns 8-9 month columns 10-11 day columns 12-13 year	9-14
6. INTLG	Length of interview in # of minutes	15-16
7. INTSUB	Interview subject 1 = Mother 2 = Father 3 = Both 4 = Other	17
8. SP	Service Provider 1 = Renee Brown 2 = Debra Jones 3 = Pam Lopez/Marilyn Carver 4 = Shirley Christensen 5 = Jeanne Kurtz 6 = Cathy Kearny Reaves 7 = Margie Anderson/Debbie Veech 8 = Pam Tanner Murry 9 = Sharon Crowley	18
9. COMP	Complications 0 = No 1 = Yes 2 = Parent reported limited contact 3 = Judged invalid by interviewer	19

FAMILY RESOURCES & SERVICES

CHILD SERVICES

10. FRSCSSD	Child Services - Social Development 00 = Not Reported 01 = Child 02 = Parent 03 = Child & Parent	20-21
11. FRSCSAD	Child Services - Adaptive Development 00 = Not Reported 01 = Child 02 = Parent 03 = Child & Parent	22-23
12. FRSCSMD	Child Services - Motor Development 00 = Not Reported 01 = Child 02 = Parent 03 = Child & Parent	24-25
13. FRSCSLD	Child Services - Language Development 00 = Not Reported 01 = Child 02 = Parent 03 = Child & Parent	26-27
14. FRSCSCD	Child Services - Cognitive Development 00 = Not reported 01 = Child 02 = Parent 03 = Child & Parent	28-29
15. FRSCSGD	Child Services - General Development 00 = None 01 = Child 02 = Parent 03 = Child & Parent	30-31
16. FRSCSBP	Child Services - Behavior Problems 00 = Not reported 01 = Child 02 = Parent 03 = Child & Parent	32-33

17. FRSCSMC	Child Services - Medical Care 00 = Not reported 01 = Child 02 = Parent 03 = Child & Parent	34-35
18. FRSCSM	Child Services - Monitoring 00 = Not reported 01 = Reported	36-37
19. FRSCSES	Child Services - Emotional Support 00 = Not reported 01 = Reported	38-39
20. FRSCSIS	Child Services - Information Sharing 00 = Not reported 01 = Reported	40-41
21. FRSCSTI	Child Services - Transition Issues 00 = Not reported 01 = Reported	42-43
22. FRSCSOR	Child Services - Outside Referrals 00 = Not reported 01 = Reported	44-45
23. FRSCSA	Child Services - Assessment 00 = Not reported 01 = Reported	46-47
FAMILY SERVICES		
24. FRSFSES	Family Services - Emotional Support 00 = Not reported 01 = Reported	48-49
25. FRSFSIS	Family Services - Information Sharing 00 = Not reported 01 = Reported	50-51
26. FRSFSOR	Family Services - Outside Referrals 00 = Not reported	52-53

01 = Reported

27. FRSFSPC	Family Services - Pregnancy Counseling 00 = Not reported 01 = Reported	54-55
28. FRSFSM	Family Services - Monitoring 00 = Not reported 01 = Reported	56-57
29. FRSFSGH	Family Services - General Helping 00 = Not Reported 01 = Reported	58-59
30. FRSPAY	Source of Payment 00 = Not Apply 01 = Personal funds 02 = Insurance 03 = Medicade 04 = Social Services 05 = Personal funds/Insurance 06 = Insurance/Medicare 07 = Personal funds/Medicare 08 = Personal funds/Social Services 09 = Insurance/Social Services 10 = Other	60-61

VISITOR ASSISTED OUTSIDE AGENCY

31. FRSOAD	Outside Agency - Developmental 00 = Not reported 01 = Reported	62-63
32. FRSOAE	Outside Agency - Education 00 = Not reported 01 = Reported	64-65
33. FRSOAF	Outside Agency - Financial 00 = Not reported 01 = Reported	66-67
34. FRSOAPS	Outside Agency - Parent Support 00 = Not reported 01 = Reported	68-69

35. FRSOAM	Outside Agency - Medical 00 = Not reported 01 = Reported	70-71
36. FRSOADC	Outside Agency - Day Care 00 = Not reported 01 = Reported	72-73
37. FRSFA	Financial Assistance 00 = No 01 = Yes 02 = Not Apply	74-75
38. CARD19	Card #	1-2
39. SITEID	Site ID # 01 = Carbon 02 = Emery 03 = Grand 04 = San Juan	3-4
40. SUBID	Subject ID #	5-7

INDEPENDENT SERVICES

41. FRSISD	Independent Services - Developmental 00 = Not reported 01 = Reported	8-9
42. FRSISE	Independent Services - Education 00 = Not reported 01 = Reported	10-11
43. FRSISF	Independent Services - Financial 00 = Not reported 01 = Reported	12-13
44. FRSISPS	Independent Services - Parent Support 00 = Not reported 01 = Reported	14-15
45. FRSISM	Independent Services - Medical 00 = Not reported 01 = Reported	16-17

46. FRSISDC	Independent Services - Day Care 00 = Not reported 01 = Reported	18-19

VISITOR AIDED INFORMAL SUPPORT

47. FRSIFSD	Informal Support - Day Care 00 = Not reported 01 = Reported/no source 02 = Family 03 = Friends 04 = Neighbors 05 = Community members 06 = Church 07 = Friends & Family	20-21
48. FRSIFSM	Informal Support - Medical 00 = Not reported 01 = Reported/no source 02 = Family 03 = Friends 04 = Neighbors 05 = Community members 06 = Church 07 = Friends & Family	22-23
49. FRSIFSE	Informal Support - Emotional Support 00 = Not reported 01 = Reported/no source 02 = Family 03 = Friends 04 = Neighbors 05 = Community members 06 = Church 07 = Friends & Family	24-25
50. FRSIFSG	Informal Support - General Help 00 = Not reported 01 = Reported/no source 02 = Family 03 = Friends 04 = Neighbors 05 = Community members 06 = Church 07 = Friends & Family	26-27

