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Early Intervention Services And Parent Involvement

Joyce Elaine Coleman

Eastern Illinois University

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EARLY INTERVENTION
SERVICES AND PARENT
INVOLVEMENT

JOYCE ELAINE COLEMAN

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Early Intervention Services and

Parent Involvement
(TITLE)

BY

Joyce Elaine Coleman

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

Master of Science

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
CHARLESTON, ILLINOIS

1984
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EARLY INTERVENTION SERVICES AND PARENT INVOLVEMENT

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THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
MASTER OF SCIENCE
IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
CHARLESTON, ILLINOIS

EARLY INTERVENTION SERVICES AND PARENT INVOLVEMENT

COLEMAN, JOYCE ELAINE, M.S. Eastern Illinois University
at Charleston, Illinois, 1984

The purpose of the study was to investigate the perceived needs of families receiving services from an early intervention program serving developmentally delayed and at risk children birth to three years of age. To accomplish this purpose a needs assessment was conducted with families receiving early intervention services. The following seven research objectives were studied:

To identify the perceived needs of parents for involvement in program activities.

To identify the perceived needs of parents for parenting information.

To identify the perceived needs of parents for improving the quality of family relationships.

To identify the perceived medical needs of parents.

To identify the perceived employment needs of parents.

To identify the perceived financial needs of parents.

To investigate the relationship of perceived needs of the parents with the demographic variables of: income level, number in the family, marital status and child's disability.

One hundred twenty-four families receiving early intervention services were the subjects for this study. The families were selected from thirteen programs serving thirty-one counties in Southern Illinois. Of the programs

studied, all of the children enrolled met the criterion of developmentally delayed or at risk.

The instrument used for assessing the needs of the families was developed by the researcher. It includes six sections with a total of fifty items asking families about their perceived needs and a seventh section requesting family data. The findings indicate rankings of needs from low to high. The criterion for a high need was established when 75% of the respondents marked a response of 4 or 5 on a five point Likert scale. The criterion for a low need was met when 75% of the respondents marked a response of one or two on a five point Likert scale. Descriptive statistics of frequencies, percentages and cross tabulations were used to analyze the data.

Useful information was gained through the study. Parents of developmentally delayed or at risk children do perceive themselves as having high needs that are addressed by the research instrument. Parenting information was rated as the most frequently cited perceived high need. The need for parenting can very appropriately be met by early intervention programs. It is the researcher's professional opinion that the needs assessment is most valuable to the service provider when evaluated on an individual basis. This is supported by the concept of individualization emphasized throughout the review of literature. Studies such as this should be reviewed for program planning with consideration of the individual families' needs being emphasized.

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CHAPTER I

THE PROBLEM

The need to provide services to families with children who are developmentally delayed or at risk of developmental delay has been documented through research. Furthermore, the earlier these families are identified, the greater and more enduring the impact of intervention. This study focused on the developmentally delayed child and at risk child, birth to three years of age. The families involved in this study were receiving services from an early intervention program.

The goal of early intervention is to reduce the vulnerabilities of the family and to promote quality interaction between the child, the caregiver, and the environment (Hanson, 1982). Early identification should include an assessment of medical disorders, environmental risk factors and biological insult(s) for potential or existing causes of developmental problems (Tjossem, 1976).

Studies conducted to measure the effectiveness of early intervention have supported the need for this service to developmentally delayed children and their families. McNulty, Smith and Soper (1983) report that without early intervention, developmental problems may become compounded and require more intense services at a later date. In contrast the positive influence of early intervention appears to significantly affect later development and performance (Schweinhart and Weikart, 1981). These positive results are consistent with all types and levels of

developmental problems. In summary, early intervention produces immediate and long term gains for the families directly involved and for society as a whole.

The literature also supports early intervention as a prevention service for the at risk child who demonstrates characteristics resulting from adverse medical or environmental factors. The environment in which the child lives includes parental attitudes and parental self esteem, combined with parental concern for the child. This environment has a significant impact on the child before his/her second birthday is reached (Stedman, 1977). In situations where families cannot supply a supportive environment, the child may benefit from placement outside of the family unit for a period of time. The medically at risk child may potentially demonstrate a developmental delay due to prenatal or postnatal biological insult or a genetic condition (Tjossem, 1976). Early and accurate identification and treatment of the child's total environment will produce the greatest gains.

The importance of early intervention services has been observed by Martin (1981), who reported consistent improvement in language skills over a two and one half year period serving hearing impaired children through the Central Institute for the Deaf. Also Bricker and Sheehan (1982) found significant gains were made across groups of children: normal; at risk; and mildly, moderately and severely

handicapped. Positive, long term effects were documented through a longitudinal study reported by Schweinhart and Weikart (1981) in the Perry Preschool Program. These at risk, low income children demonstrated a stronger commitment to schooling, a higher scholastic achievement, and a reduced need for special education services.

Early intervention programs have been operated for the past ten years by various agencies using one of several program models. Depending upon the identity of the governing body, the goals and objectives will vary, as will the types of families being served. Examples of service providers are Association for Retarded Citizens, mental health agencies, Easter Seal Societies and university clinics. Any of these might follow a therapeutic, educational or medical model; each could be home based or center based.

Some programs have specialized in services to children with specific developmental disabilities such as hearing impairment, visual impairment or Downs Syndrome. Even within the programs serving a specifically defined population, there may be variations. Consequently, it is difficult to compare programs and to draw conclusions about success and failure when the many variables are considered.

Regardless of the type of service delivery system, the early intervention services provided must include a quality program designed to meet the individual needs of the family unit. To insure this desirable program design, appropriate

assessments and accurate interpretation of these assessment results must occur. Once the intervention program is established for a particular family, the procedures must be monitored with sufficient frequency and sensitivity to make necessary modifications (Rostetter and Hamilton, 1982). In summary, the literature suggests that the most successful early intervention programs are those which are individualized and emphasize parent involvement as part of the service.

Significance of the Study

Improving program effectiveness is a vital concern to the service provider and to the families receiving the service. The research data collected during this study should provide a basis for policy-making regarding service delivery systems to developmentally delayed and at risk children birth to three years of age and to their families. As a result of this study families receiving early intervention services will have increased knowledge to enable them to better function independently. In summary this study should be beneficial to educators, social service and health agency professionals, and consumers of these services.

Statement of the Problem

The problem addressed by this study was the identification of the perceived needs of families receiving services from an early intervention program serving birth to

three year old developmentally delayed and at risk children.

The terms used in this study are defined in the following way:

Intervention--attenuating the vulnerability of infant and caregiver to adverse conditions and maximizing opportunities for optimal commerce with the environment (Hanson, 1982, p. 251).

Parent involvement--activities promoting appropriate interaction between parent and child based on a point of view that continually takes into account the needs and skills of the entire family (Foster, Berger and McLean 1981, p. 4).

Developmentally delayed and at risk--
. infants manifesting early appearing aberrant development related to diagnosed medical disorders with established risk for developmental outcome;
. infants at environmental risk consequent to limiting life experiences;
. infants at high probability for risk consequent to biological insult(s) frequently, but not always associated with developmental delay (Tjossem, 1976, p.4).

Research Objectives

The purpose of the study was to investigate the perceived needs of families receiving services from an early intervention program serving developmentally delayed and at risk children birth to three years of age. The research objectives were:

1. To identify the perceived needs of parents for involvement in program activities.
2. To identify the perceived needs of parents for parenting information.
3. To identify the perceived needs of parents for improving the quality of family relationships.

