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**EVALUATION OF
EARLY INTERVENTION IMPACT
IN ALENTEJO**

child, family and community



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“It takes a whole village to raise a child”
(ancient proverb, source unknown)

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Introduction

The investigation project “**Evaluation of early intervention impact in Alentejo**” was the consequence of several actions that, in the past 7 years, provided the three districts of Alentejo with an early intervention child development net, that was pioneered in Portugal and that brings together the initiatives from the regional services of the Health, Education and Social Security Ministries along with private non-profitable institutions of social care. For the first time, it was possible to create a large, uniform net, covering a large area, with a coordinated structure and articulated work and intervention models, laying down as the main purpose support to children with developmental disturbances or in risk, and the families of those children.

[9]

After these services were implemented, it became necessary to verify the impact that it had produced in the different systems among the professionals and, above all, among the children and families that tried to help.

This kind of study is essentially focused on the results that come from the practices, considered in a comprehensive and systemic way. So far, the investigation in this area has been centred, above all, on the conceptual validation or on the evaluation of satisfaction with the answers provided (Cruz, 2003). The consolidation of an early intervention system will have to be based on a set of principles, orientations and practices that prove to be adequate and executable both on regional and national levels and that imposes itself because of the results it achieves.

Bairrão and Almeida (2002, p.11) called attention to the risks of transposing an intervention model for a country like ours in a plain and simple way. Portugal has “no tradition of working in this area, the practice is still incipient and with a remarkable scientific delay” and has no previous work to reflect upon, “which is the best way to use this model, if, in fact, it is the most adequate model to our reality”. The creation of an intervention system truly adequate to Portuguese reality has to base itself on the evaluation of the results, with a strong pragmatic component.

That was our strongest motivation in producing the work we are presenting now. We know and share a reality that extends to our daily view of committed professionals but that does not extend to the strictness of the systematic research.

This text tries to present the results of the research of the impact of early

intervention in Alentejo, taking into consideration three kinds of readers: investigators, early intervention professionals and the general public, including those who are responsible for making decisions that will affect the net work. Obviously we had some difficulties in writing a text that would meet the interests of these three publics, keeping the seriousness and the form that researching work demands. We had to find some compromising solutions. We tried not to overload the text with too much statistic information, theories or bibliography. However, for those who are interested in further information about data and study procedures, we decided to include as extra a complete version of data pictures and analyses that were made.

[10]

The work is divided into 6 large chapters. In the first chapter we will present the study framing, in the scope of the concepts and practices concerning early intervention and its regional and national evolution; in the second chapter we will present the project's objectives, its different studies, and the methods that were used; in the third chapter we will present the results of the impact study in the health system, namely among family doctors and health centre nurses; in the fourth chapter we will present the results of the impact study in the practices of kindergarten teachers (regular and supporting); in the fifth chapter we will analyse the impact in the development of children and their families (here, we will use the data that we got from the professionals in charge of the teams that follow the children and their families, and also the data that we got directly from the families); finally, in the last chapter, we will try to summarise what seems to be more relevant when we analyse the results we obtained. We also present the bibliography references and, annexed, the instruments we used.

We would like to thank to the people that gave a decisive contribution to make such a long and complex work possible. First of all, and in a very special way, to Dr. Cristina Miranda, who coordinates the regional team of early intervention in Alentejo and the main stimulator of the net. She deserves all the recognition for the way she encouraged, supported, and committed herself to find resources to make the investigation possible. But she also deserves credit for the independence and autonomy she gave to the team that conducted the study, which proved to be essential to an investigation in which results are not compromised with any intention of showing the good things or to be used as instruments of functional objectives of any kind. We have strong convictions that research can not be confused with an activity report or be used to corroborate practices and options, but only to produce the most accurate and comprehensive image possible of the reality, with the conclusions and implications that may come left to others.

We thank ARS for sustaining this project based on the financial support of *PorAlentejo* Regional Operational Programme.

We thank the Direct Intervention Teams of all the areas involved who, except in very specific situations, were extremely open and cooperative, never seeming frightened or creating obstacles but, rather, on the contrary: always welcoming the investigation into their practice, assuming an attitude we appreciate and recognize as the only one considerable by those who really want to improve their professional skills and the quality of the social responses they provide.

We thank the professionals (doctors, nurses, kindergarten teachers and people in charge of the children) that answered the questionnaires.

A word of gratitude to the families that joined us in this study; they are, after all, the ultimate and common concern for those who are involved in Early Intervention.

We also thank all that somehow contributed to this project: building and taking questionnaires, collecting information, treating data, translation and text edition. A special word for Eng. Fernando Miranda, his commitment and patience in this project management.

The last word of recognition is a tribute to Professor Joaquim Bairrão Ruivo, for all he did for Early Intervention in Portugal, and with whom we wished we had been able to discuss the results of this work and, unfortunately, did not have the chance to.

1. Framework

1. Framework

1.1. Early Intervention in Alentejo

In the past 20 years there have been several attempts to implement an early intervention programme in children development in Alentejo. The first tries took place in the late 80 ´s, in education, and tried to follow the first attempts that were being made in Portugal in order to create specialised answers to support children with development difficulties. The first experience took the form of a stimulation room to receive and support children with some form of development problem.

[15]

In the early 90 ´s, the first two atypic agreements to give Early Technical Support were signed with the social security in Évora. Two teams were then created: CERCIMOR promoted the celebration of a three part agreement with social security, education and health which gave sustainability to the Early Intervention project in Montemor-o-Novo (and that functioned, since the beginning, in a very similar model to the PIIP from Coimbra) ; Évora's APPC-Cerebral Palsy Portuguese Association created CDIP - Early Intervention and Development Center, with a team devoted to the support and intervention with children with cerebral palsy or development neurological disturbances. These agreements were signed in 1992, and both institutions maintain their activity, uninterruptedly, until today; they are among the oldest in the country and have a solid and significant experience based on the support they have provided to hundreds of children and families.

The need for a wider cover for the intervention net in the children development field led to the attempt of creating teams in Évora and a regional structure that involved the teams and teachers from the Education Office, hospital and health services (depending on the Health Office) the region social security services and the private non-profitable institutions that work with handicapped and childhood. In the late 90 ´s, several steps were attempted in order to create a wider net that could articulate services and needs, avoiding duplication of efforts and articulating the answers provided. In the meanwhile, in the regions of Beja and Portalegre, the institutions and services that already existed created the first punctual responses in the field of Early Intervention.

Based on the dispatch 891/99, in 2001 it was possible to create and consolidate a regional net of Early Intervention that progressively covered the

districts of Évora and Portalegre and now is being expanded to the District of Beja, in an innovative form for our country.

The Alentejo Early Intervention Regional Team started its action in 2000, with a survey of needs done by the services of the three offices involved. The regional teams were developed by the end of the first semester of 2001 and, based on the data that the survey had brought, started the planning of their activities, using the initiatives that already existed as a platform.

[16]

In 2002 and 2003 the organization of the net services took place in the areas of Évora and Portalegre, while Beja, for several reasons, showed a slower progression. Only in 2004 was it possible for Beja's team to overcome the first difficulties and assume a regular intersection work.

Until the end of 2005, all the regions of Évora and Portalegre were totally covered by the Teams net, although in Évora the head office had not yet settled completely. Four institutions supported more than one Direct Intervention Team: APCE, CERCIDIANA, CERCIMOR and Santa Casa da Misericórdia from Reguengos de Monsaraz. This was the solution that the Coordination Team considered to make sure that it was possible to cover the areas where a major investment in local partnerships was necessary, in order to find the best institution that could assume the role of promoter entity.

In Portalegre region the net was based on three institutions that already supported the handicapped population and that assured the covering of different areas: APPACDM from Elvas, APPACDM from Portalegre and CRIPS from Ponte de Sôr. In the beginning each institution was responsible for more than one Direct Intervention Team, in order to assure that the entire region was covered. Over the years there was a progressive transfer of the Teams' responsibilities to other institutions that integrated the services net, within a local coherence.