51. FRSIFSN	Informal Support - Necessities 00 = Not reported 01 = Reported/no source 02 = Family 03 = Friends 04 = Neighbors 05 = Community members 06 = Church 07 = Friends & Family	28-29
52. FRSIFSF	Informal Support - Financial Assistance 00 = Not reported 01 = Reported/no source 02 = Family 03 = Friends 04 = Neighbors 05 = Community members 06 = Church 07 = Friends & Family	30-31

INDEPENDENT INFORMAL SUPPORT

53. FRSIFSDC	Independent Informal Support - Day Care 00 = Not reported 01 = Reported/no source 02 = Family 03 = Friends 04 = Neighbors 05 = Community members 06 = Church 07 = Friends & Family	32-33
54. FRSIIFSM	Independent Informal Support - Medical 00 = Not reported 01 = Reported/no source 02 = Family 03 = Friends 04 = Neighbors 05 = Community members 06 = Church 07 = Friends & Family	34-35

55. FRSIFSES	Independent Informal Support - Emotional Support 00 = Not reported 01 = Reported/no source 02 = Family 03 = Friends 04 = Neighbors 05 = Community members 06 = Church 07 = Friends & Family	36-37
56. FRSIFSGH	Independent Informal Support - General Help 00 = Not reported 01 = Reported/no source 02 = Family 03 = Friends 04 = Neighbors 05 = Community members 06 = Church 07 = Friends & Family	38-39
57. FRSIIFSN	Independent Informal Support - Necessities 00 = Not reported 01 = Reported/no source 02 = Family 03 = Friends 04 = Neighbors 05 = Community members 06 = Church 07 = Friends & Family	40-41
58. FRSIFSFA	Independent Informal Support - Financial Assistance 00 = Not reported 01 = Reported/no source 02 = Family 03 = Friends 04 = Neighbors 05 = Community members 06 = Church 07 = Friends & Family	42-43
59. FRSMH	Most Helpful 01 = Home Visitor Service 02 = Developmental Services 03 = Medical Services 04 = Financial Services 05 = Day Care Services 06 = Parent Support Services 07 = Other	44-45

60. FRSMHR — Reason Most Helpful — 46-47
- 01 = Knowledge/Information
- 02 = Contacts/Referrals
- 03 = Emotional Support
- 04 = Financial Assistance
- 05 = Other

61. FRSLH — Least Helpful — 48-49
- 00 = None/All Helplful
- 01 = Home Visitor Service
- 02 = Developmental Services
- 03 = Medical Services
- 04 = Financial Services
- 05 = Day Care Services
- 06 = Parent Support Services
- 07 = Other

62. FRSLHR — Reason Least Helpful — 50-51
- 00 = Does Not Apply
- 01 = Not practical
- 02 = Difficult to understand
- 03 = Did not use
- 04 = Did not need
- 05 = Too time consuming
- 06 = Other

FAMILY SUPPORT PRINCIPLES

63. FSPCA — Community Activities — 52-53
- 01 = negative response
- 02 = affirmative response
- 03 = affirmative + 1 example
- 04 = affirmative + 2 examples
- 05 = affirmative + 3+ examples

64. FSPFLX — Flexible and Responsive — 54-55
- 01 = negative response
- 02 = affirmative response
- 03 = affirmative + 1 example
- 04 = affirmative + 2 examples
- 05 = affirmative + 3+ examples

65. FSPWR — Describe Working Relationship — 56-57
- 00 = negative response
- 01 = neurtal response
- 02 = positive response
- 03 = positive + 1 example
- 04 = positive + 2 examples
- 05 = positive + 3+ examples

66. FSPWT — Working Together — 58-59
01 = negative response
02 = affirmative response
03 = affirmative + 1 example
04 = affirmative + 2 examples
05 = affirmative + 3+ examples

67. FSPPBV — Respects Personal Beliefs & Values — 60-61
01 = negative response
02 = affirmative response
03 = affirmative + 1 example
04 = affirmative + 2 examples
05 = affirmative + 3+ examples

68. FSPIRF — Improves Family Relations — 62-63
01 = negative response
02 = affirmative response
03 = affirmative + 1 example
04 = affirmative + 2 examples
05 = affirmative + 3+ examples

69. FSPCS — Control in Services Received — 64-65
01 = negative response
02 = affirmative response
03 = affirmative + 1 example
04 = affirmative + 2 examples
05 = affirmative + 3+ examples

70. FSPCWN — Control in When & Where Services Received — 66-67
01 = negative response
02 = affirmative response
03 = affirmative + 1 example
04 = affirmative + 2 examples
05 = affirmative + 3+ examples

71. FSPFNC — Family Needs & Concerns — 68-69
01 = Family concerns
02 = Visitor concerns
03 = Both
04 = Neither

72. FSPTNS — Teaches New Skills — 70-71
01 = Teaches new skills
02 = Prevents & treats problems
03 = Both
04 = Neither

Variable	Description	Columns
73. CARD20	Card #	1-2
74. SITEID20	Site ID # 01 = Carbon 02 = Emery 03 = Grand 04 = San Juan	3-4
75. SUBID20	Subject ID #	5-7
COMPARATIVE CASE MATERIAL		
76. CCMF	Flexibility 01 = Very Negative 02 = Negative 03 = Neutral 04 = Positive 05 = Very Positive	8-9
77. CCMR	Respect 01 = Very Negative 02 = Negative 03 = Neutral 04 = Positive 05 = Very Positive	10-11
78. CCMC	Control 01 = Very Negative 02 = Negative 03 = Neutral 04 = Positive 05 = Very Positive	12-13
79. CCMS	Support 01 = Very Negative 02 = Negative 03 = Neutral 04 = Positive 05 = Very Positive	14-15
80. CCMOR	Overall Relationship 01 = Very Negative 02 = Negative 03 = Neutral 04 = Positive 05 = Very Positive	16-17

POLICY/PRACTICE RECOMMENDATIONS

SUGGESTIONS & RECOMMENDATIONS

81. PPRFS — First Suggestion — 18-19

00 = None
01 = Visitor as model
02 = More activities
03 = More time
04 = More visits
05 = More accessible
06 = More service providers
07 = More information
08 = More follow-up
09 = Greater awarness
10 = Less jargon
11 = Advertise available services
12 = Involve more families
13 = More financial assistance to families
14 = More money to programs
15 = More services in general
16 = Other