4. To identify the perceived medical needs of parents.

5. To identify the perceived employment needs of parents.

6. To identify the perceived financial needs of parents.

7. To investigate any relationship of perceived needs of the parents with the demographic variables of income level, number in the family, marital status, and child's disability.

CHAPTER II

REVIEW OF THE LITERATURE

Throughout the review of the literature the following areas of concern were identified regarding early intervention services: the task of parenting the normal child, the increased challenge of parenting the developmentally delayed child, the results of poor parenting skills, types of early intervention programs, characteristics of successful parent programs and the effectiveness of parent involvement.

The terms developmental delay, handicapped and infants at risk are used interchangeably throughout the literature. During this study the term developmental delay as defined by Tjossem (1976) is used. Tjossem (1976) identifies three categories of infants who can be regarded as in need of special early intervention services to assure the child's optimal cognitive development and life adjustment as follows:

- . infants manifesting early appearing aberrant development related to diagnosed medical disorders with established risk for developmental outcome;
- . infants at environmental risk consequent to limiting life experiences;
- . infants at high probability for risk consequent to biological insult(s) frequently, but not always associated with developmental delay (p.4).

Parenting the Normal Child

Many people enter the role of parenting lacking the necessary skills to assist children in developing to their fullest potential (Bigner, 1979). Parenting involves awareness of developmental growth patterns, medical and

nutritional needs, behavior management techniques, as well as the ability to promote quality family relationships. For many, there are no formal parent training programs. Where such programs exist, effectiveness requires timeliness. Readiness for parent training may not occur until the first pregnancy or until the first awareness of a need for parenting skills. White (1975) suggests that most families can provide adequate care in terms of education and development for the first six to eight months of their child's life, but from the eight to thirty-six month period, no more than ten percent of the children are as well educated and developed as they could and should be.

Parenting the Developmentally Delayed Child

The developmentally delayed child increases the challenges of parenting. Parents of the developmentally delayed child often demonstrate insecurities regarding the psychological and physical development of their child (Brown, 1976). In addition, because of his/her developmental condition, the child may be less able to elicit nurturing responses from his/her parents (Schell, 1981).

Multiple factors influence the poor cyclical interaction between parent and child. The family of a developmentally delayed child may experience a grieving process similar to that of those who lose a loved one through death. Bristol and Gallagher (1982) summarize this as:

The introduction of a handicapped child into a family causes a symbolic death of the child-who-will-never-be and thus the death of all the role expectancies that the parents had projected for themselves (p. 140).

In addition to this acute sense of loss, the daily struggle to meet the needs of a handicapped child may precipitate a chronic grieving. Also, the family members may be experiencing a financial or marital crisis, family illness or frustration with role expectancies. Finally, there is a need to place the developmentally delayed child's needs into perspective with sibling, spouse and parental self-fulfillment (Brown, 1976).

Often the parents of a developmentally delayed child feel isolated with their problem. The extended family and friends may lack the knowledge to offer advice and support. The severity of the handicap, the number of hospitalizations and the coping skills of the family make a difference in the quality of the parent-child relationship. The greatest concern for these families is that parents of children with developmental problems are more likely to become abusive or neglectful (Schell, 1981; Barnard, 1981).

Results of Poor Parenting Skills on the Child

In addition to the impact that the developmentally delayed and at risk child can have on the family, there is a reciprocal affect poor parenting skills can have on the developmentally delayed and at risk child. Fewell (1981) assesses the outcome of poor parenting as follows:

- . Parents who are overly restrictive and who also

direct hostility toward the child encourage the development of adult-directed emotional dependency.

. Parents who do not provide young children with consistent external rewards for appropriate self-control behaviors, who fail to model self-control behaviors themselves, and who fail to provide the young child with meaningful cognitive structuring (mediated cognitions) of the application of rewards and punishments contribute to developing lowered levels of internalization of self-control strategies in their children.

. Parents who fail to demand age-appropriate behavior, to enforce rules firmly and consistently, and to encourage responsive communication with their children contribute to the development of lowered levels of independence and autonomy in their children.

. Parental punitiveness and nonacceptance of their children is consistently positively related to displays of aggressiveness in children's behavior.

. Parental nonacceptance is also generally related to the presence of with-drawn, neurotic behaviors and psychosomatic disorders in children (p. viii).

To prevent these negative outcomes of parenting, early intervention is critical. With the normal developing population, intervention most often occurs no earlier than age three. However, with the at risk population, intervention must begin at birth.

Early intervention is initiated by outside agencies, but prescribed activities must be implemented by the parents on a daily basis. The family is critical in the development of the child just as the family is a part of a system that makes up the neighborhood, the community and society (Goldberg, 1981). Therefore, the needs of the family must be met. Bronfenbrenner (1975) refers to this as:

ecological intervention as an aim to effect changes in

the context in which the family lives that enable the family as a whole to exercise the functions necessary for the child's development (p. 468).

Outside agencies must be aware of the factors that influence the family. The family must have adequate health care, nutrition, housing and financial resources, if early intervention programs are to be effective in promoting the child's development.

Types of Early Intervention Programs

Early intervention with the birth to three population has been approached from several different programming models. Home visitation programs provide early intervention services to the individual families in their homes. The Portage Project (Shearer and Shearer, 1974) is a nationally recognized and widely replicated home visitation program. The Project started as a demonstration program in 1969, serving twenty-three school districts in south central, rural Wisconsin. The children served by this project were diagnosed as behaviorally disturbed, emotionally disturbed, mentally retarded, physically handicapped, visually impaired, hearing impaired, culturally deprived, or handicapped in the area of speech or language, or a combination of these disabilities. A teacher was assigned to each child enrolled in the program. Weekly home visits were made by the teacher for the purpose of instructing the parents how to teach their child. Individualized educational program plans were developed for each child based on the

curriculum guide which the Project created. Shearer and Shearer (1974) provide the rationale for the Project's decision to serve children through home visits:

- . Learning occurs in the parent and child's natural environment.

- . If instruction occurs in the home, there is more opportunity for full family participation in the teaching process.

- . Because the home teacher is working on a one-to-one basis with parents and child, individualization of instructional goals for both is an operational reality (p.16).

One advantage of a home based program, as compared with the center-based program, is that the parent may feel less intimidated by the professional when instruction is occurring in a nonthreatening environment like the home. The prime disadvantage to the home-based approach is the financial consideration of duplicating therapy and equipment in each home.

Center-based programs provide early intervention services to families at a central location . Both the parent and child may attend the center at regularly scheduled times to receive medical, therapeutic, or educational treatment. Some center-based programs operate using a day care model with a full day schedule to include treatment and respite (child care service) for the family. An additional service to the family may be transportation to and from the center.

One advantage of the center-based program is that in situations where families cannot supply a supportive

environment, an external supportive environment providing intensive treatment may contribute to the child's development (Stedman, 1977). The severity of the child's handicap also contributes to the decision as to whether the child should participate in a program outside of the home. The resources available at the center, both professionals and adaptive equipment, may provide the child a better opportunity for optimal action or interaction with the environment (Gordon and Schwartz, 1976). The most obvious disadvantage to the center-based program is the ethical issue of separating a young child from his/her family.

Finally, in a study of different program models, Ramey and Bryant (1982) report that the scope of the program is the pivotal element determining quality intervention. Included are the amount of time that the program has direct involvement with the children and their families, plus the variety of services offered. Examples of services to be provided to this population are therapeutic treatment, medical and nutritional care, and social work services. All of these factors are contingent upon skilled personnel who are motivated to provide a quality program to families.