By the end of 2004 there was a reformation of the net in Beja; new agreements were signed in two other areas which meant that, by the end of 2005, five Teams with cooperation agreements signed were working and two others were starting the process of surveying needs (in Almodôvar and Aljustrel); these two consolidated their work in the following year, although without signed agreements. In 2006 the net spread over 4 new areas, in a very incipient way, but with the settling of informal partnerships that allowed needs surveys and the attribution of a few resources to create the first answers.

1.2. Early Intervention in Portugal

The fact that this response was given in Alentejo was totally innovating for Portuguese reality once that, despite the dispatch 891/99, created a net that involved all services, institutions and local authorities, in a way that as of yet was not possible to create in any other region of the country. However we cannot dissociate it from a path of implementing a certain perspective and practices concerning Early Intervention in Portugal that owes a lot to the pioneering initiative of the PIIP Early Intervention Integrated Project from Coimbra (in a partnership that was stimulated by Coimbra's Pediatric Hospital and APPACDM) and the teams it promoted, trying to find a work methodology that was adequate for children and families' needs in an essentially territorial basis.

[17]

The elaboration of responses to the global needs of younger handicapped children development began to be structured in the second half of the 60's with the Children Welfare Institute, Welfare and Health Office and the Domiciliary Orientation Service. Their main goal was blind children and their families. Those were the first programmes for handicapped children using a medical model and related to the health services (Costa, 1984).

After this first response of specialised support to blind children, it was time for children with Cerebral Palsy to also have a specific response through the Cerebral Palsy Centres and the Cerebral Palsy Portuguese Association. In the meanwhile, the APPACDM began to rise with a particular vocation for the mentally handicapped.

The 70's were marked first of all by the rising of the Special Education Centres, providing the Education Office with a structure dedicated to children with special needs. Although it was very rare for handicapped children to attend kindergartens, Special Education Teams became responsible for responding to their educational needs.

After 1974, there were significant changes concerning the support to children with development disturbances with the creation of CERCI institutions, although this kind of response was more adjusted to children during the school years. Some non profitable institutions made also a considerable effort to integrate handicapped children in kindergartens and in the access to pre-school education.

The Águeda Project was the first experiment that tried to integrate the efforts of Health, Education, Social Security and other public and private

institutions. It experimented a model with children that had development problems and children at risk; a model that later would inspire the basic concept of PIIP, in Coimbra.

In the 80's, the need to create early educational responses that would follow the rehabilitation perspective that had already been developed by multiple institutions was highly emphasised. Early detection became a key concept to childhood health and to developmental disturbances and the idea of early stimulation signalled the importance of intervening as soon as possible, motivating programmes that aimed to organise that intervention. The first Early Intervention programmes emerged "with a consistent theoretical framework and organizational structure" (Bairrão & Almeida, 2002) very attached to the work that had been developed in COMP, COOMP/DSOIP (essentially using the Portage Model) and later the PIIP, from Coimbra. This programme started its activity in 1989 and created a new cooperation model between different public (Education, Health and Social Security) and private (non profitable organizations) services.

[18]

The orientations and options chosen by Coimbra's PIIP led to the dispatch 891/99 dated from 18/10; so far this document has been the main reference for the decisions that both governments and institutions have taken in this area. It was not possible to implement it at a national level but it guided some of the local projects. Although its experimentation period is over, it is still the most important legal document and we used it to create the experiment we are trying to evaluate here.

1.3. The concept of Early Intervention

At an international level, the concept of Early Intervention appeared deeply linked to handicapped children but, progressively, assumed a more comprehensive perspective. In different countries the practices concerning Early Intervention vary according to the different traditions and political opinions about health, education and children welfare, therefore leading to very diverse decisions, both in political and scientific fields.

The Early Intervention conceptualisation rests on three big developmental and psychological grounds:

The first one is provided by the contributions of the neuro-sciences field and involves brain plasticity, which means that something that is affecting or

threatening early development can be confronted by using the malleability and potential of quick maturation that the Central Nervous system has during that period.

The second great column lays on the studies of childhood development that emphasize the importance of the first stages of life, of the relationship between mother and child and that make obvious the enormous capacities of babies and small children. Furthermore, all these capacities point to the creation of bonds and to the ability to establish relationships and transactions (Sameroff & Fiese, 2000) that are crucial to development.

In the third place lays the contribution of the ecological (Bronfenbrenner, 1979) and systemic perspectives that have emphasized the importance of factors such as: familiar surroundings, environment and developmental contexts.

Today, and as a consequence of this, the strategies and intervention programmes consider not only personal and inter-individual aspects of development (biological, physical, emotional and cognitive condition) but also relational and transactional aspects (namely within the family) and the systemic and contextual dimensions of development (social, cultural and political-organizational environment).

This is the reason why one of Early Intervention's strong points is the fact that that it does not settle on a classical field of intervention (namely education, health or special education) but on the inter-section of all the systems and practices that have the young child as target. This is also the reason why we have decided to give this study a sub-title that brings light to the scope of the evaluation we intend to do and that considers both the child as the family and as the enlarged community that surrounds them.

1.4. Definition and objectives of Early Intervention

All the definitions of Early Intervention, besides identifying a specific age, establish a few principles that are implied and common. They all consider the child as a whole and so tend to consider the intervention in a global way. They also consider not only the child's inherent and individual characteristics, but they insert them in a certain life context, both relational and cultural. They emphasise the need for the intervention to have a right and opportune moment, as early as possible, to be done, no matter what the nature of the specific actions may be.

Dispatch 891/99 dated 18/10, that established the guiding principles for Portugal, defines Early Intervention as:

An integrated support measure, centred in the child and the family, through actions of a preventive and qualifying nature, namely in the sphere of education, health and social care, with the objective of: a) assuring conditions that will make easier the development of the handicapped child or the child that is at risk of becoming severely retarded; b) improving family interactions; c) strengthening the family abilities as a pillar of its progressive capacity and autonomy concerning deficiency.

[20]

Most definitions consider also as fundamental aspects the following:

- It is oriented to children up to 6 years old (with a particular emphasis up to 3 years old);
- It is oriented to children with handicaps, developmental disturbances or at risk of showing disturbances some time in the future;
- It is oriented to the child as a whole, and not only to the deficient aspects of its development;
- It aims to assure all the conditions for a positive development;
- It is an integrated measure (at the levels of health, education and social welfare);
- It is oriented not only to the child, but also to its family and context.

According to the same dispatch, these are the objectives of Early Intervention:

a) To produce conditions that will make the child's global development easier, minimising the problems that may come from the deficiency or the risk of a retarded development and preventing eventual sequels.

b) To optimise the conditions for child/family interaction, by giving information about the problem they are facing, the enforcement of the capacities and abilities of each of them (namely in the identification of the resources they and the community have) and also about the capacity for taking decisions and controlling their lives as a family.

c) To involve the community in the process of intervention, in a continuous and articulated way, optimising the resources that already exist and the formal and informal support networks.

1.5. The structure of the Early Intervention network

Therefore, the goal of the Early Intervention programmes is to promote changes in the quality of the care and services provided to children under 6, who also have a handicap or are at risk and last, but not least, to promote a better development and inclusion within the community.

In order to do that, the Dispatch 891/99 establishes the creation of a geographic based network that integrates the local structures of health, social care and education (health centres, hospitals, local welfare services, kindergartens and educational structures that promote inclusion)and also other public and private local structures that work in this area (social care institutions that include rehabilitation or childhood care, local authorities and other institutions involved in the social protection).

[27]

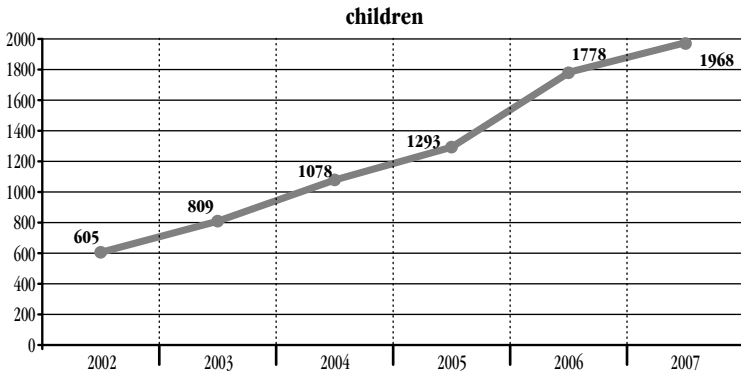
These are the local structures that each Direct Intervention Team uses through the involvement and the contributions from the different partners. It is also predicted that the different local structures respond beyond a Coordination Team of regional ambit that articulates itself with a wider coordinator.