82. PPRSS — Second Suggestion — 20-21

00 = None
01 = Visitor as model
02 = More activities
03 = More time
04 = More visits
05 = More accessible
06 = More service providers
07 = More information
08 = More follow-up
09 = Greater awarness
10 = Less jargon
11 = Advertise available services
12 = Involve more families
13 = More financial assistance to families
14 = More money to programs
15 = More services in general
16 = Other

83. PPRTS — Third Suggestion — 22-23

00 = None
01 = Visitor as model
02 = More activities
03 = More time
04 = More visits
05 = More accessible
06 = More service providers
07 = More information
08 = More follow-up

09 = Greater awarness
10 = Less jargon
11 = Advertise available services
12 = Involve more families
13 = More financial assistance to families
14 = More money to programs
15 = More services in general
16 = Other

84. PPRFTS — Fourth Suggestion — 24-25

00 = None
01 = Visitor as model
02 = More activities
03 = More time
04 = More visits
05 = More accessible
06 = More service providers
07 = More information
08 = More follow-up
09 = Greater awarness
10 = Less jargon
11 = Advertise available services
12 = Involve more families
13 = More financial assistance to families
14 = More money to programs
15 = More services in general
16 = Other

85. GPA — Group Assignment — 26

0 = Control
1 = Experimental

CODING PROBLEMS SHEET

ID# INITIALS	VARIABLES IN QUESTION	EXPLANATION

FAMILY INTERVIEW CODING CONVENTIONS

Contained in this document are the conventions or basic rules for coding the information in the Family Interviews for each child involved in the Southeast Utah project. While coding interview information, these rules should be used to make most decisions. If information is missing or not available, the item should be coded "-".

GENERAL CODING CONVENTIONS

Before coding any information, become familiar with the questions on the interview. You will need the following materials:

* Coding Instrument
* Coding Dictionary
* Coding Conventions
* Coding Problems Form
* List of interviews to be coded
* Original Interview for each child
* Transcribed Interview for each child

1. Always code with a #2 pencil.

2. Always code the entire interview in one sitting.

3. Use a "-" for missing data. Every cell in a utilized column must contain either data or the "missing data" code.

4. Use a "99" when the interviewer has written "NA" beneath a question on the original interview form, or when the question is not asked on the transcribed form. In addition, on occasion a parent's response will not make sense or fit the question which was asked. In this case, code the parent's response as "99."

5. Use a "66" code for "DK" (don't know) or "NR" (no response).

6. Be sure to fill in all digits, including leading zeros.

7. Before entering data onto the coding sheet, be sure to first list the card #, located in the coding dictionary, which corresponds with the data being coded.

8. The first two or three letters of any variable correspond with the title of the section, under which the information is found. For example:

   FRS = FAMILY RESOURCE SERVICES
   FSP = FAMILY SUPPORT PRINCIPLES
   CCM = COMPARATIVE CASE MATERIAL
   PPR = POLICY/PRACTICE RECOMMENDATIONS

9. There are two sources of information: the original interview and the transcribed version. You will use both in the coding process. Use the original interview to aid in following the format and use the transcribed version to obtain responses to be coded. In the event that information is missing from the transcribed version, use the original to obtain the information needed to code a response.

10. If you run into a problem or have a question with an interview, record the following information on the Coding Problems Form: the interview ID#, the variable(s) in question, a brief explanation of the problem, and your initials.

11. All coding should take place at EIRI in either the conference room or a private desk. At the end of each day, completed and uncompleted materials should be returned to either Amy or one of the secretaries. PLEASE remember that this information is confidential and discretion should be used when working with the materials.

12. Please note that the item numbers for the coding sheet variables DO NOT correspond with the question numbers on the interview. The interview question numbers are only used as "landmarks" and are mentioned throughout the conventions to help you keep your place in the interview.

13. Helpful hint: Break down areas of the transcribed interview by question - by drawing a small line where one question ends and another begins. Do not "double code" an answer. For each question, read the parent's response, and code each idea only once, in the category which it best fits.

14. Please note: When you use an "other" code, please record the response briefly, beside the proper variable on the coding instrument.

IDENTIFYING INFORMATION

This information is coded at the beginning of each new card. Information for items 1 - 9 can be found either on coding dictionary (card #) or on the first page of the original interview (all others).

1. Card # - List the two digit card number which precedes the variables to be coded on the coding dictionary.

2. Site ID - This is the code number given to each of the four counties. The site ID should be listed on the interview, but may also be determined by the name of the service provider listed on family interview.

Renee Brown / Margie Anderson / Debbie Veach = **Carbon**
Debbie Jones / Cathy Kearny-Reaves = **Emery**

Pam Lopez / Marilyn Carver / Pam Tanner-Muray = **Grand**
Shriley Christensen / Jeanne Kurtz / Sharon Crowley = **San Juan**

3. Subject ID - Each child in the SEUT project was given a code number for purposes of confidentiality. The child's number is listed at the top of the interview.

4. Interviewer - The name of the interviewer is listed on the first line of the original interview. Determine the code for the interviewer as listed in the coding dictionary.

5. Date of Interview - This information is located on the first line of the first page of the interview. If the year is not listed, code "92," since all interviews took place in 1992.

6. Interview Length - Code the length of the interview in the form of minutes with 60 min = 1 hour. The information is located on the second line of the first page of the interview. If this information is missing, simply code "--".

7. Interview Subject - The status of the interviewee is not specified on the interview form. However, this information is often included in the first few lines of the transcribed interview. The person interviewed was the child's primary care giver, therefore if it is not specified - if the respondent is female code "mother" and if male code "father," unless otherwise stated. Sometimes both parents were present for the interview, in which case code "both." If someone other than the child's parent participated in the interview, use the "other" code and write their relation on the coding instrument.

8. Primary Service Provider - This is the name of the visitor who was discussed in the interview. The information is located on the last line of the first page of the original interview. A code number for each visitor is listed in the coding dictionary.

9. Complications - Check the first page of the original interview for any complications the interviewer may have noted. Indicate (yes/no) if any complications have been noted or if the interviewer has questioned the validity of the interview. In a few cases, nothing will be noted in the complication section, but several times during the interview the parent will indicate that they had limited contact with the visitor, for example "We hardly saw her" or "I don't know, she only came twice." If this is the case, then recode the COMP variable to reflect this.