Characteristics of Successful Parent Programs

Throughout the literature regarding early intervention services, the concepts of treating the total family unit, measuring strengths and needs, and providing individualization were stressed as critical components of a

quality program. To adequately serve the total family unit, a parent involvement component must be included in the service delivery system. The Education For All Handicapped Children Act of 1975 (P.L. 94-142) mandates inclusion of parent participation in identification, diagnosis, and program planning and placement (Garland, Stone, Swanson and Woodruff, 1979). The Head Start Programs developed in the mid 1960's deemed parent involvement a necessary component to expand social opportunities of families from low socioeconomic backgrounds (Foster, Berger and McLean, 1981). Significant research substantiates the value of involving parents in early intervention programs (Cartwright, 1976). Bronfenbrenner (1975) observed:

the earlier and more intensely mother and child were stimulated to engage in communication around a common activity, the greater and more enduring the gain in IQ achieved by the child (p. 460).

The parent involvement component of an early intervention program may take several forms, but successful parent programs have similarities including the following outlined by Cartwright (1981):

- . Structure is obvious in the program; objectives for parents and children are clear, and procedures and responsibilities are described precisely.
- . The decision about who will intervene has been resolved by the parents, teachers, paraprofessionals, and community volunteers.
- . The intervention occurs early and is coordinated.
- . Programs are individualized, most often for the children, but often for the parents as well.

. Planning emphasizes the reciprocity between parent and child and deals with the family as a unit.

. Ultimate goals for children involve functioning in the least restrictive environment, with the understanding that early, segregated experiences may be necessary as preparation for later, integrated experiences.

. Ultimate goals for parents involve participation in decision-making and policy discussions to prepare them to become advocates on behalf of their child throughout the child's life span (p. 7).

It is through an intense early intervention program with birth to three developmentally delayed and at risk children and their families that the foundation for quality parent-child interaction can be promoted.

Parent Involvement Effectiveness

The effectiveness with which the birth to three program involves the parent is dependent upon the readiness of the parent to become involved. The progression of parent involvement has been discussed by Cartwright:

.parents as an audience- a passive role in which parents become the recipients of information about their child or child rearing in general.

.parents as supporters and references- a slightly more active role but one that benefits the program rather than the child directly (e.g., clerical, custodial, or fund-raising functions on behalf of the program or information-giving functions about their child);

.parents as learners- an active role for parents but one that separates them from the child (e.g., parents involved in learning activities designed to improve their knowledge of child development or their care-giving and home-making skills);

.parents as teachers for their children- an interactive role for parents as teachers of their children in home or center settings and as paid volunteer workers.

.parents as therapists- an interactive role similar to that of parents as teachers with the exception that parents engage in analyzing emotional problems and providing a therapeutic environment;

.parents as decision-makers, policy-makers, and advisors- the most active, powerful role for parents, since they can control discussions affecting the child by participating on advisory councils, boards of directors, and other policy-making groups (p.4).

Providing parents the opportunity to participate in policy-making decisions and advisory roles regarding choices of services should be an ultimate goal of parent involvement. However, vital to assisting the parent in the decision-making is an awareness of the family needs which change at different points in time (Winton and Turnbull, 1981).

Summary of the Review of Literature

The following conclusions were made from reviewing the literature concerning birth to three early intervention programs and parent involvement. The literature would appear to support the need for early and active intervention by service agencies and parents. In order for intervention to be effective, parent needs assessment and parent participation in policy making must be a part of the service. These program components are necessary for the treatment to be individualized and to meet the scope of the child and family needs. The ultimate goal of early intervention services is for the child to function at his/her maximum potential and for the parent to develop advocacy skills for his/her child's educational needs. In summary, to

establish a service delivery system for promoting appropriate interaction between parent and child, the needs and skills of the entire family must continually be taken into account.

CHAPTER III

METHODS AND PROCEDURES

The purpose of this study was to investigate the perceived needs of families receiving services from an early intervention program serving developmentally delayed and at risk children birth to three years of age. To accomplish this purpose a needs assessment was conducted with families receiving early intervention services. The development of the assessment instrument was based on information gained through the literature review and by interviewing sixteen families receiving early intervention services. Also a pilot study was completed to further refine the instrument.

Sample

One hundred twenty-four families receiving early intervention services were the subjects surveyed for this study. The families were selected from thirteen programs serving thirty-one counties in Southern Illinois. In the programs studied all of the children enrolled met the criterion of developmentally delayed or at risk.

Instrumentation

The instrument used for assessing the needs of the families was developed by the researcher based on information gained 1) through the literature review (Caldwell, 1978; Bromwich, 1979; Shearer and Shearer, 1977) 2) by interviewing families with children enrolled in a birth to three program and 3) by conducting a pilot study. The items included on the instrument were those most

frequently identified in the literature and at the parent interviews as ones which would improve the quality of interaction between the parent and child and their environment.

To determine indicators of types of parent needs for the needs assessment instrument, interviews with sixteen families currently receiving early intervention services from one county program were conducted. The researcher was the interviewer for the sixteen families. In Appendix A is a summary of the opening remarks presented to each family at the interview.

The data form (see Appendix B) was used to record the responses from the families. Each family was allowed time to respond to the interview topic. When the family members felt they had exhausted the subject of possible needs and interests, the researcher made additional suggestions for the family to consider. These suggestions were based on the researcher's professional experience and information gained from the literature review. Examples of these suggestions were the need for: involvement in program activities, parenting information, skills for improving family relationships, medical assistance, change in employment status, and financial assistance. This information was later categorized and restated in the form of a questionnaire.

The next step in the instrument development was to conduct a pilot study using Form A (see Appendix C)

developed from the information collected through the sixteen interviews and the literature review. The pilot study was conducted in a test program, serving birth to three year old developmentally delayed and at risk children. The program director of the early intervention test program, serving as a pilot for the larger study, was instructed by the researcher in the procedure to be used for completing the questionnaires. Ten families were considered representative of the population to be studied.

Although there were no negative responses regarding the questionnaire reported from the pilot test, a decision was made to revise the last section of the instrument. Due to the sensitive nature of the question concerning income, this question was moved to the end in an effort not to discourage the respondent early in the interview. Also, more space was provided for personal comments. The researcher's graduate committee reviewed, suggested changes, and approved the revised instrument.

The finalized instrument, Form B (see Appendix D) includes six sections with a total of fifty items asking families about their perceived needs. The six sections included items addressing perceived needs about: (1) involvement in program activities; (2) parenting information; (3) improving the quality of family relationships; (4) medical needs; (5) employment; and (6) financial resources. A Likert-type scale was used for the

responses with 1 indicating a low need through 5 indicating a high need for each item.

The seventh section of the questionnaire asks for family data about length of time and number of children in the program, ages and marital status of persons in the household, developmental diagnosis of the child and income level of the household. These questions were answered through checking a response from choices listed or by filling in a blank with a number response. Space for comments was provided at the end. The last entry was a two digit geographic code assigned for each county and labeled geocode. Program directors were asked to label the last page of each questionnaire according to the county geocode.

Data Collection

Agreement to participate in the study was solicited from thirteen early intervention program directors serving thirty-one counties in Southern Illinois. Contact with these programs was made through the Southern Illinois Birth to Three Council, of which the researcher is president. At the January 14, 1984 council meeting the program directors serving the thirty-one counties provided the researcher with the numbers of the families they were presently serving. A total of 348 questionnaires were mailed with a cover letter, (see Appendix E), to the thirteen program directors. The following table illustrates the number of questionnaires distributed and returned by program.

TABLE I. Questionnaires distributed and returned by program.