Under this perspective, the Alentejo Regional Team promoted the creation of different regional level structures, in an inter-sectorial partnership dynamic that allowed the significant covering of the 3 Alentejo regions by Direct Intervention Teams, thanks to a wise use of the resources and a large investment , both material and human, by the Offices that were involved. This allowed Alentejo, by the end of 2007, to be almost completely covered by the Early Intervention network, with 35 Direct intervention Teams that include 39 areas. Beja is the single region where there are 4 areas still in an initial level of implementing responses.

The regional network includes 25 organizations that assure the teams' institutional support and also a multiplicity of services and structures that constitute the local resources of each community. The Direct Intervention Teams are multidisciplinary and have therapists, psychologists, kindergarten teachers, social care workers and, in some cases, family doctors and nurses.

The numbers of the supported population increased significantly over the years, as we can see in **graphic n.1**. Between 2002 and 2007, the number of supported children grew from 605 to 1968, with a peak in 2006. This growing was constant in the 3 regions: in Évora, it went from 295 to 940; in Portalegre, it went from 122 to 590; and in Beja, from 188 to 438.

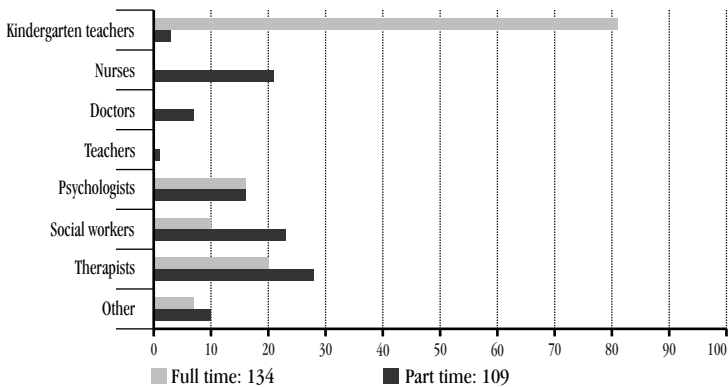
Graphic n.1 - Evolution of the supported population



[22]

The number of professionals involved in the teams has also grown in a gradual way; by the end of 2006 there were 243 and 134 of them worked on a full time basis (**graphic n.2**). Most of them are kindergarten teachers to whom the Education Office gave permission to work in the teams; there is also a large number of psychologists, therapists (physiotherapists, speech therapists and occupational therapists) and social workers, both full and part time. The doctors and nurses work only part time , which means they continue to work in their

Graphic n.2 - Number of professionals involved



former services, namely Health Centres.

Under the perspective of a total territorial covering, settled on a structure that includes Local and Regional Coordination Teams, local Direct Intervention Teams and also Enlarged Teams (partners council or local coordination teams) it was possible to stimulate the articulation and proximity among the services and at different levels. At a regional level, through the involvement of each Office in the actions planning and in the financing of the necessary resources; at a local level with the emphasis on the primary health care, through the Health Centres, that proved to be a fundamental element for the early detection of children with developmental problems, leading into the necessary responses and the involvement of the professionals in the available responses, both for the children and their families. It also allowed for deep partnerships at the other levels involved, namely with Social Security, through the relationship between the diverse Social Security teams and the Direct Intervention teams and at the Education level, with the use of resources and the improvement of the inter sectorial articulation among the several sectors of Education.

[23]

The nature of this network settles on the will to allow closer solutions to the population. Closer to children and families that this way will not need to displace themselves and, on the other hand, putting the solution of problems on a closer frontier, using institutions and resources from the local communities:

- Health care centres (including family doctors and nurses);
- Kindergartens (including regular teachers and specialized teachers);
- Hospital services (Pediatrics, Obstetrics, Neonatology, Risk and Development Consultations, Specialised Consultations, Children Mental Health Services);
- Social Security support services to children and families;
- Institutions that support the development and rehabilitation of handicapped people;
- Institutions that support childhood;
- Local authorities;
- Security forces that are involved with the protection of children;
- Other services that support children and families.

The existence of a close services network may be profitable at different levels. First of all, because of the effective accessibility to those services, without the need to travel to the big urban centres, where usually these services are. Within this proximity the Health Centres and, above all, the family doctors, play a fundamental

role as problem indicators, even if they are not members of the local teams of direct intervention or partner teams.

A second aspect that comes out of this network procedure is the real improvement of the articulation between the services. There are multiple responsibilities, competences and resources in each region and they all can be used to create integrated responses, taking the best advantages of the existing resources and increasing the capacity of the community to produce responses to complex problems that not only include the health or education support, but also comprehensive and integrated responses.

2. General objectives and methodology

2. General objectives and methodology

In order to define the objectives and pattern of the present study, we considered the contributions from different authors and investigations about the specificity of Early Intervention.

According to Bairrão & Almeida (2003) the Early Intervention programmes' nature is simultaneously individualised and comprehensive. Individualised because each child is seen as an unique human being, with specific characteristics and needs that demand a programme that is drawn for its reality; and comprehensive because it is not just addressed to the child, but also to the family and the community where they both belong. This way, the impact should be evaluated at two levels: the effects achieved by the child in terms of its development and abilities and the results concerning the family and that are related with the way we understand the impact that the given support had in the child's life and in its family.

[27]

Under this perspective, the ultimate objective is always the impact on the child development. However, we can not dissociate this from the events that occur in the family or with the development of the other agents that are involved in the child care process. The same author (Bairrão, 2002) quotes a Dunst definition that points some clues to the characteristics that a quality service should have, considering Early Intervention as: *“a form of support given by members of both formal and informal social networks, that will have a direct and indirect impact on the functioning of parents, family and community”*. This helped us to define the territory of what we intend to evaluate: the child, the family and the community.

The Orientation Document of “L'Office des Personnes Handicapées du Québec” (Begin, 1992) also identifies as signs of efficacy of the Early Intervention:

- Parents feeling more competent;
- Parents more involved in the children education;
- Family more adapted to the child handicap;
- Prevention of more serious problems;
- Improvement in the child development and general condition;
- Child living with the family;
- Easier integration in the regular school.

This leads us to emphasise the basic assumption that Early Intervention

should, on the one hand, promote to the limit all the child capacities and, on the other hand, to develop the family capacities to stimulate the child development and adjust to its characteristics.

Shonkoff & Meisels (2000) define 3 areas in the evaluation of the results of Early Intervention in the families: the quantity and quality of the mother - child interaction, the dimension and utility of the family social support network and the stress perceived by the parents.

[28]

On the other side, Turnbull (Bailey *et al.*, 1998) conceptualised the results in the families in two classes: the results on motivation, that include self -efficacy, perceived control, hope, energy and persistency and the results on knowledge and capacities, namely on information, problems solving, capacity to cope and to communicate. This helps us to look for the nature of the expected impact on the families development.

National Early Intervention Longitudinal Study - NEILS (Hebbeler *et al.*, 1998, 1999, 2001) is a study about the Early Intervention services in the United States, coordinated by SRI International and occurring between 1997 and 1998. It covered 3 338 handicapped or at risk children and their families and had a longitudinal character, following the children and families since they entered the Early Intervention Programme until the end of kindergarten. The great lines of NEILS investigation settled on 4 fundamental questions: a) who are the children and the families that have access to EI services; b) what services are these and how do they operate; c) how much do they cost; d) which results were obtained with the children and families. Its conceptual frame reflects a transactional and ecological perspective that defends that these children development is influenced by many inter related factors , namely biological (genetic disturbances) social (the way family interacts with the child) environmental (for example, the toys the child has at home) and cultural (concerning family traditions and beliefs on how to raise a child).