FRS, FSP, CCM, & PPR

Understanding Variable Names As mentioned earlier, each variable name begins with the abbreviation of the section under which it is located (i.e. FRS, FSP, CCM, & PPR). Some of these sections also include subheadings. The purpose of the subheadings is to

separate and set off questions which correspond to several variables. For example, the first question of the interview asks about child services. There are 14 variables which are coded from this single question. The variables which fall under each subheading contain the initials of the subheading in their variable name. For example, the variable name for item 10 is FRSCSGD - Family Resources & Services: Child Services - general development.

There are specific instructions on how to code the information in each section. However, sometimes parents will answer one question in the context of another, and then not repeat this information later. An example of this would be listing referrals to other agencies (e.g. social service, WIC, physicians) when asked about what services the visitor provided to the child. In this case, the information the parent provided should be coded under the VISITOR ASSISTED OUTSIDE AGENCY section, even if they do not repeat the information in the questions which correspond to that section. The rule here is to get the best picture of the parent's perception of the services, even if it their answers don't exactly fit the format of the interview.

This rule also applies for the various variables under each subheading. In some cases, one response may fill two different categories. For example, for Child Services, if the parent reports "she gave me information about how to get her to talk," two different variables apply: language development and information sharing - both with the parent as the mode of intervention (see below explanation).

Family Resources and Services

Items 10 - 62 will be coded from information found in this section of the interview. The variable name for each variable in this section begins with the letters FRS. This section has 6 primary subheadings: Child Services, Family Services, Visitor Assisted Outside Agency, Independent Services, Visitor Aided Informal Support, and Independent Informal Support.

Child Services Items 10 - 23 fall under this subheading and each has a variable name which begins with the letters FRSCS. The information for each of these variables is located in the first question of the interview: "What types of services or resources has ____ provided to your child?" There are two possible ways to code data for these variables. 1) Simply determine whether or not the information was reported. 2) First determine whether or not the service was reported, and if so, identify the mode of the intervention (e.g. child, parent or both). For example, for the variable general development, if the parent reports that the visitor worked directly with the child on developmental skills this would be coded as Child; if they report that the visitor taught them to work with their child on dev. skills, this would be coded as Parent; if the parent reports both, code this Child & Parent. In general, interventions at the Child level will be direct work with the child, while Parent interventions will involve

teaching, sharing information, and referrals. Interventions at the Child/Parent level would include some combination of this.

10. Child Services - Social Development: Also deals with development, but with the development of social skills specifically. This would include skills such as sharing, playing with others, getting along, etc. Determine the mode of intervention.

11. Child Services - Adaptive Development: Represents specific developmental skills which help the child get along in the world. Examples: eating, sleeping, toileting, hygiene. Determine the mode of intervention.

12. Child Services - Motor Development: Includes developmental of both gross and fine motor skills. Examples: Walking, running, throwing, coloring, writing. Determine the mode of intervention.

13. Child Services - Language Development: Includes development of both expressive and receptive communication skills. Determine the mode of intervention.

14. Child Services - Cognitive Development: Involves skills focused on intellectual development. Examples: learning, counting, letters. Determine the mode of intervention.

15. Child Services - General Development: Includes any comments about services related to child development in general, <u>which do not fit any</u> other developmental category. Examples: development, skills, teach child what to do. Determine the mode of intervention. Please see the above example.

16. Child Services - Behavior Problems: Includes interventions or suggestions intended to minimize behavior problems. Examples: temper-tantrums, hitting, screaming, fighting. Determine the mode of intervention.

17. Child Services - Medical Care: Includes information related to and the provision of medical services. Examples: immunizations, weighing, information about immunizations or illnesses.

18. Child Services - Monitoring: Includes checking on the status of the child (or family) in a number of different areas. Examples: health, development, family relations. Determine the mode of intervention.

19. Child Services - Emotional Support: Include reports of emotional support to the parent or family. Examples: "she was always there," " she gave me someone to talk to."

20. Child Services - Information Sharing: Includes any kind of information which is given to or shared with the parent. Examples: developmental milestones, available services, ideas for working with child.

21. Child Services - Transition Issues: Includes information or activities which have to do with transitions in the child's development. Examples: home from the hospital, early intervention to preschool, end of the program.

22. Child Services - Outside Referrals: Includes referrals to or appointments with other professionals and services. Sometimes this information is not listed in this section but is reported under Visitor Assisted Outside Agency. If so, make sure to code that information here as well. Examples: doctors, specialists, speech therapists, physical therapists, preschools, WIC, day care, other agencies & programs.

23. Child Services - Assessment: Generally refers to some form of testing. Examples: tested skills, tested development, testing.

Family Services Items 24 - 29 fall under this subheading and each has a variable name which begins with the abbreviation FRSFS. The information for each variable is located in the second half of the first question of the interview "What services did the visitor provide to your family." This variable addresses services which impact the welfare of the family, rather than the individual child. It may also include services targeted at one member of the family, so long as it is not the target child. **Sometimes parents will list "child services" for this question, in which case the information should be coded under the appropriate child services variable.** For each Family Services variable you will only determine whether or not the service was reported.

24. Family Services - Emotional Support: Includes helping behavior, but more specific - providing emotional support the family. Examples: Someone to talk to, provided advise, there for the family, helped with problems I was having with my husband, available to call any time.

25. Family Services - Information Sharing: Includes any form of information dealing with a family issue, which is given to or shared with the parent. Examples: Medical information, ways to help family functioning, literature about college.

26. Family Services - Outside Referrals: Includes referrals to other agencies or professionals to help another member of the family or the family as a whole. Examples: Family therapy, specialist for a sibling, school/day care for siblings, drug/alcohol rehab for a parent.

27. Family Services - Pregnancy Counseling: Includes help or advise given to the mother during pregnancy. Examples: Help during target child's pregnancy, help/information during other pregnancies.

28. Family Services - Monitoring: Involves basically checking on the family. Examples: Checking to see if family needs anything, checking on family, keeps in touch.