PROGRAM	DISTRIBUTED	RETURNED
A	15	9
B	25	22
C	40	0
D	25	6
E	35	12
F	35	0
G	45	22
H	8	8
I	25	7
J	20	0
K	45	17
L	20	15
M	10	6
TOTAL 13	348	124

The rate of return of 36% was lower than expected. Follow-up efforts were made by the researcher through phone calls to the program directors and a verbal request at two different monthly council meetings. The program directors reported that some families were reluctant to complete the questionnaires or had misplaced them.

CHAPTER IV

RESULTS AND DISCUSSION

The purpose of this study was to investigate the perceived needs of families receiving services from an early intervention program serving developmentally delayed and at risk children birth to three years of age. To accomplish this purpose a needs assessment was conducted with families receiving early intervention services. Descriptive statistics of frequencies, percentages and cross tabulations were used to analyze the data.

Results

Frequency counts and percentages were calculated to determine the perceived needs of families receiving early intervention services based on the six divisions of the survey instrument: (1) involvement in program activities, (2) parenting information, (3) family relationships, (4) medical resources, (5) employment, and (6) financial resources. This information was cross tabulated with the demographic variables: income level, number in the family, marital status, and child's disability. The findings indicate rankings of needs from low to high. The established criterion for a high need was 75% of the respondents marking a response of 4 or 5 on a five point Likert scale. The criterion for a low need was met when 75% of the respondents marked a 1 or 2 on a five point Likert scale.

Demographic data regarding the families surveyed were collected from the questionnaire. Distribution of income

levels among 115 families was reported as follows: Under \$5000 (25 families); \$5,000 - 9,999 (23 families); \$10,000 - 14,999 (20 families); \$15,000 - 19,999 (14 families); \$20,000 - 29,999 (23 families); \$30,000 and over (10 families). Nine families did not respond to this question.

The number of children in each family was reported as follows: 1 child (29 families); 2 children (52 families); 3 children (20 families); 4 children (12 families); 5 or more children (10 families). One family did not respond to this question.

The marital status of 113 families was reported as follows: single (9 families); married (95 families); divorced (9 families). Eleven families did not respond to this question.

The 114 families' perceptions of their child's disability was reported as follows: high risk (16 families); developmental delay (47 families); physically handicapped (13 families); mentally handicapped (4 families); multiply handicapped (9 families); speech/language delay (14 families); other (11 families). Ten families did not respond to this question.

Perceived needs of parents for involvement in program activities

Research objective number one was to identify the perceived needs of parents for involvement in program activities. Fourteen items regarding program activities were

presented for the respondent to rank as a low or high need on a five point Likert scale. As can be seen on Table II no high needs were reported using the criterion of 75% marking a response of 4 or 5.

Respite care was reported as a low need based on the criterion of 75% on Table II. Depending upon the severity of the child's disability, parents may prefer to have family or friends care for their child. Consequently, this need appears to be adequately met for this group.

Perceived needs of parents for parenting information

Research objective number two was to identify the perceived needs of parents for parenting information. Fourteen items regarding parenting information were presented to the respondent to rank as a low or high need on a five point Likert scale. As can be seen on Table III no high or low needs were reported using the criterion of 75%.

Perceived needs of parents for improving the quality of family relationships

Research objective number three was to identify the perceived needs of parents for improving the quality of family relationships. Seven items concerning family relationships were presented for the respondent to rank as a high or low need on a five point Likert scale. Table IV illustrates the results with no low or high needs being reported using the criterion of 75%.

TABLE II. Perceived needs of parents for involvement in program activities (N = 124).

Program activities	F = frequency P = percentage	low		high			n
		1	2	3	4	5	
1. Home visits to learn how to work with my child.	F= 12 P= 10	9	31	12	58	122	
2. Home visits to provide emotional support.	F= 28 P= 23	15	27	16	36	122	
3. Newsletter sent on a monthly basis to provide information.	F= 25 P= 20	14	36	13	35	123	
4. Formal parent meetings.	F= 29 P= 24	21	32	17	24	123	
5. Social parent meetings.	F= 31 P= 25	20	27	21	25	124	
6. Contacts with individual parents.	F= 21 P= 17	20	26	20	35	122	
7. Phone contacts with staff to exchange information.	F= 23 P= 19	17	37	21	25	123	
8. Phone contacts with staff to receive emotional support.	F= 34 P= 28	20	36	13	20	123	
9. Volunteer work with children.	F= 51 P= 41	15	28	9	19	122	
10. Volunteer work other than with children.	F= 54 P= 45	15	27	12	13	121	
11. Teaching other parents.	F= 51 P= 42	15	28	13	14	121	
12. Meetings with staff to learn about my child.	F= 16 P= 13	15	25	22	45	123	
13. Center based program.	F= 26 P= 22	8	21	24	41	120	
14. Respite program.	F= 82 ** P= 67	10	12	10	8	122	

** Low need - 75% marking a response of 1 or 2.

TABLE III. Perceived needs of parents for parenting information (N = 124).

Parenting	F = frequency	low					n
		1	2	3	4	5	
P = percentage					high		
1. How children grow and develop.	F= 28 P= 23	12 10	35 28	19 15	30 24	124	
2. Discipline skills.	F= 19 P= 15	10 8	31 25	23 19	41 33	124	
3. Speech/language development.	F= 10 P= 8	11 9	24 19	24 19	55 44	124	
4. Cognitive development.	F= 9 P= 7	9 7	31 25	33 27	42 34	124	
5. Physical development.	F= 14 P= 11	10 8	35 28	27 22	38 31	124	
6. Self-care development.	F= 17 P= 14	14 11	25 20	23 19	45 36	124	
7. Social development.	F= 23 P= 19	15 12	26 21	24 19	36 29	124	
8. Emotional development.	F= 21 P= 17	15 12	34 27	23 19	31 25	124	
9. First aid, safety, CPR.	F= 35 P= 28	15 12	19 15	14 11	40 33	123	
10. Toys for children.	F= 22 P= 18	15 12	25 20	27 22	34 28	123	
11. Food and nutrition.	F= 34 P= 28	16 13	26 21	19 15	28 23	123	
12. Play.	F= 19 P= 15	13 11	31 25	28 23	32 26	123	
13. Medical terms.	F= 39 P= 32	4 3	25 20	19 15	36 29	123	
14. Educational rights.	F= 32 P= 26	4 3	19 15	13 11	55 45	123	

TABLE IV. Perceived needs of parents for improving the quality of family relationships (N = 124).

Family relationships		low					high	
F = frequency		1	2	3	4	5	n	
P = percentage								
1. Time for recreation.	F= 30 P= 25	5	35	24	28	122		
2. Money for recreation.	F= 30 P= 25	13	26	16	37	122		
3. Communication skills.	F= 36 P= 30	17	23	27	18	121		
4. Help with household chores.	F= 48 P= 39	8	23	20	23	122		
5. Emotional support.	F= 34 P= 28	13	30	19	26	122		
6. Child care services.	F= 45 P= 37	11	21	8	37	122		
7. Counseling.	F= 55 P= 45	17	23	9	18	122		

Perceived medical needs of parents

Research objective number four was to identify the perceived medical needs of parents. Six items concerning medical needs were listed for all the respondents to rank as a low or high need on a five point Likert scale. Table V presents the results of medical needs with no low or high needs reported using the criterion of 75%.

TABLE V. Perceived medical needs of parents (N = 124).