Within this study, Bailey *et al.* (1998) considers that, in opposition to most of the studies on Early Intervention that only consider the results on the child, a comprehensive evaluation can not leave the results on the family out, according to the enlarged objective of supporting the families that have handicapped or development disturbed children. It identifies two types of results, reflected on a combination of expected experience and involves the satisfaction with the services provided: adequacy, efficacy, professionals sensibility and personalisation of services. A positive view of the perceptions of its qualifications as providers of

2. General objectives and methodology

services, the capacity of working with the professionals, reinforcing its focus of control, optimism about the future, the increase of life quality and the help to build a strong support system. Although it was not our intention to work on the families satisfaction or on their perception of the services, the identification of the impact results had to settle, above all, on this second type of indicators.

2.1. Objectives

After implementing the Early Intervention projects in the region, no study was made that could allow the results, although there is much information about the activities developed and the system functioning. In other regions, some studies have been made, about particular aspects of Early Intervention, namely about its practices in the Education field and the level of satisfaction with the programme, but there is no information about the impact of Early Intervention practices on a certain area or in a large scale.

[29]

After this first period of implementing the Early Intervention responses on the ground, it becomes necessary to look at the results of this new reality.

On the one hand, and because this was the first regional experiment,, it is important to know the practices used from the different agents points of view, so it will be possible to verify in what way the implemented practices are corresponding to the objectives that are supposed to accomplish. “ First of all, it is necessary to collect data about the Early Intervention practices by their actual agents and, next, to analyse in which way those practices can be adjusted to a service network that will function according to what today is internationally considered as a quality service (Bairrão & Almeida , 2002, p.11).

On the other hand, under a regional network perspective, it becomes crucial to evaluate the results of the finished work, so it will be possible to correct eventual unsuitableness and move progressively to globally effective forms of intervention and consonant with their goals.

On the sequence of what has been emphasised by other authors, this evaluation should be done at the level of the several components of the system, namely the supported families and the development of handicapped children or in risk, the health professionals (family doctors and nurses) and the kindergarten and Educational Supporting Teams teachers, as active participants of the ecosystem in which the child development is processed. Other elements of the

social system could be targeted for evaluation, but these are, definitely, the most operational. We leave out fundamental elements of the social support (enlarged family, friends, neighbours, etc.) the evaluation of the relationship with the peers and also diverse professional groups that, one way or the other, are involved in the care network.

Considering also the investment that was made, there is the need to evaluate and quantify the impact provoked by all those resources. Both the direct impact that was caused by the technical action of the professionals from the Early Intervention Teams, and the impact provoked by the practices of the children attending and caring in the services and professionals that already existed before the project and that articulate with it.

[30]

The global aim of this research is to evaluate the impact of the o actions that were developed by the Early Intervention projects implemented in Alentejo within the orientations of the dispatch 891/99.

The specific objectives are:

- To evaluate the impact of the Early Intervention in the handicapped children or in serious risk;
- To evaluate the impact of the Early Intervention in the development of the supported families;
- To evaluate the impact of the Early Intervention in the functioning of the community involved, namely in the health and education services.

We do not intend to evaluate the nature of the work that was developed by the professionals in the teams, but only the impact it provoked. It is also not our objective to evaluate the way the professionals or teams work under the light of a certain theoretical reference; or to evaluate if the practices were adequate to the theory models, although the results that were obtained have to be necessarily evaluated according to the goals that the system pretends to achieve.

The satisfaction of the implicated agents, families, professionals or services is also not an objective of this study and, particularly in the evaluation of the impact in the families, we attempted to make sure that this aspect was not confounded with the evaluation of the change that was felt in the inter family area or in the child.

Although there are other elements of the community implied in the support or in the intervention system, they will not be, as we said, a study object. In some cases because they have less typified practices and are, therefore, more

difficult to evaluate in terms of change. This does not represent any undervaluation of the professional activities implied in the responses of the network (for example, the therapists or the social workers).

So, the problem that this investigation intends to approach is the dimension and the shape of the impact resulting from the implementation of measures and practices of the Early Intervention at different levels, or in different elements of the system:

- functioning and development of the families;
- children development;
- health professionals;
- education professionals.

2.2. Methodology

In order to reach such a wide group of objectives, we decided to do 3 studies, each one of them out of the questioning of 2 populations:

Study 1 - Evaluation of the impact of Early Intervention in the health system, from the answers given by doctors and nurses from the Health Centre;

Study 2 - Evaluation of the impact of the Early Intervention in the educational practices, from the answers given by the Kindergarten Teachers and the professionals of the Intervention Teams;

Study 3 - Evaluation of the impact of the Early Intervention in the children and their families, from their answers and the answers of the professionals in charge of the Intervention Teams.

The impact evaluation is centred, essentially, in the way the different agents evaluate it, never considering, at least in the beginning, the viability to follow direct observation methodologies. For example, we did not do the evaluation of the child development before and after implementing a programme to evaluate the profit obtained, but we considered the evaluations of those profits from the family and the professionals perspectives. The same happens about other agents and partners, where the approach was made in the sense of identifying the profit the professionals mention or the way they see the situation, even if their practices were not directly observed.

We tried to use methodologies that would allow to listen to the intervenient in the process. As a general methodology we decide to build and use questionnaires that allowed to collect the opinion of each of the studied groups.

The collecting of other type of information, namely the consultation of the activities reports was not used as search content but was useful to build the instruments.

The type of questionnaire, the way it was built, its use and its comprehension was different in each one of the studies. To the first study we choose to do the questions by phone because it was the easier way to have access to the subjects; the questions were more objective, closed and of quick answer. In the second study, we decided to collect the answers by mail, since it was difficult to meet the subjects because of their geographic dispersion. In the third study we choose the direct collect which, although slower and demanding of more wide resources, proved to be the only one that could assure the quality and accuracy of the answers and its more qualitative development.

[32]

The building process of each one of the instruments, its content and the way they were used will be explained with more details when we present the studies.

As in any other investigation, we tried to be ethically and deontologically careful concerning the methodologies we used and the way we related to the participants. All of them were previously informed about the nature and objectives of the study, in a way that would not interfere in the sense of the answers. In the situations where it was justifiable, we asked for permission to the necessary authorities and respected the institutions hierarchies, in order to guarantee their cooperation. This way, all who accepted to participate in the study gave their informed consent so their responses could be included in the investigation, always under guarantee of total confidentiality. In order to guarantee the confidentiality of the answers, the presentation of results will never allow the individual identification of the answerer, the child or the family or even any small group (team, council or professionals).

3. Evaluation of the impact on the health system

3. Evaluation of the impact on the health system

3.1. Objectives

In this first study we intended to evaluate the impact that the existence of an Early Intervention net had in the health system, in the practices of doctors and nurses in the health centres. Through the hearing of these professionals we intend to verify:

[35]

- Information doctors and nurses in health centres have about early intervention;
- Existence of contact or connection with the local teams (regional and /or of direct intervention);
- Knowledge and use of files or other procedures to identify the cases;
- Changes in the articulation with other services;
- Facility and speed in the leading of the situations;
- Changes in the kind of problems responded to;
- Changes in the comprehension of the problems, namely the attention to those related with development, family or other professionals contribution;
- Inter subject and inter institutions articulation;
- Changes in the frequency of services;
- Changes of the available resources;
- Changes on the proximity of services;
- Changes in practices.

3.2 Instruments and methods

The evaluation of the Early Intervention impact on the health system was centred on the level of primary health care, considered as the first element of a continuous process of health assistance. Health Centres are the institutional base of the network, which mission settles on “the promotion and empowerment of the primary health care, oriented to the community and the family” (OE, 2007).

This is the reason why the study fell upon its professionals, family doctors and nurses, so it would be possible to evaluate the impact of the Early Intervention

Teams network, both on health care and on the articulation of the several community services.

To the elaboration of the questionnaires it was considered the definition of the role of family doctors and nurses in their practice in the Health Centres and what is expected to be their participation in the Early intervention network. Since the questionnaires were supposed to be used during a phone conversation, its building tried to assure the facility and speed of application, being largely constituted of close questions, with dichotomic answers (Y/N).