29. Family Services - General Helping: Includes any form of general helping behavior at the family level which will not fit any other category. This is like an "other" category. Examples: Helps with everything, helps us out, helped parent with other children, offered assistance, keeps track of sibling immunizations.

30. Source of Payment - This information follows the second question on the interview "How were these services paid for?" Code the response which corresponds with those listed on the coding instrument. If the response is not a listed choice, code 10 for other. Often times this question did not apply and therefore was not asked. In this case code 00 as indicated in the coding instrument.

Visitor Assisted Outside Agency: Items 31 - 36 fall under this subheading and each has a variable name which begins with the abbreviation FRSOA. The information for these variables follows question 3, "What types of services has the visitor helped you obtain from other programs or agencies?" As noted above, sometimes parents listed this information in the Child & Family Services section. This information needs to be coded in both places. Under Child Services or Family Services it is coded in general terms as an "Outside Referral." In this section the information needs to be more specific. Refer back to the CS and FS sections and note any information coded as Outside Referral, then code this information under the appropriate categories (development, education, finance, parent support, medical, & day care) listed in this section. For each category determine whether or not the service was reported.

31. Visitor Assisted Outside Agency - Developmental: Includes referrals to agencies and professionals for services which will aid in the child's development. Examples: Physical therapists, speech therapists, early intervention, Baby Your Baby.

32. Visitor Assisted Outside Agency - Education: Includes referrals to agencies and professionals for educational services. Examples: Preschool, school for siblings, parent's education.

33. Visitor Assisted Outside Agency - Financial: Includes referrals to agencies which provide financial assistance to the family. Examples: WIC, Social Services, welfare/food stamps, Medicaid.

34. Visitor Assisted Outside Agency - Parent Support: Includes referrals to agencies, groups, and professionals for services which provide parent support. Examples: Parent support groups, respite care, counseling.

35. Visitor Assisted Outside Agency - Medical: Includes referrals to agencies or professionals for medical services. Examples: Children's Special Health Services, traveling clinics, audiologists, orthopedic doctors, other medical specialists. Medicaid or medical card would not be included in the category because those are services which provide financial assistance.

36. Visitor Assisted Outside Agency - Day care: Includes referrals to agencies or individuals for day care services. Examples: Day care agencies or specific providers.

37. Financial Assistance: This information follows question 4, "Did she help you obtain financial assistance for these services?" It refers to financial assistance for other programs. Often times this question did not apply and therefore was not asked. Determine if the question was asked (if not code 02 "Not Apply") and if so, what was the response.

New Card This is the beginning of a new card. The first three variables of a new card are always 1) Card ID, 2) Site ID, and 3) Subject ID. This ensures organization in the system.

38. Card ID - This is the beginning of the second card: Card 19. Write this card number in the appropriate blank. Note: the card number can also be found in the coding dictionary.

39. Site ID - Copy the Site ID number from the first card: Card 18.

40. Subject ID - Copy the Subject ID from the first card: Card 18.

Independent Services Items 41 - 46 fall under this subheading and the variable name for each item begins with the abbreviation FRSIS. This information follows question 5 "Did you obtain any of these services without the visitor's assistance?" This section mirrors the Visitor Assisted Outside Agency section, except these services were obtained without the visitor's help or before the visitor started working with the family. There should not be overlap between this section and the Child and Family Services sections, since CS and FS involve services the visitor provided and this does not.

41. Independent Services - Developmental: Includes contacts with agencies and professionals for services which will aid in the child's development. Examples: Physical therapists, speech therapists, early intervention, Baby Your Baby.

42. Independent Services - Education: Includes contacts with agencies and professionals for educational services. Examples: Preschool, Head Start, school for siblings, parent's education, Voc Rehab.

43. Independent Services - Financial: Includes contacts with agencies which provide financial assistance to the family. Examples: WIC, Social Services, welfare/food stamps, Medicaid.

44. Independent Services - Parent Support: Includes contacts with agencies, groups, and professionals for services which provide parent support. Examples: Parent support groups, respite care, counseling.

45. Independent Services - Medical: Includes contacts with agencies or professionals for medical services. Examples: Children's Special Health Services, traveling clinics, audiologists, orthopedic doctors, other medical specialists. Medicaid or medical card would not be included in the category because those are services which provide financial assistance.

46. Independent Services - Day Care: Includes contacts with agencies or individuals for day care services. Examples: Day care agencies or specific providers.

Visitor Aided Informal Support Items 47 - 52 fall under this subheading and each variable name begins with the abbreviation FRSIFS. This information follows question 6, "What other types of assistance has the visitor helped you obtain from other people like relatives, friends, neighbors, etc.?" The purpose of this question is to assess assistance with informal support. The various forms of informal support are broken down into categories (e.g. day care, medical, emotional support, general help, necessities, and financial assistance) with the potential providers listed beneath each category. In order to qualify, the visitor must have suggested contacting or aided in contacting the source for assistance. For each category determine if the service was reported, and if so, determine the classification (e.g. No Source, family, friends, neighbors, community members or friends and family) of the individual who provided the service.

47. Informal Support - Day care: Includes informal day care (not a paid service) provided by family or occasional baby-sitting by friends or neighbors. Example: My mother takes care of her, sometimes the neighbor watches him, my sister will baby-sit. Determine if the service was reported and who provided it.

48. Informal Support - Medical: Includes attention or assistance for medical issues. Examples: My sister helped me during/after the pregnancy, my mother keeps track of the immunization

records, my neighbor referred me to a good pediatrician. Determine if the service was reported and who provided it.

49. Informal Support - Emotional Support: Includes general emotional support provided to the parent. Examples: My parents are very supportive, my friend has always been there for me, the family gives us lots of moral support, sometimes the neighbor offers to watch her so that I can get out. This last example may seem like day care, however, the primary purpose is to give the mother a break - the friend offered, the mother had not planned to leave and wasn't looking for a sitter. Determine if the service was reported and who provided it.

50. Informal Support - General Help: Includes general assistance which does not fit another category. Examples: My mom helps a lot, my sister does everything for me, the neighbor always offers to help out.