Medical	F = frequency P = percentage	low					n
		1	2	3	4	high 5	
1. Information about medical services.	F= 46 P= 37	13	21	12	31	123	
2. Money for routine checkups.	F= 55 P= 45	13	14	12	29	123	
3. Money for emergency care.	F= 57 P= 46	12	12	11	31	123	
4. Money for checkups by other professionals.	F= 46 P= 37	12	20	7	38	123	
5. Money for prescription medications.	F= 61 P= 50	10	21	8	23	123	
6. Money for adaptive equipment.	F= 77 P= 63	7	13	3	22	122	

Perceived employment needs of parents

Research objective number five was to identify perceived employment needs of parents. The respondents were asked to rate four items regarding employment. The results are shown on Table VI. No high needs were reported whereas 78% rate a job for the spouse as a low need.

TABLE VI. Perceived employment needs of parents
(N = 124).

Employment	F = frequency	low			high		n
		1	2	3	4	5	
1. Job for myself.	F= 59	4	22	8	30	123	
	P= 48	3	18	7	24		
2. Job for my spouse.	F= 87	5	8	2	15	117	
	** P= 74	4	7	2	13		
3. Job training.	F= 61	7	11	6	36	121	
	P= 50	6	9	5	30		
4. Job satisfaction.	F= 65	4	14	9	29	121	
	P= 53	3	12	7	24		

** Low need - 75% marking a response of 1 or 2.

Perceived financial needs of parents

Research objective number six was to identify perceived financial needs of parents. Five items regarding financial needs were presented to the respondent to rank as a low or high need on a five point Likert scale. Four items; food, clothing, transportation to get a job, and transportation for the family were ranked as a low need using a criterion of 75%. No high needs were reported as shown on Table VII.

TABLE VII. Perceived financial needs of parents (N = 124).

Financial	F = frequency P = percentage	low		high		n
		1	2	4	5	
1. Improved housing.	F= 77 P= 63	6	10	5	25	123
2. Better food.	F= 86 ** P= 76	1	17	1	8	113
3. Comfortable clothing.	F= 94 ** P= 79	2	15	4	4	119
4. Transportation to get a job.	F= 90 ** P= 74	6	8	6	12	122
5. Transportation to meet family needs.	F= 84 ** P= 69	7	5	9	17	122

** Low need - 75% marking a response of 1 or 2.

Relationship of perceived needs of the parents with the demographic variables of: income level, number in the family, marital status, and child's disability

Research objective number seven was to investigate any relationship of perceived needs of the parents with the demographic variables of: income level, number in the family, marital status, and child's disability. The established criterion for a high need was 75% of the respondents marking a response of 4 or 5 on a five point Likert scale. Tables (VIII, IX, X, and XI) show the high needs by demographic variables. Table XII illustrates the results of the cross tabulation. The category of parenting was most frequently identified as a perceived high need.

TABLE VIII. Perceived high needs based on income level
(N = 115).

Income level	n	Question number	High needs
Under \$5000	25		None
\$5000 - 9999	23		None
\$10000 - 14999	20	B3 B4	Speech/Lang. Dev. Cog. Dev.
\$15000 - 19999	14		None
\$20000 - 29999	23	B3	Speech/Lang. Dev.
\$30000 & over	10		None

* Question number: The letter indicates the section of the questionnaire and the number indicates the item number in that section (see Appendix D).

Income variables did not produce a significant difference in perceived high needs as can be seen from Table VIII. Items under the category of parenting information were perceived as high needs by this group.

TABLE IX. Perceived high needs based on number of children in family (N = 123).

Number of children	n	Question number	High need
One child	29		None
Two children	52		None
Three children	20		None
Four children	12	B2 B3 B4 B6 B9	Discipline Speech/Lang. Dev. Cog. Dev. Self-Care Dev. First aid, safety
Five + children	10	A1	Home visits

* Question number: The letter indicates the section of the questionnaire and the number indicates the item number in that section (see Appendix D).

From Table IX it appears that the number of children in the family does affect perceived high needs. Items under the category of parenting information were perceived as high needs by the families with four children.

TABLE X. Perceived high needs based on marital status
(N = 113).

Marital status	n	Question number	High needs
Single	9	B1 B11 C2	Child growth/Dev. Child nutrition Money for rec.
Married	95		None
Divorced	9	B12 D4 E4	Play Medical checkups Job satisfaction

* Question number: The letter indicates the section of the questionnaire and the number indicates the item number in that section (see Appendix D).

In looking at the relationship of marital status to perceived high needs there appears to be a difference as shown on Table X. The married group reported no high needs which might be an indication that a two parent family can better meet their perceived needs.

TABLE XI. Perceived high needs based on child's disability
(N = 114).

Child's disability	n	Question number	High needs
High risk	16		None
Developmentally delayed	47		None
Physically handicapped	13		None
Mentally handicapped	4	A4 A5 A6 A12 B1 B2 B3 B4 B5 B6 B7 B8 B10 B14 D1	Form. parent mtngs Soc. parent mtngs Contact w/parents Staff meetings Child growth/Dev. Discipline Speech/lang. Dev. Cog. Dev. Physical Dev. Self-care Dev. Social Dev. Emotional Dev. Toy information Ed. rights info. Medical info.
Multiply handicapped	9	B3 B14	Speech/lang. Dev. Ed. rights info.
Language delayed	14	B3	Speech/lang. Dev.
Other	11		None

* Question number: The letter indicates the section of the questionnaire and the number indicates the item number in that section (see Appendix D).

The four families with mentally handicapped children identified the most high needs. This should be considered by the service provider in program planning.

TABLE XII. Cross tabulation of perceived high needs of parents with income level, number in the family, marital status, and child's disability.

	Income level	# of children	Marital status	Child's disability
Program activities		A1		A4 A5 A6 A12
Parenting information	B3 B4	B2 B3 B4 B6 B9	B1 B11 B12	B1 B2 B3 B4 B5 B6 B7 B8 B10 B14
Family relationships		C2		
Medical			D4	D1
Employment			E4	
Financial				

* High needs - represent 75% of the respondents within a demographic category ranking a need 4 and/or 5 on the five point Likert scale.

See Form B (Appendix D) for the needs indicated by letter and number.

Discussion

The findings from this study indicate that families receiving services from an early intervention program do perceive themselves as having needs addressed by the assessment instrument including: program activities, parenting, family relationships, medical, employment and financial. These needs were cross tabulated with demographic data including: income level, number in the family, marital status and the child's disability. While program activities were not established as a high need for the general sample (see Table II), for some subgroups within the sample, program activities were a high perceived need.

Perceived high needs of parents for involvement in program activities

As shown in Tables IX & XI parents with large families and with mentally handicapped children do perceive themselves as having a high need for particular program activities. Home visits to learn how to work with their child; formal parent meetings; social parent meetings; contacts with individual parents; and meetings with staff to learn about their child were all rated as high needs in the cross tabulation analysis (see Table XII). It is the researcher's professional opinion that the service provider finds parent meetings a challenge to organize and to implement and then is often discouraged by low turnouts. However, this study would indicate that there is perceived

value for parents in parent meetings.

Perceived high needs of parents for parenting information

With the exception of item thirteen, information regarding medical terms, all items under the category of parenting were ranked as high needs as shown on Table XII of cross tabulation. This result may be attributed to the fact that parents of at risk or developmentally delayed children are better informed about the value of parenting to promote their child's development. It also indicates an area needing strong emphasis for program planning and service providers.

Perceived high needs of parents for improving the quality of family relationships

As shown on Table XII item C-2, money for recreation, was identified as a high need. It is the researcher's opinion that recreation is highly valued by society today and that this resource is a valuable component in the quality of family relationships. This need may be further emphasized in families with very young children who need specialized babysitting or child care resources which increases these significant costs.