[36]

Three analysis dimensions of the impact on the health system were considered:

- **INFORMATION:** it deals with what information exists in the area concerning Early Intervention, if that information increased with the Team working there, the knowledge about the leading procedures or signalling used and about its utility.
- **CHANGE:** it is related to the changes caused by the network in some aspects of the functioning on the health care system, namely concerning the facility and speed in the leading, the kind of problems that were responded to, the articulation with other services, the comprehension on facing the problems that is materialised in the attention it is given to the developmental problems, to the family and to the contribution of other technical areas. It also attempts to find the opinion of the inquired on the impact Early Intervention has had on the cost of transportation and on bringing health services closer to the users and the community.
- **PRACTICE:** it is focused in the professionals practice and in the changes that result from the contact with Early Intervention network at the level of signaling, cases support and interinstitutional and interdisciplinary articulation.

The questionnaires elaborated to family doctors and nurses contain identical questions in these dimensions: Characterization of the inquired, Information and Change. The questions about the Practice were adequate to the activities and responsibility of each professional category.

The analysis dimensions that were considered above were operated in a synthetic form on the **chart 1**.

The data were given by doctors and nurses through a structured telephone

3. Evaluation of the impact on the health system

Chart 1 - Dimensions and variables of the questionnaires for doctors and nurses

DIMENSION	
• Variables	
CHARACTERIZATION OF THE INQUIRED	<ul style="list-style-type: none"> • Location of the health centre where he works; • Duration of service in the workforce and in the health centre.
INFORMATION	<ul style="list-style-type: none"> • Acquaintance with the Early Intervention Team and its head-office; • One of the members of the team works in the health centre; • Acquaintance with the way situations are led; • Acquaintance with the signalling file its use and usefulness.
CHANGE	<ul style="list-style-type: none"> • Easiness in detecting development and family problems that may bring risks to the children development; • Attention paid to family problems; • Speed of medical responses; • Increasing of the number of attended children; • Attention given to the improvement of the family capacities and to the families autonomy promotion; • Sensibility to other professionals contributions; • Apply to the multi subject team; • Easiness in the development evaluation; • Increasing in the medical support to the child/family; • Diminution of money expenses; • Approximation between the health centre and the families.
PRACTICE	<ul style="list-style-type: none"> • Participation in meetings with the different teams; • Acquaintance with the Direct team and the local team/partners; • Number of cases already signed and still to sign; • Procedures for signalling; • Articulation with hospitals: new born leading, feed-back of medical appointments and exchange of written information; • Follow up of the cases after signalling; • Regular information about the team work; • Easiness in the articulation with the Team; • Leading process during routine medical appointments (only for nurses); • Working contexts (only for nurses) where the signalling is done.

interview, because it proved to be the easier way to have access to the professionals that were selected to the sample, considering their wide geographic distribution and the lack of availability for long conversations. Previously it was asked permission and cooperation to the Health Centres Directors, and then the contact was made to the Health Centre and specifically to the doctor or nurse that had been selected for the sample.

The interviews were made by Psychology graduates that were previously prepared to do it. They followed a guide, to conduct the interview and collect and systematize the answers, that was called: “Questionnaire for the Family Doctors” containing 54 questions (11 were opened and 43 were closed). The “Questionnaire for Nurses” contained 62 questions (14 were opened and 48 closed).

[38]

3.3. Population and sample

The studied sample was constituted by Doctors and Nurses that work in the Health Centres and its extensions in the 3 regions covered by the Early Intervention network. Hospital professionals or from other specialized services were not considered.

Only 5% of the selected to the Doctors sample could not be contacted because they were, at the moment away from the service or repeatedly unavailable, which meant that the final sample was constituted by 71 doctors and 90 nurses.

3.3.1. Geographic distribution

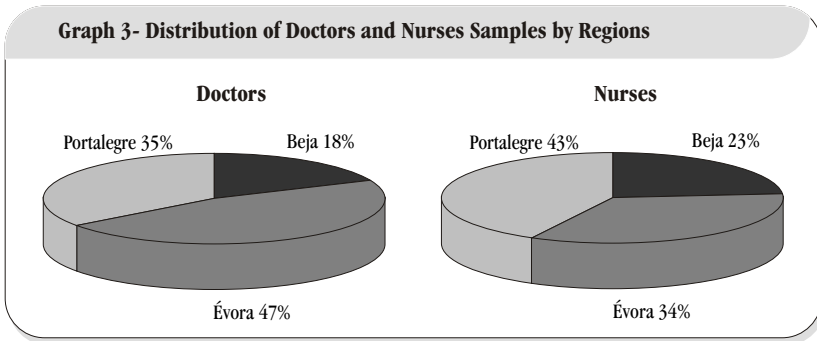
As we can read in the following box, the sample of doctors considered is constituted by 13 from Beja region, 33 from Évora and 25 from Portalegre, corresponding to a distribution that is adequate to the total number of professionals that work in each of the regions. The sample of nurses is constituted by 21 from Beja region, 31 from Évora and 38 from Portalegre.

In both cases we should remember that this population

Chart 2 - Sample Geographic Distribution

REGION	doctors		nurses	
	population	sample	population	sample
	N	n	N	n
Beja	118	13	183	21
Évora	139	33	163	31
Portalegre	111	25	171	38
Total	368	71	517	90

3. Evaluation of the impact on the health system



[39]

corresponds to the total of professionals that work in all the regions but, to constitute the sample, we only considered those places where there is an Early Intervention Team. If, in the cases of Évora and Portalegre, that corresponds to all the region, in the case of Beja were only considered: Beja, Castro Verde, Mértola, Moura and Odemira. Therefore, the number of individuals that constitute that sample is smaller.

3.3.2. Professional experience and duration of service in the workforce

In terms of professional characteristics of the used samples, we can verify, in Board 3, that the average duration of service for doctors is 23,34 years, and that 80% has been working for 20 years now, or more, revealing this way an experimented population with a great number of professionals arriving at the end of their careers. Among the Nurses, the average figures are lower, 17,03, and

Chart 3 - Total duration of service and in the present Centre

DURATION	doctors				nurses			
	duration of service		service in HC		duration of service		service in HC	
	n	%	n	%	n	%	n	%
Until 9 years	8	11,3	20	28,2	8	8,9	40	44,4
10 - 19 years	6	8,5	16	22,5	52	57,8	36	40,0
20 - 29 years	51	71,8	34	47,9	23	25,6	10	11,1
30 - 39 years	5	7	1	1,4	7	7,8	4	4,4
+ 40 years	1	1,4	0	0	0	0	0	0
N	71	100	71	100	90	100	90	100
Mean	23,34		15,67		17,03		11,42	
S.D.	7,329		8,927		7,431		7,926	

almost 70% have a professional experience of less than 20 years.

This also happens when we consider the duration of the service in the present Health Centre, where the doctors average is 15,67 years and 71,8% have been there for 10 years or most; nurses average is again lower, and only 55,6% have been working in the present centre for 10 years or more.

3.4. Results

[40] 3.4.1. Doctors

We present here the main results that were obtained from the interviews with the doctors, in its three dimensions previously presented: *Information*, *Change* and *Practice*.

3.4.1.1. Information

The Information dimension is constituted by 9 variables and concerns the information family doctors have about the existence and functioning of the Early Intervention network services, as well as about the signalling instruments and signalling and articulation forms.