51. Informal Support - Necessities: Includes assistance in the form of food, clothes, shelter, toys, etc. Examples: Neighbors brought food when she left the hospital, our parents give the kids toys, my sister gives us her kid's hand-me-downs, my parents gave us the trailer to live in.

52. Informal Support - Financial Assistance: Includes general financial assistance which does not fit the necessities category. Examples: My parents help us with money, the church helped us get back on our feet financially.

Independent Informal Support Items 53 - 58 fall under this subheading and each variable name begins with the abbreviation FRSIIFS. This information follows question 7, "What types of assistance have you obtained on your own form these people?" This section mirrors the Visitor Aided Informal Support Section, except these services were obtained independently, without the help of the visitor. For each item determine if the service was reported and if so, who provided the service.

53. Independent Informal Support - Day care: Includes informal day care (not a paid service) provided by family or occasional baby-sitting by friends or neighbors. Example: My mother takes care of her, sometimes the neighbor watches him, my sister will baby-sit. Determine if the service was reported and who provided it.

54. Independent Informal Support - Medical: Includes attention or assistance for medical issues. Examples: My sister helped me during/after the pregnancy, my mother keeps track of the immunization records, my neighbor referred me to a good pediatrician. Determine if the service was reported and who provided it.

55. Independent Informal Support - Emotional Support: Includes general emotional support provided to the parent. Examples: My parents are very supportive, my friend has always been there for me, the family gives us lots of moral support, sometimes the neighbor offers to watch her so that I can get out. This last example may seem like day care, however, the primary purpose is to give the mother a break - the friend offered, the mother had not planned to leave and wasn't looking for a sitter. Determine if the service was reported and who provided it.

56. Independent Informal Support - General Help: Includes general assistance **which does not fit another category.** Examples: My mom helps a lot, my sister does everything for me, the neighbor always offers to help out.

57. Independent Informal Support - Necessities: Includes assistance in the form of food, clothes, shelter, toys, etc. Examples: Neighbors brought food when she left the hospital, our parents give the kids toys, my sister gives us her kid's hand-me-downs, my parents gave us the trailer to live in.

58. Independent Informal Support - Financial Assistance: Includes general financial assistance which does not fit the necessities category. Examples: My parents help us with money, the church helped us get back on our feet financially.

59. Most Helpful - This information follows question 8, "Of all the services you received, which have been the most helpful?" Determine which service the family found most helpful and code the corresponding response, as listed in the coding dictionary.

60. Reason Most Helpful - This information is included in the second half of question 8, "Why?" The responses listed in the coding dictionary are in the form of general categories. Pick the category which most closely represents the parents response.

61. Least Helpful - This information follows question 9, "Which services have been least helpful?" Again, the responses listed in the coding dictionary are in the form of general service categories. Pick the category which most closely represents the parent's response.

62. Reson Least Helpful - This information is included in the second half of question 9, "Why?" Choose the code in the coding dictionary which is closest to the parent's response. If none of the choices listed match the parent's response, the "other" code is to be used. If the parent did not give an answer for item 61, then code 00 "does not apply." This will often be the case.

Items 63 - 72 will be coded from information found in this section of the interview. The variable name for each variable in this section begins with the letters FSP. This section is relatively short and does not contain any subheadings. It is marked by the statement "Now I would like you to describe some of the ways in which the visitor has worked with your child and your family."

Items 62 - 70 **(except 65)** are all coded the same way - in terms of **depth of the response.** For each of these items you will determine two things: 1) Is the response negative or affirmative and 2) if affirmative, how many examples (1, 2, or 3) did the parent give to support their answer. Please note, the terms "negative & affirmative" are not qualitative (bad/good) but rather quantitative (no/yes). For example, when asked "How have the services been flexible?" If the parent replies "they haven't," this would be coded as a negative response. But, if the parent replied "Oh, she has always worked with us, especially with scheduling," this would be coded affirmative + 1 example (scheduling). If the parent gives a vague response which indicates that the service was given, but does not give a specific behavior, this would be coded affirmative (with no example). When trying to determine the number of examples use these rules: 1) Different ideas count as separate examples, 2) Different several examples conveying the same idea count as separate examples, 3) If the parent restates the question, or agrees with an example provided by the interviewer, it is not counted as an example, only as an affirmative response - the parent must provide the example or elaborate on an example given by the interviewer. **Caution:** Do not mistake long-windedness for extra examples. Ask yourself "Are they giving me any new information?" If so, count the information as another example.

63. Comunity Activities - This information follows FSP question 1, "How has the visitor helped your family participate in community activities?" Determine whether the response is negative or affirmative and how many examples, if any, were provided. It is not necessary to for them to state a specific community activity; general encouragement to "get out" would also be coded as affirmative. Now code the response as listed in the coding dictionary.

64. Flexible & Responsive - This information follows FSP question 2, "How have the services the visitor provided been flexible and responsive?" Determine whether the response is negative or affirmative and how many examples, if any, were provided. Now code the response as listed in the coding dictionary.

65. Woring Relationship - This information follows FSP question 3, "How would you describe your working relationship?" This question is coded **differently.** <u>This is the **only** time</u> the "negative" response means **"bad."** Please note that a **neutral** response has also been added and the "affirmative" response is now **positive.** Use the following examples to determine negative,

neutral and positive categorization. Negative: Bad, awful, not very good, could have been better. Neutral: Okay, alright, fine. Positive: Good, great, wonderful. First determine whether the response is negative, neutral, or positive. Second, if the response was positive, was an example provided, and if so how many. Finally, code the response as listed in the coding dictionary.

66. Working together - This information follows FSP question 4, "Describe how your family and the visitor have worked together to get services for your child and your family." First determine whether the response is negative or affirmative and then how many examples, if any, were provided. Finally, code the response as listed in the coding dictionary.

67. Respects Personal Beliefs - This information follows FSP question 5, "Does the visitor show respect for your family's personal beliefs ... ?" First, determine whether the response is negative or affirmative and then how many examples, if any, were provided. Finally, code the response as listed in the coding dictionary.

68. Improves Family Relations - This information follows FSP question 6, "How do the services the visitor provides make the relationships among your family members better?" First, determine whether the response is negative or affirmative and then how many examples, if any, were provided. Finally, code the response as listed in the coding dictionary.