Perceived high medical needs of parents

The perceived high medical needs are items D-1, information about medical services, and D-4, money for checkups by other professionals as illustrated by Table XII. Parents of at risk or developmentally delayed children are typically anxious to learn about any medical services that

might best treat their child's problem. Sometimes parents of children with developmental problems will go through a denial stage and shop for medical professionals who will provide the reassurance they would like to hear (Bristol and Gallagher, 1982). Developmentally delayed children often need evaluation and ongoing treatment by the occupational therapist, physical therapist, and speech therapist. These services are costly and in many cases not readily available.

Perceived high employment needs of parents

Table XII shows the perceived high employment needs through cross tabulation as E-4, job satisfaction. Of the 115 respondents reporting their income level, 71% make \$20,000 or less a year. Therefore, job satisfaction might correspond to income level.

Perceived high financial needs of parents

As can be seen on Table XII no perceived high needs were reported for the items listed under the financial section. Of the 115 families reporting their annual income 71% are making \$20,000 or less; 50% are making \$15,000 or less; and 21% reported an annual income under \$5,000. The lack of perceived high need for financial services may be an indication that social service agencies are adequately providing financial assistance.

Relationship of perceived high needs of the parents with the demographic variables

Parenting needs were most frequently reported as high

needs across all demographic variables. This finding is important information to service providers as birth to three programs can most appropriately meet this need.

The objectives established by the researcher were met by this study. Parents receiving early intervention services do perceive themselves as having needs addressed by the questionnaire (see Tables II - VII). Perceived high needs most frequently reported were under the section addressing parenting information. Perceived low needs were respite, better food, comfortable clothing, transportation to get a job, transportation for the family (see Tables II - VII). The researcher might speculate that these low needs are being met for some families by social service agencies.

The rankings of perceived needs were reviewed by the researcher. The cross tabulation of perceived high needs with the demographic variables provided useful information to the researcher. The perceived high need for parenting information can very appropriately be met by early intervention programs. It is the researcher's professional opinion that the needs assessment is most valuable to the service provider when evaluated on an individual basis. This is supported by the concept of individualization emphasized throughout the review of literature (Bronfenbrenner, 1975; Cartwright, 1976). Studies such as this should be reviewed for program planning with consideration of the individual families' needs being emphasized.

CHAPTER V

SUMMARY AND IMPLICATIONS

The purpose of the study was to investigate the perceived needs of families receiving services from any early intervention program serving developmentally delayed and at risk children birth to three years of age. To accomplish this purpose a needs assessment was conducted with families receiving early intervention services. The following seven research objectives were studied:

- . To identify the perceived needs of parents for involvement in program activities.

- . To identify the perceived needs of parents for parenting information.

- . To identify the perceived needs of parents for improving the quality of family relationships.

- . To identify the perceived medical needs of parents.

- . To identify the perceived employment needs of parents.

- . To identify the perceived financial needs of parents.

- . To investigate the relationship of perceived needs of the parents with the demographic variable of: income level, number in the family, marital status and child's disability.

One hundred twenty-four families receiving early intervention services were the subjects for this study. The families were selected from thirteen programs serving thirty-one counties in Southern Illinois. Of the programs studied, all of the children enrolled met the criterion of developmentally delayed or at risk. All of the programs

received funding through the Department of Mental Health and Developmental Disabilities and using a therapeutic or educational model, provided services through home based or center based programs.

The instrument used for assessing the needs of the families was developed by the researcher. It included six sections with a total of fifty items asking families about their perceived needs and a seventh section requesting family data. The findings indicate rankings of needs from low to high. The criterion for a high need was met when 75% of the respondents marked a response of 4 or 5 on a five point Likert scale. The criterion for a low need was met when 75% of the respondents marked a response of 1 or 2 on a five point Likert scale. Descriptive statistics of frequencies, percentages and cross tabulations were used to analyze the data.

The results of the study indicate that:

1. Parents of developmentally delayed or at risk children do perceive themselves as having needs that are addressed by the research instrument.

2. Parenting information is rated as the most frequently cited perceived need.

3. Low income level does not necessarily produce a perceived high need for medical, employment or financial assistance.

4. More children in the family may result in more perceived high needs.

5. Marital status may have an influence on perceived high needs.

6. The parents' perception of their child's disability may be a factor in determining perceived high needs.

The rankings of perceived needs were reviewed by the researcher. The cross tabulation of perceived high needs with demographic variables provided useful information to the researcher. The perceived high need for parenting information can very appropriately be met by early intervention programs. It is the researcher's professional opinion that the needs assessment is most valuable to the service provider when evaluated on an individual basis. This is supported by the concept of individualization emphasized throughout the review of literature (Bronfenbrenner, 1975; Cartwright, 1976). Studies such as this should be reviewed for program planning with consideration of the individual families' needs being emphasized.

Limitations of the study

The instrument used did not provide a response for describing how the parent views the need for information on parenting. The question of whether the parent feels inadequate or simply interested in learning more about parenting his/her child was not addressed in this study. Also, knowledge of child growth and development was not differentiated from the ability to apply parenting skills.

Many children are enrolled in a birth to three program with an initial diagnosis of developmental delay. The high

risk category includes both the medically and environmentally at risk infant. The diagnostic labels are very much subject to interpretation. This problem was considered by the researcher when evaluating the results.

The instrument could be improved upon to further clarify the individual needs of the family unit. No response was provided in terms of how the family felt these needs could best be met. The instrument could be supplemented with an evaluation form to measure the growth of the family.

Implications for Future Research

An expanded research project to examine the case managers' opinions of their families' needs would provide an interesting comparison to the families' responses. This subsequent research would identify the extent to which the service provider is recognizing the individual needs of the family unit. The need to establish a service delivery system for promoting appropriate interaction between parent and child must continually be taken into account.

Implications for Community Use

Funding sources

Funding sources should be aware of the scope of services needed for this population. Presently, the Department of Mental Health and Developmental Disabilities primarily bases funding formulas on professional/child ratios. Results of this study indicate that effective programming can best be accomplished by addressing the needs of the total family unit. The intensity of the treatment must be considered when

recommending staff/client ratios. A summary of this study will be provided to the funding sources.

Interagency Cooperation

A report to the other education/social service providers in the community will be provided. Other agencies not having an evaluation system for determining the extent to which they are meeting their families' needs should find this study useful. Most agencies must be concerned with cost effectiveness and cost efficiency and could benefit from this information. This will also assist the birth to three service provider in their effort to meet the needs of the total family unit.

Service Providers

Birth to three service providers share a concern of meeting the needs of the families they serve through a quality service delivery system. Service providers must consider the focus of the program. Individualized programming must be applied in a broader perspective than appropriate developmental goals for the child. Based on this study, parent involvement must be a primary concern of early intervention services. A summary will be provided to the Birth to Three Council of Southern Illinois.

Families

Families need to be informed of the concerns shared by other families receiving birth to three services. The feeling of isolation can add strain to an existing depressed condition. A request will be made at the Birth to Three

Council meeting to provide parents this information. As a result of this information parents may feel more comfortable in providing feedback to the birth to three service provider regarding their needs.

SUMMARY

The objectives established by the researcher were met. Parents of developmentally delayed or at risk children do perceive themselves as having needs that are addressed by the research instrument. Parenting information was cited as the most frequently perceived high need. A limitation of the study was the lack of differentiation between knowledge of child growth and development from the ability to apply parenting skills.

Implications for community use would include the consideration by funding sources for intensity of treatment when recommending staff/client ratios. For interagency cooperation there is a need for the service providers to work together in meeting the needs of the total family unit. Also, parent involvement must be a primary concern of early intervention providers. Finally, families must feel comfortable in expressing their needs to the service provider.