As we can see, family doctors are well informed (87,7%) about the existence of an Early Intervention team in the area covered by their Health Centre. The information levels are also relevant concerning the ways to contact the team (77,5%) effective contacts with the Teams (71,4) and knowledge and use of the

Chart 4 - Doctors: Information

VARIABLES: INFORMATION	yes		no		dk/da	
	n	%	n	%	n	%
Existence of an EI Team in the working area	62	87,3	6	8,5	3	4,2
Correct identification of the Team workplace	24	33,8	16	22,5	31	43,7
Contact with the Team	50	71,4	12	17,1	8	11,4
Is part of the Team	6	8,5	57	80,3	8	11,3
Another doctor is part of the Team	27	38	26	36,6	18	25,4
Acquainted with the way to contact the Team	55	77,5	8	11,3	8	11,3
Acquainted with the signalling form	37	52,1	24	33,8	10	14,1
Use of signalling form	21	29,6	39	54,9	11	15,5
Usefulness of the signalling form	47	66,2	0	0	24	33,8

3. Evaluation of the impact on the health system

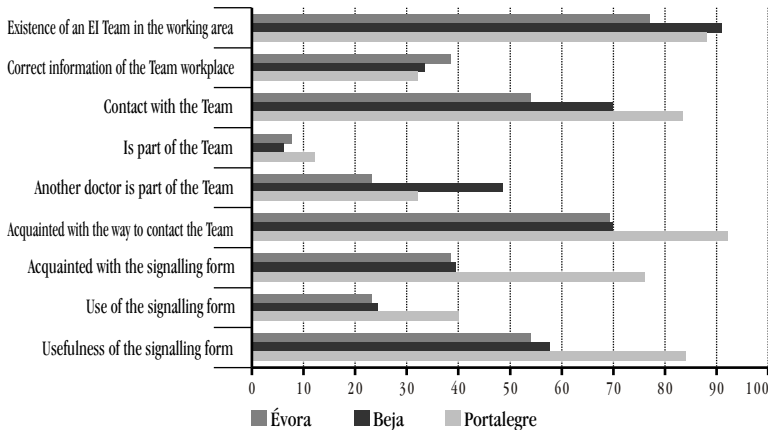
signalling form in situations that are covered by EI (66,2% and 52,4%).

The level of information is low when it concerns the presence of other doctors in the team (38%) the correct identification of the team workplace (33,8%) the effective use of the signalling form (29,6%) and, most of all, the being part of the Early Intervention team, since only 8,5% say they are part of a team.

Comparing the different regions, globally Portalegre has clearly more contact with the team, knows better how to make that contact and knows and uses the signalling form regularly. Generally, Évora is the region that shows lower levels of information, excepting the identification of the team workplace. This difference is particularly notorious in the contact with the Team (only a little bit higher than half, contrasting with 80% in Portalegre) and in the acquaintance with the signalling form.

[47]

Graph 4- Doctors: Information (according to regions)



3.4.1.2. Change

The Change dimension integrates 14 variables and describes how the doctors evaluate the changes that occurred as consequence of an Early Intervention Team existence in their Health Centre region.

As we can see in the **chart 5**, most doctors mention significant changes related with the implementation of the Early Intervention network. The largest

Chart 5 - Doctors: Change

VARIABLES: CHANGE	yes		no		dk/da	
	n	%	n	%	n	%
Easiness in detecting the child development problems	48	67,6	9	12,7	14	19,7
Easiness in detecting family problems	53	74,6	4	5,6	14	19,7
Attention to family problems	52	73,2	5	7	14	19,7
Easiness in leading or speed of response from the specialists	35	49,3	0	28,2	16	22,5
Support in the Health Centre of children from other services	32	45,1	18	25,4	21	29,6
Attention to capacities and autonomy of the family	46	64,8	7	9,9	18	25,4
Sensitivity to the contribution of other professionals	48	67,6	9	12,7	14	19,7
Applying to the EI team professionals	43	60,6	16	22,5	12	16,9
Easiness in evaluating the child development	45	63,4	12	16,9	14	19,7
Frequency of the medical assistance to the child/ family	33	46,5	24	33,8	14	19,7
Proximity of supports and children	51	71,8	5	7	15	21,1
Diminution of the costs with travels to medical appointments and treatments	25	35,2	17	23,9	29	40,8
Approximation between families and the Health Centre	42	59,2	11	15,5	18	25,4
Easiness in leading to specialized medical appointments	45	63,4	10	14,1	16	22,5

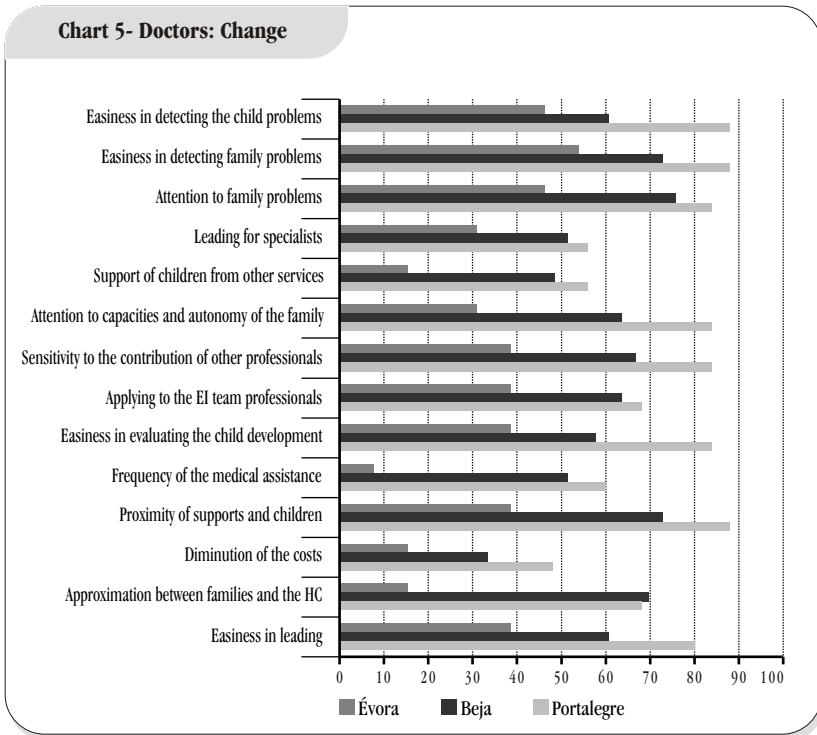
[42]

changes are in the EASINESS IN DETECTING FAMILY PROBLEMS THAT MAY PUT THE CHILD DEVELOPMENT IN RISK (74,6%), ATTENTION TO FAMILY PROBLEMS (73,6%) PROXIMITY OF SUPPORTS AND CHILDREN (71,8%) EASINESS IN DETECTING THE CHILD DEVELOPMENT PROBLEMS (67,7%) SENSITIVITY TO THE CONTRIBUTION OF OTHER PROFESSIONALS (67,7%) ATTENTION TO CAPACITIES AND AUTONOMY OF THE FAMILY (64,8%) EASINESS IN LEADING OR SPEED OF RESPONSE FROM THE SPECIALISTS (63,4%) EASINESS IN EVALUATING THE CHILD DEVELOPMENT (63,4%) . Changes were less notorious in the following dimensions: FREQUENCY OF THE HEALTH CENTRE OF CHILDREN FROM OTHER SERVICES (45,1%) AND TREATMENTS (35,2%).

A high number refers that there was no significant change in terms of FREQUENCY OF THE MEDICAL ASSISTANCE TO THE CHILD/FAMILY (33,8%) and DON'T KNOW is the most common answer to the item DIMINUTION OF THE COSTS WITH TRAVELS TO MEDICAL APPOINTMENTS AND TREATMENTS (40,8%).

Comparing the different regions, the most evident changes occurred in Portalegre, in all the variables, and the less evident changes occurred in Évora; here changes are always mentioned by less of 50% of the doctors.

3. Evaluation of the impact on the health system



3.4.1.3. Practice

The Practice dimension, with 22 variables, represents the Doctors practices in different aspects of their activity and identifies the ways the professional articulates with the Early Intervention Team. Due to the fact that they are not part of the teams, only 14,1% of the doctors attend the Direct Intervention Team meetings and those who participate in the local Team are even less, although a large per cent can not answer, even because this coordination structure does not exist in all the areas and only 53,5% is aware of its existence.

Concerning the signalling of the cases, 67,6% say they do it through a connection element, being this the most common way of making that articulation. Other ways of doing the signalling are the direct contact with the team (58%) or the organization of meetings (28,2%). On the contrary, signalling through mail or the use of the family as signalling vehicle are mostly refused (67,6% and 66,2% answered NO). The loss of signalled cases does not seem to happen often (57,7% deny it and only 11% admit it).