69. Control in Services Received - This information follows FSP question 7a, "In what ways do you feel you have some say in deciding **what** services your child and your family receive from the visitor?" ** Sometimes families' frustrations with other services will appear here so it is important to read the responses carefully and only code information which pertains to services provided by the visitor.** First, determine whether the response is negative or affirmative and then how many examples, if any, were provided. Finally, code the response as listed in the coding dictionary.

70. Control in When & Where Services Received - This information follows FSP question 7b, "In what ways do you feel you have some control in deciding **when and where** services are provided?" Again, only code information which pertains to services provided by the visitor. First, determine whether the response is negative or affirmative and then how many examples, if any, were provided. Finally, code the response as listed in the coding dictionary.

71. Family Needs and Concerns - This information follows FSP question 8, "Does the visitor work with you on what **you feel** are your families needs and concerns or does she tell you what

concerns **she thinks** need to be addressed?" Choose a code from the coding dictionary which best represents the parent's response.

72. Teaches New Skills - This information follows FSP question 9, "Does the visitor give you new information or teach you new skills so that you can get your own needs met, or does she focus on preventing and treating problems?" Choose a code from the coding dictionary which best represents the parent's response.

New Card This is the beginning of a new card. The first three variables of a new card are always 1) Card ID, 2) Site ID, and 3) Subject ID. This ensures organization of the system.

73. Card ID - This is the beginning of the third card: Card 20. Write this card number in the appropriate blank. Note: The card number can also be found in the coding dictionary.

74. Site ID - Copy the Site ID number form the first card: Card 18.

75. Subject ID - Copy the Subject ID number from the first card: Card 18.

Comparative Case Material

Items 76 - 80 will be coded from information found in this section of the interview. The variable name for each variable in this section begins with the letters CCM. The section begins with the statement "Now I would like you to describe some situations that reflect the ways in which the visitor has worked with you and how these situations make you feel. For each question I will ask for an example of a situation you felt good about and one you did not."

This section is coded in a different manner than the previous sections. Rather than coding each question individually, the responses within the section are coded as a group on five different variables (relationship, flexibility, respect, control, and support). Each variable is referred to in a specific question, however, it may also be addressed in the examples provided for other questions. Therefore, each time you code a variable, you must read the entire CCM section, before arriving at a code for that item.

Each variable will be coded using a Likert Scale format:

Very Negative	Negative	Neutral	Positive	Very Positive

The code will be based on the examples and feelings which are described in the various questions, in this section. Look at both the positive and negative examples. What is the general tone? If the parent did have a negative experience did it seem to affect their attitude about the visitor, or was it more of an inconvenience which

could not be avoided. As a general rule, determine first if the responses for that variable are more positive or more negative in nature. If you cannot determine this, the response should probably be coded "neutral." A "neutral" response is fairly matter of fact, without much feeling one way or the other. If it is clearly positive or negative, go back over the section to determine the degree of positivity or negativity. Is it extreme, with several modifiers or examples given to support the point (probably a very positive or very negative) or is it mild, with no modifiers or examples (positive or negative)? One hint is the depth of the response. When people feel strongly about something, they tend to say more about it and often give examples. However, it is important to take into account the parents response style. For example, if they usually give one word answers, a six word response may really say a lot for them. To help guide your coding, examples for each code are provided under each variable.

76. Flexibility - This addresses the flexibility of the visitor and the services she provided. Examples:

Very Negative: "Everything was on her terms, she wouldn't ever compromise."

Negative: "She was usually busy so appointments had to revolve around her schedule."

Neutral: "Once it (the appointment) had to be on a certain day, but that wasn't bad, it didn't bother me at all."

Positive: "She's flexible all the time, it made me feel good."

Very Positive: "She's here anytime, anytime at all, anytime we need her."
"I can call her any time, even late at night."

77. Respect - This addresses the amount of overall respect the family perceived. Examples:

Very Negative: "I was really irritated, I didn't think she had any business telling me that."

Negative: "It bothered me a little."

Neutral: "I felt okay about it." "It was okay, she didn't try to interfere."

Positive: "She always respected us." "She didn't ever impose her beliefs on us and I was glad."

Very Positive: "She's very respectful of our situation and our family."
"She was real considerate and sensitive about everything."

78. Control - This addresses the amount of overall control the family perceived. Examples:

Very Negative: "She was really pushy and did not include us in decision."
"She always acted like she knew what was best, and that's what she did."

Negative: "She usually told us what to do and we did it." "I usually wasn't included in decisions."

Neutral: "She was the expert so we listened to her." "I guess I had control."
Positive: "She'd make suggestions but she'd tell me I was doing good on my own too."

Very Positive: "She made it clear that it was always our decision."
"We were always in control."
"She always included me on everything."

79. Support - This addresses the amount of overall support the family perceived. Examples:

Very Negative: "She was never there and we didn't need her anyway."

Negative: "I didn't see her very often, she wasn't around much."

Neutral: "She would make home visits to see if the kids were okay."

Positive: "She helped us out" "I was glad to have her around" "I felt I could call her if I needed to."

Very Positive: "She was really good when Johnny was sick, she called all the time to check and see how he was doing."
"All I had to do was call and she'd come, anytime at all." "Lots of times I called her at night because I didn't know what to do and she always gave me sound advice."

80. Overall Relationship - This addresses the family's perception of the relationship. Examples:

Very Negative: "We didn't get along, so I asked her not to come over any more."

Negative: "It didn't make any difference if she came or not."

Neutral: "It was okay," "She was fine."

Positive: "It was good, I liked her" "I'm glad she came around, she helped us."

Very Positive: "I was really glad she was around, I don't know what I would have done without her."
"She's great, I give her credit for the improvements I've seen in Johnny."
" She was so good for us, she was always there and helped out any way she could."

Policy & Practice Recommendations

Items 81 - 83 will be coded with information from this section of the interview. The variable name for each variable in this section begins with the letters PPR. The section usually begins with the statement "Now I have a couple of general questions for you" or "These last two questions are pretty general..." The items in this section will also be coded as a group rather than as individual questions. Parents often gave all their suggestions in the first question and did not provide additional information in the second question, or vice versa. Therefore, read the entire section before coding any items. Then, code the first suggestion as one item, the second suggestion as another item, and so on. Below is a list of possible responses for each of the items, and a brief description or example of each.