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APPENDIX A

PARENT INTERVIEW

NANON WOOD CENTER FOR CHILDREN
PARENT INTERVIEW FORM
January 1984

Child's Name:..... Time:..... Date...

Members of household interviewed:.....

The purpose of this meeting is to talk to you about your involvement with the birth to three program. For my master's thesis I am developing a questionnaire to identify needs and interests of families receiving birth to three early intervention services. I would like to discuss with you ways that the birth to three program has already assisted you or ways the program could better provide a more beneficial and quality program to promote the growth and development of your child. After talking with approximately ten families in Effingham county about parent involvement activities I will use their suggestions to develop a questionnaire. The questionnaire will be distributed to you and other families in Southern Illinois that are presently involved with a birth to three early intervention program. Your identity will be kept confidential, of course. The results of the study will be compiled and made available to you.

APPENDIX B

PARENT INTERVIEW DATA FORM

PARENT INTERVIEW
Needs and interests assessment inventory

Child:..... Date.....

Family members present:..... Time.....
.....

Responses from parents:

APPENDIX C

PILOT INSTRUMENT: FORM A

arc



Serving Effingham County
Association for Retarded Citizens

618 West Main Street, Teutopolis, Illinois 62467, (217) 857-3186

Michael W. Fortner
Executive Director

NANON WOOD CENTER
Children's Service -- Birth to Three
2502 S. Veterans Drive
Effingham, Illinois 62401
(217) 347-5118

OPPORTUNITY CENTER
Vocational Development Services
618 West Main Street
Teutopolis, Illinois 62467
(217) 857-3186

February 14, 1984

Dear Parent,

I am conducting a study of parent involvement activities as a part of my thesis work at Eastern Illinois University. The results of the study will be provided to your birth to three program. Hopefully, this information will assist birth to three service providers in program planning.

The attached questionnaire looks at needs of families in the following areas: program activities, parenting, family relationships, medical, employment and financial. To provide the best program for your child I believe the family's needs must be considered.

If you do not understand a question, please ask your program director/coordinator for assistance. Please return by February 29, 1984 to your program director/coordinator. Thank you in advance for your time in completing this questionnaire.

Sincerely,

Joyce Coleman

Joyce Coleman
Birth To Three Director
Effingham County

BIRTH TO THREE STUDY TO ASSESS PARENT INVOLVEMENT

QUESTIONNAIRE

The following information will be used to learn about needs of parents. Please read each of the items below. Circle the number to the right of each item which best indicates your level of need.

Circling (1) indicates that your level of need is low for the item mentioned.

Circling (5) indicates that your level of need is high for the item mentioned.

Circling (2, 3, or 4) indicates that your level of need falls in-between.

A. PROGRAM ACTIVITIES: I have a (low-high) need for:	low				high
1. Home visits to learn how to work with my child.	1	2	3	4	5
2. Home visits to provide emotional support.	1	2	3	4	5
3. Newsletters sent on a monthly basis to provide information about children and families.	1	2	3	4	5
4. Formal parent meeting with speakers and time to discuss different topics of information.	1	2	3	4	5
5. Social parent meetings to get to know other families.	1	2	3	4	5
6. Contacts with individual parents with similar needs to exchange information and support.	1	2	3	4	5
7. Phone contacts with the birth to three staff to exchange information.	1	2	3	4	5
8. Phone contacts with the birth to three staff to receive emotional support.	1	2	3	4	5
9. Contact with the program by volunteering my time with the other children enrolled.	1	2	3	4	5
10. Contact with the program by volunteering my time doing activities other than working with children.	1	2	3	4	5

February 14, 1984

I have a (low-high) need for:		low				high
		1	2	3	4	5
11.	Contact with the program teaching other parents about working with children.	1	2	3	4	5
12.	Meetings with staff members to learn more information about my child and his/her program.	1	2	3	4	5
13.	A center based program - an educational program for my child to attend during the day.	1	2	3	4	5
14.	A respite program - a place for my child to stay overnight or for several days.	1	2	3	4	5
B. PARENTING: I have a (low-high) need for information about:		low				high
1.	How children grow and develop.	1	2	3	4	5
2.	Discipline skills - help with correcting misbehavior.	1	2	3	4	5
3.	Speech and language development - how children learn to speak and learn to understand language.	1	2	3	4	5
4.	Cognitive development - how children think and solve problems.	1	2	3	4	5
5.	Physical development - small and large muscle development.	1	2	3	4	5
6.	Self care development - feeding, dressing, toileting.	1	2	3	4	5
7.	Social development - getting along with other people.	1	2	3	4	5
8.	Emotional development - expression of feelings and feeling good about oneself.	1	2	3	4	5
9.	First aid, safety, and CPR.	1	2	3	4	5
10.	Toys for children which are safe and educational.	1	2	3	4	5
11.	Food and nutrition for young children.	1	2	3	4	5
12.	Play - types of play and the value of play.	1	2	3	4	5
13.	Medical terms describing my child's handicapping condition.	1	2	3	4	5

February 14, 1984

I have a (low-high) need for:		low				high
14.	Educational rights of handicapped children.	1	2	3	4	5
C. FAMILY RELATIONSHIPS: I have a (low-high) need for:		low				high
1.	Time for recreation for all family members.	1	2	3	4	5
2.	Money or resources for recreation.	1	2	3	4	5
3.	Communication skills - learning how to talk to and listen to family members.	1	2	3	4	5
4.	Help from my family with household chores.	1	2	3	4	5
5.	Emotional support from my family - understanding and caring about my feelings.	1	2	3	4	5
6.	Child care or babysitting services.	1	2	3	4	5
7.	Counseling to help solve family problems.	1	2	3	4	5
D. MEDICAL: I have a (low-high) need for:		low				high
1.	Information about available medical services.	1	2	3	4	5
2.	Money or resources for routine checkups for the entire family.	1	2	3	4	5
3.	Money or resources for emergency medical care.	1	2	3	4	5
4.	Money or resources for routine checkups by other professionals (i.e. OT, PT, Speech Therapist, Psychologist).	1	2	3	4	5
5.	Money or aid for buying needed prescription medications.	1	2	3	4	5
6.	Money or aid for buying needed adaptive equipment (wheel chairs, walkers, etc.).	1	2	3	4	5
E. EMPLOYMENT: I have a (low-high) need for:		low				high
1.	A job for myself.	1	2	3	4	5
2.	A job for my spouse.	1	2	3	4	5

I have a (low-high) need for:		low				high
3.	Training to get a better paying job.	1	2	3	4	5
4.	A job I would enjoy more.	1	2	3	4	5
F. FINANCIAL: I have a (low-high) need for:		low				high
1.	Housing - more space or better heating and cooling.	1	2	3	4	5
2.	Better Food - daily nutritious meals.	1	2	3	4	5
3.	Comfortable clothing - for cold and hot weather.	1	2	3	4	5
4.	Transportation to get a job.	1	2	3	4	5
5.	Transportation to meet family needs - grocery shopping, medical needs, educational meetings, recreational needs.	1	2	3	4	5

Members of household completing questionnaire: _____ Father _____ Mother
 _____ Other (Specify)

Income Level of household:

_____ under \$5000	_____ \$15000 - 19999
_____ \$5000 - 9999	_____ \$20000 - 29999
_____ \$10000 - 14999	_____ \$30000 or over

Length of time you have been involved with the birth to three program. _____

_____ Under 6 months _____ 1 year _____ 3 years or more
 _____ 6 months - 1 year _____ 2 years

Number of children in your household _____

Ages of children in your household. _____

Ages of people over 18 in your household. _____

Number of children you have enrolled in the birth to three program. _____

Your Marital Status: _____ single _____ married _____ divorced

Your child's developmental diagnosis: _____ high risk
 _____ developmentally delayed
 _____ physically handicapped
 _____ mentally handicapped
 _____ multiply handicapped
 _____ speech/language delayed
 _____ Other: _____ Specify

Comments:

Geocode: _____

February 14, 1984

APPENDIX D

QUESTIONNAIRE: FORM B

arc



Serving Effingham County
Association for Retarded Citizens

618 West Main Street, Teutopolis, Illinois 62467, (217) 857-3186

Michael W. Fortner
Executive Director

NANON WOOD CENTER
Children's Service -- Birth to Three
2502 S. Veterans Drive
Effingham, Illinois 62401
(217) 347-5118

OPPORTUNITY CENTER
Vocational Development Services
618 West Main Street
Teutopolis, Illinois 62467
(217) 857-3186

February 14, 1984

Dear Parent,

I am conducting a study of parent involvement activities as a part of my thesis work at Eastern Illinois University. The results of the study will be provided to your birth to three program. Hopefully, this information will assist birth to three service providers in program planning.