Articulation with the Hospitals is more relevant in the cases of newborns in risk (36,6% YES and 25,4% NO) while that does not happen when it concerns feedback from medical appointments and information exchanges (40,8% and 43,7%, respectively). Some results are particularly significant, concerning: EASINESS IN ARTICULATION WITH EIT (66,2%) FOLLOW UP OF SIGNALLED CHILDREN (63,4) FEEDBACK FROM SIGNALLED CASES (49,3%) ACQUAINTED WITH THE PROFESSIONAL IN CHARGE OF THE CASE (46,5%).

Concerning the increase of appliance to the Health Centres by the families, the figures of the answers YES, NO and DO NOT KNOW is very similar (around 30% each).

[44]

Less frequent practices are: RECEIVING REGULAR INFORMATION FROM THE TEAM (53,8% does not receive it) and RECEIVING THE IDENTIFICATION FORM FROM THE EARLY INTERVENTION TEAM (only 16,9% claims to receive it).

Chart 6 - Doctors: Practice

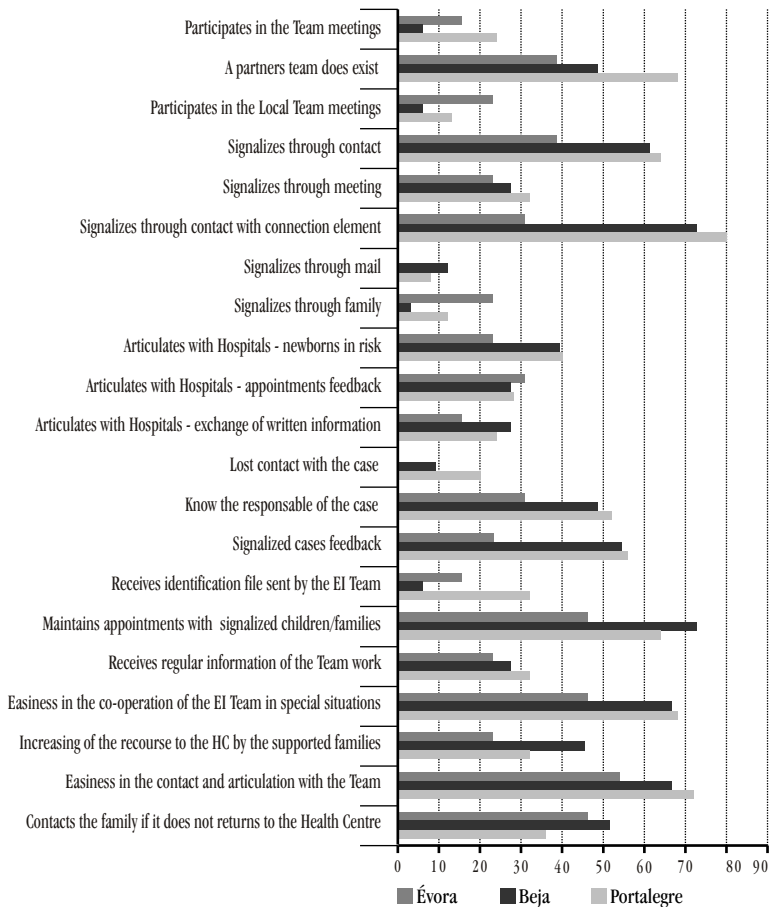
VARIABLES: PRACTICE	yes		no		dk/da	
	n	%	n	%	n	%
Participation in the Direct Early Intervention meetings	10	14,1	51	71,8	10	14,1
Existence of a Local Team (or partners)	38	53,5	3	4,2	30	42,3
Participation in municipal team	8	11,6	36	50,7	25	36,2
Signalization of cases through contact with the Team	40	58	13	18,8	16	23,2
Signalization of cases through meeting with the Team	20	28,2	35	49,3	16	22,5
Signalization of cases through the contact as connection element	48	67,6	7	9,9	16	22,5
Signalization of cases through mail	6	8,5	48	67,6	17	23,9
Signalization of cases through family	7	9,9	47	66,2	17	23,9
Articulation with the Hospitals in the leading of newborns at risk	26	36,6	18	25,4	27	38
Articulation with the Hospitals in the appointments feedback	20	28,2	29	40,8	22	31
Articulation with the Hospitals in the exchange of written information about the cases	17	23,9	31	43,7	23	32,4
Loss of contact with signalized cases	8	11,3	41	57,7	22	31
Acquaintance of the responsible for the signalized cases	33	46,5	15	21,1	23	32,4
Feed back of the signalized cases	35	49,3	11	15,5	25	35,2
Reception of the identification file sent by the EI Team	12	16,9	31	43,7	28	39,4
Maintenance of appointments with signalized children/families	46	64,8	2	2,8	23	32,4
Regular information about the work developed by the Team	20	28,2	38	53,5	13	18,3
Easiness in obtaining the Team collaboration in special/ urgent situations	45	63,4	6	8,5	20	28,2
Increasing of the recourse to the Health Centre by supported families	26	36,6	23	32,4	22	31
Easiness in the contact and articulation with the EI Team	47	66,2	7	9,9	17	23,9

3. Evaluation of the impact on the health system

Comparing the answers by regions, we realise again that the lowest level of responses in Évora, in most of the items, excepting the participation in the local team meetings, higher feedback in the articulation with the hospitals and higher signalization through family. Beja has the highest scores in the items CONTACT WITH THE FAMILY WHEN IT DOES NOT COME BACK TO THE HEALTH CENTRE, MAINTENANCE OF APPOINTMENTS WITH SIGNALIZED CHILDREN, REGULAR INFORMATION ABOUT THE WORK DEVELOPED BY THE TEAM, INCREASING OF

Graph 6 - Doctors: Practice (by regions)

[45]



THE RECOURSE TO THE HEALTH CENTRE BY SUPPORTED FAMILIES and HIGHER WRITTEN ARTICULATION WITH THE HOSPITAL.

Concerning the real articulation between Doctors and Teams, we realise that 55 of the inquired (which mean 77,4%) led 172 cases to the early Intervention Teams, with an average of 3,13 cases per Doctor (3,4). They also refer they have 33 cases in conditions to be led, which constitutes a positive marker of the real functioning of the Health Centre Doctors and of the Health System itself concerning Early Intervention.

[46]

3.4.1.4. Crossing of variables

In order to take a better look to the value of some variables in the understanding of the changes and practices, it was defined a set of independent variables and, through the crossing of variables, it was studied its relationship with all the others, considered as dependents , so it would be possible to arrive at some conclusions about its influence. The following variables were tested as independent:

- Region;
- Time of service as a Doctor;
- Time of service in the present Health Centre;
- To have contact with the EI Team;
- To be acquainted with the signalization file;
- To use the signalization file.

Because of the variables nature, the QUI SQUARE was applied, which tests the independence between two nominal variables , with a 5% level of significance and a P value of 0,05.

The tested Hypothesis or Null Hypothesis (H0) is that the variables are independent, being that we can only reject this hypothesis and considerer the existence of a co-relation when the value of P is $\leq 0,05$. When the value of P is higher than 0,05, we accept the H0 and we conclude that there is independence among the variables. When the value of P is equal or inferior to 0,05, the decision is to reject the H0 and accept the H1, which means that there is a relation among the studied variables. In these cases the test of association is made in order to study the level of relation that exists. The used measure was the V test of Cramer that, with a variation between 0 (lack of relation) and 1 (perfect association) studies the intensity of this dependence.

3. Evaluation of the impact on the health system

Chart 7 - Region vs Change	Independence test <i>Qui-Square (χ^2)</i>		Association test
	p	decision	Cramer's V
REGION VS CHANGE			
Easiness in detecting development problems	0,028	Reject H0	0,277
Increasing of the attention given to the family autonomy and capacitation	0,027	Reject H0	0,278
Increasing of the frequency of medical appointments with child/family	0,014	Reject H0	0,297
Closeness of the families to the Health Centre	0,0013	Reject H0	0,298

Chart 8 - Region vs Practice	Independence test <i>Qui-Square (χ^2)</i>		Association test
	p	decision	Cramer's V
REGION VS PRACTICE			
Meeting with the team as a form of signalization	0,050	Reject H0	0,259
Contact with the connection element as a form of signalization	0,020	Reject H0	0,287
Sent by family as a form of signalization	0,005	Reject H0	0,324
Receives copy of the signalization file	0,029	Reject H0	0,276

[47]

When we considered the variable REGION , there was no significant relation concerning Information.