* **None** - No recommendations.
* **Visitor as model** - Visitor did a great job, no improvements, more providers should be like visitor.
* **More Activities** - Suggest activities for family to do with child.
* **More Time** - Spend more time with family or child.
* **More Visits** - Generally more contact with visitor.
* **More Accessible** - Visitor or other providers need to be more accessible to family.
* **More Service Providers** - Family acknowledges shortage of service providers, too many kids and not enough visitors
* **More Information** - Information about the child's disability including causes, prognosis, prevention, exercises, etc.
* **More Follow-up** - Follow-up after services are provided to see how family is doing and if they're having any problems.
* **Greater Awareness** - Aware of alternative reasons for child's problem, general awareness of family situation.
* **Less Jargon** - Use terms which are simple and easy for parents to understand.
* **Advertise** - Parent acknowledges the problem of not knowing what services are available, need for providers to make services known.
* **Involve more Families** - Parent acknowledges that many families could benefit from these services.
*More Financial Assistance to Families - Parent suggests that programs need to provide families with more money or financial assistance.
* **More $ to Programs** - Parent realizes that programs need more money to function and believes that money should be provided.
* More Services in General - **Use this category when the parent suggests more help or services are needed for families, but does not**

list specific aspects of help like time, accessibility, follow-up, etc. They just want more services.
* **Other** - When nothing else will fit .

81. First Suggestion - This is the first suggestion or recommendation given by the parent in the PPR section. Locate the list of possible responses given in the coding dictionary and select the response which best represents the parent's first suggestion. Only use the "other" code as a last resort when none of the other codes will work.

82. Second Suggestion - This is the second suggestion or recommendation given by the parent in the PPR section. Locate the list of possible responses given in the coding dictionary and select the response which best represents the parent's second suggestion. Only use the "other" code as a last resort when none of the other codes will work. If the parent did not make a second suggestion code 00 for "no recommendation."

83. Third Suggestion - This is the third suggestion or recommendation given by the parent in the PPR section. Locate the list of possible responses given in the coding dictionary and select the response which best represents the parent's third suggestion. Only use the "other" code as a last resort when none of the other codes will work. If the parent did not make a third suggestion code 00 for "no recommendation."

84. Fourth Suggestion - This is the fourth suggestion or recommendation given by the parent in the PPR section. Locate the list of possible responses given in the coding dictionary and select the response which best represents the parent's fourth suggestion. Only use the "other" code as a last resort when none of the other codes will work. If the parent did not make a fourth suggestion code 00 for "no recommendation."

85. Group Assignment

FAMILY INTERVIEW CODING INSTRUMENT

1. CARDID ___ ___
2. SITE ID ___ ___
3. SUBID ___ ___ ___
4. INTV ___
5. DATE ___ ___ / ___ ___ / ___ ___
6. INTLG ___ ___
7. INTSUB ___
8. SP ___
9. COMP ___

FAMILY RESOURCES & SERVICES

CHILD SERVICES

10. FRSCSSD ___ ___
11. FRSCSAD ___ ___
12. FRSCSMD ___ ___
13. FRSCSLD ___ ___
14. FRSCSCD ___ ___
15. FRSCSGD ___ ___
16. FRSCSBP ___ ___
17. FRSCSMC ___ ___
18. FRSCSM ___ ___
19. FRSCSES ___ ___
20. FRSCSIS ___ ___
21. FRSCSTI ___ ___
22. FRSCSOR ___ ___
23. FRSCSA ___ ___

FAMILY SERVICES

24. FRSFSES ___ ___
25. FRSFSIS ___ ___
26. FRSFSOR ___ ___
27. FRSFSPC ___ ___
28. FRSFSM ___ ___
29. FRSFSGH ___ ___
30. FRSPAY ___ ___

VISITOR ASSISTED OUTSIDE AGENCY

31. FRSOAD ___ ___
32. FRSOAE ___ ___
33. FRSOAF ___ ___
34. FRSOAPS ___ ___
35. FRSOAM ___ ___
36. FRSOADC ___ ___
37. FRSFA ___ ___

NEW CARD

38. CARDID ___ ___
39. SITEID ___ ___
40. SUBID ___ ___ ___

INDEPENDENT SERVICES

41. FRSISD ___ ___
42. FRSISE ___ ___
43. FRSISF ___ ___
44. FRSISPS ___ ___
45. FRSISM ___ ___

46. FRSISDC ___ ___

VISITOR AIDED INFORMAL SUPPORT

47. FRSIFSDC ___ ___

48. FRSIFSM ___ ___

49. FRSIFSES ___ ___

50. FRSIFSGH ___ ___

51. FRSIFSN ___ ___

52. FRSIFSFA ___ ___

INDEPENDENT INFORMAL SUPPORT

53. FRSIIFSDC ___ ___

54. FRSIIFSM ___ ___

55. FRSIIFSES ___ ___

56. FRSIIFSGH ___ ___

57. FRSIIFSN ___ ___

58. FRSIIFSFA ___ ___

59. FRSMH ___ ___

60. FRSMHR ___ ___

61. FRSLH ___ ___

62. FRSLHR ___ ___

FAMILY SUPPORT PRINCIPLES

63. FSPCA ___ ___

64. FSPFLX ___ ___

65. FSPWR ___ ___

66. FSPWT ___ ___

67. FSPPBV ___ ___

68. FSPIRF ___ ___

69. FSPCS ___ ___

70. FSPCWN ___ ___

71. FSPFNC ___ ___

72. FSPTNS ___ ___

NEW CARD

73. CARDID ___ ___

74. SITEID ___ ___

75. SUBID ___ ___ ___

COMPARATIVE CASE MATERIAL

76. CCMF ___ ___

77. CCMR ___ ___

78. CCMC ___ ___

79. CCMS ___ ___

80. CCMOR ___ ___

POLICY/PRACTICE RECOMMENDATIONS

81. PPRFS ___ ___

82. PPRSS ___ ___

83. PPRTS ___ ___

84. PPRFTS ___ ___

85. GPA ___