The attached questionnaire looks at needs of families in the following areas: program activities, parenting, family relationships, medical, employment and financial. To provide the best program for your child I believe the family's needs must be considered.

If you do not understand a question, please ask your program director/coordinator for assistance. Please return by February 29, 1984 to your program director/coordinator. Thank you in advance for your time in completing this questionnaire.

Sincerely,

Joyce Coleman

Joyce Coleman
Birth To Three Director
Effingham County

BIRTH TO THREE STUDY TO ASSESS PARENT INVOLVEMENT
QUESTIONNAIRE

The following information will be used to learn about needs of parents. Please read each of the items below. Circle the number to the right of each item which best indicates your level of need.

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Circling (5) indicates that your level of need is high for the item mentioned.
Circling (2, 3 or 4) indicates that your level of need falls in between.

A. PROGRAM ACTIVITIES: I have a (low-high) need for:	low				high
1. Home visits to learn how to work with my child.	1	2	3	4	5
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3. Newsletters sent on a monthly basis to provide information about children and families.	1	2	3	4	5
4. Formal parent meetings with speakers and time to discuss different topics of information.	1	2	3	4	5
5. Social parent meetings to get to know other families.	1	2	3	4	5
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7. Phone contacts with the birth to three staff to exchange information	1	2	3	4	5
8. Phone contacts with the birth to three staff to receive emotional support.	1	2	3	4	5
9. Contact with the program by volunteering my time with other children enrolled.	1	2	3	4	5
10. Contact with the program by volunteering my time doing activities other than working with children.	1	2	3	4	5
11. Contact with the program teaching other parents about working with children.	1	2	3	4	5
12. Meetings with staff members to learn more information about my child and his/her program.	1	2	3	4	5
13. A center based program - an educational program for my child to attend during the day.	1	2	3	4	5
14. A respite program - a place for my child to stay overnight or for several days.	1	2	3	4	5

February 14, 1984

	low				high
B. PARENTING: I have a (low-high) need for information about:					
1. How children grow and develop.	1	2	3	4	5
2. Discipline skills - help with correcting misbehavior.	1	2	3	4	5
3. Speech and language development - how children learn to speak and understand language.	1	2	3	4	5
4. Cognitive development - how children think and solve problems.	1	2	3	4	5
5. Physical development - small and large muscle development.	1	2	3	4	5
6. Self care development - feeding, dressing, toileting.	1	2	3	4	5
7. Social development - getting along with other people.	1	2	3	4	5
8. Emotional development - expression of feelings and feeling good about oneself.	1	2	3	4	5
9. First aid, safety, and CPR.	1	2	3	4	5
10. Toys for children which are safe and educational.	1	2	3	4	5
11. Food and nutrition for young children.	1	2	3	4	5
12. Play - types of play and the value of play.	1	2	3	4	5
13. Medical terms describing my child's handicapping condition.	1	2	3	4	5
14. Educational rights of handicapped children.	1	2	3	4	5
C. FAMILY RELATIONSHIPS: I have a (low-high) need for:					
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2. Money or resources for recreation.	1	2	3	4	5
3. Communication skills - learning to talk to and listen to family members.	1	2	3	4	5
4. Help from my family with household chores.	1	2	3	4	5
5. Emotional support from my family - understanding and caring about my feelings.	1	2	3	4	5
6. Child care or babysitting services.	1	2	3	4	5
7. Counseling to help solve family problems.	1	2	3	4	5

	low				high
D. MEDICAL: I have a (low-high) need for:					
1. Information about available medical services.	1	2	3	4	5
2. Money or resources for routine checkups for the entire family.	1	2	3	4	5
3. Money or resources for emergency medical care.	1	2	3	4	5
4. Money or resources for routine checkups by other professionals (i.e. OT, PT, Speech Therapist, Psychologist).	1	2	3	4	5
5. Money or aid for buying needed prescription medications.	1	2	3	4	5
6. Money or aid for buying needed adaptive equipment (wheel chairs, walkers, etc.)	1	2	3	4	5
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2. A job for my spouse.	1	2	3	4	5
3. Training to get a better paying job.	1	2	3	4	5
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2. Better food - daily nutritious meals.	1	2	3	4	5
3. Comfortable clothing - for cold and hot weather.	1	2	3	4	5
4. Transportation to get a job.	1	2	3	4	5
5. Transportation to meet family needs - grocery shopping, medical needs, educational meetings, recreational needs.	1	2	3	4	5

Members of household completing this questionnaire: Father Mother
 Other (please specify): _____

Length of time you have been involved with the birth to three program.
 Under 6 months 6 months-1 year 1 year 2 years 3 years or more

Number of children you have enrolled in the birth to three program. _____

Number of children in your household. _____

Ages of children in your household. _____

Ages of people over 18 in your household. _____

Your marital status. ___single ___married ___divorced

Your child's developmental diagnosis: ___high risk
___developmentally delayed
___physically handicapped
___mentally handicapped
___multiply handicapped
___speech/language delayed
___other: _____ please specify

Income Level of household:

___ under \$5,000	___ \$15,000 - 19,999
___ \$5,000 - 9,999	___ \$20,000 - 29,999
___ \$10,000 - 14,999	___ \$30,000 or over

Comments:

Geocode: _____

February 14, 1984

APPENDIX E

COVER LETTER: PROGRAM DIRECTORS



Serving Effingham County
Association for Retarded Citizens

618 West Main Street, Teutopolis, Illinois 62467, (217) 857-3186

Michael W. Fortner
Executive Director

NANON WOOD CENTER
Children's Service — Birth to Three
2502 S. Veterans Drive
Effingham, Illinois 62401
(217) 347-5118

OPPORTUNITY CENTER
Vocational Development Services
618 West Main Street
Teutopolis, Illinois 62467
(217) 857-3186

March 2, 1984

Dear Birth To Three Service Provider,

I explained at the last Birth To Three Council meeting that I am conducting a study of parent involvement activities as a part of my thesis work at Eastern Illinois University. I am enclosing the questionnaire to assess parent involvement. The results of the study will be provided to each of you. Hopefully, this information will assist you in program planning.

Attached are geographic codes for each of the counties you are serving. When distributing these forms to your parents please place the appropriate code on page 4, the bottom right hand corner. If you would like to identify your parents you may add an additional one or two digit number after the county code for your personal use.

If you have any questions please contact me immediately. Thank you for your cooperation.

Sincerely,

A handwritten signature in cursive script that reads "Joyce Coleman".

Joyce Coleman
Program Director
Effingham County