When we considered CHANGE, we discovered significant results in the variables that constitute the following chart:

Concerning the PRACTICE, we only discovered significant results in the variables related to the way of signalization (meeting with team, contact with connecting element, sent by family and receive a copy of the file).

The variables Time of Service and Time of Service in the present Health Centre did not reveal significant relations with the dependent variables, but when considering Contact with the Team, the relations with all the variables of the Change and Practice dimensions are very significant.

The relations between Acquaintance with the Signalization File and the variables of Change and Practice are also significant.

If, instead of using the mere acquaintance with the signalization file, we add its use, the results are even superior in all the variables of the two dimensions.

Evaluation of early intervention impact in Alentejo: *child, family and community*

[48]

Chart 9 - Contact with the Team vs Change	Independence test		Association test
	Qui-Square (χ^2)		
CONTACT WITH THE TEAM VS CHANGE	p	decision	Cramer's V
Higher easiness in detecting development problems	0,000	Reject H0	0,495
Higher easiness in detecting family problems	0,000	Reject H0	0,499
Higher attention to the problems	0,000	Reject H0	0,497
Higher easiness in leading or higher speed of responses from the medical experts	0,000	Reject H0	0,455
Support given by the Health Centre to children from other services	0,000	Reject H0	0,392
Higher attention given to the family capacitation and autonomy	0,000	Reject H0	0,446
Increasing sensibility to the contribution of other professionals	0,000	Reject H0	0,478
Recourse to EI professionals	0,000	Reject H0	0,554
Easiness in the evaluation of developing problems	0,000	Reject H0	0,508
Increasing of the frequency of medical appointments with the child/family	0,000	Reject H0	0,496
Increasing of closeness of supports to the children	0,000	Reject H0	0,470
Lower costs in travelling to medical appointments or treatments	0,002	Reject H0	0,349
Closeness of the families to the Health Centres	0,000	Reject H0	0,403
Higher easiness in leading to specialized appointments	0,000	Reject H0	0,464

Chart 10 - Contact with the Team vs Practice	Independence test		Association test
	Qui-Square (χ^2)		
CONTACT WITH THE TEAM VS PRACTICE	p	decision	Cramer's V
Contact with the team as a form of signalization	0,000	Reject H0	0,487
Meeting with the team as a form of signalization	0,000	Reject H0	0,455
Contact with the connecting element as a form of signalization	0,000	Reject H0	0,484
Mail as a form of signalization	0,000	Reject H0	0,474
Sent by family as a from of signalization	0,000	Reject H0	0,433
Better articulation with the hospital in the leading of newborn in risk	0,032	Reject H0	0,274
Better articulation with the hospital in the feedback of appointments	0,005	Reject H0	0,338
Better articulation with the hospital in the exchange of written information	0,002	Reject H0	0,352
After signalization loses the case	0,000	Reject H0	0,429
Acquainted with the person in charge of the case	0,000	Reject H0	0,456
Feedback existence of the signalized cases	0,000	Reject H0	0,452
Receives copy of the signalization file sent by the team	0,000	Reject H0	0,418
Maintains the child under regular medical appointments	0,000	Reject H0	0,411
Regular information about the team work	0,000	Reject H0	0,565
Easiness in obtaining the team co-operation for urgent situations	0,000	Reject H0	0,513
Increasing of the recourse to the health centre by the supported families	0,000	Reject H0	0,401
Easiness in articulating with the team	0,000	Reject H0	0,557

3. Evaluation of the impact on the health system

Chart 11 - Acquaintance with the Signalization File vs Change	Independence test <i>Qui-Square (χ^2)</i>		Association test
	p	decision	Cramer's V
ACQUAINTANCE WITH THE SIGNALIZATION FILE VS CHANGE			
Higher easiness in detecting development problems	0,000	Reject H0	0,521
Higher easiness in detecting family problems	0,000	Reject H0	0,563
Higher attention to the problems of the supported families	0,000	Reject H0	0,577
Higher easiness in the leading or speed of specialized responses	0,000	Reject H0	0,523
Support given by the Health Centre to children from other services	0,000	Reject H0	0,486
Increasing of the attention given to the family capacitation and autonomy	0,000	Reject H0	0,503
Increasing sensibility to the contribution of other professionals	0,000	Reject H0	0,565
Recourse to EI professionals	0,000	Reject H0	0,610
Easiness in the evaluation of development problems	0,000	Reject H0	0,564
Higher frequency of medical appointments with the child/ family	0,000	Reject H0	0,532
Higher closeness of the supports to the children	0,000	Reject H0	0,516
Lower costs with travels to medical appointments and treatments	0,000	Reject H0	0,410
Closeness of the families to the Health Centres	0,000	Reject H0	0,471
Higher easiness in leading to specialized appointments	0,000	Reject H0	0,505

[49]

Chart 12 - Acquaintance with the Signalization File vs Practice	Independence test <i>Qui-Square (χ^2)</i>		Association test
	p	decision	Cramer's V
ACQUAINTANCE WITH THE SIGNALIZATION FILE VS PRACTICE			
Contact with the team as a form of signalization	0,000	Reject H0	0,471
Meeting with the team as a form of signalization	0,000	Reject H0	0,473
Contact with the connecting element as a form of signalization	0,000	Reject H0	0,532
Mail as a form of signalization	0,000	Reject H0	0,449
Family as a form of signalization	0,000	Reject H0	0,448
Better articulation with the hospital in the leading of newborn in risk	0,001	Reject H0	0,371
Better articulation with the hospital in the feedback of appointments	0,001	Reject H0	0,370
Better articulation with the hospital in the exchange of written information	0,001	Reject H0	0,355
After signalization, loses the case	0,000	Reject H0	0,425
Acquaintance with the responsible for the case	0,000	Reject H0	0,403
Feedback of the signalized cases	0,000	Reject H0	0,491
Receives a copy of the signalization file sent by the team	0,000	Reject H0	0,457
Maintains the child in regular medical appointment	0,001	Reject H0	0,374
Regular information about the team work	0,000	Reject H0	0,670
Easiness in getting the team collaboration for urgent situations	0,000	Reject H0	0,499
Increasing of the recourse to the health centre by the supported families	0,000	Reject H0	0,444
Easiness in articulating with the team	0,000	Reject H0	0,525

3.4.2. Nurses

As it was said, the “Questionnaire for Nurses” allowed the construction of a base to analyse the collected data, which was constituted by 62 variables, corresponding to 48 closed questions and 14 open ones. The nurses answers, as it happened with doctors, formed 3 major categories: Information, Change and Practices. In the first one we tried to verify the level and the kind of knowledge they have about the existence of the net and the early intervention teams, their functioning, articulation forms, contact or participation. In the Change category, we tried to verify how nurses evaluate the changes that occurred as a consequence of having an Early Intervention team. In the third part, we tried to know the practices of the nurses in different dimensions of their activity that are directly connected with the work of children and families and, in that way, can be placed in the field of action of Early Intervention.

[50]

Chart 13 - Nurses: Information

VARIABLES: INFORMATION	yes		no		dk/da	
	n	%	n	%	n	%
Existence of an EI Team in the region of practice	74	82,2	10	11,2	5	5,6
Correct identification of the Team workplace	35	38,9	12	13,3	43	47,8
Contact with the Team	63	70,0	18	20,0	9	10,0
Belonging to the Team	20	22,2	60	66,7	10	11,1
Belonging of another nurse to the Team	50	55,6	31	34,4	9	10,0
Acquainted with how to make contact with the Team	67	74,4	13	14,4	10	11,1
Acquainted with the signalization file	40	44,4	38	42,2	12	13,3
Use of the signalization file	22	24,4	57	63,3	11	12,2
Utility of the signalization file	68	75,6	3	3,3	19	21,1

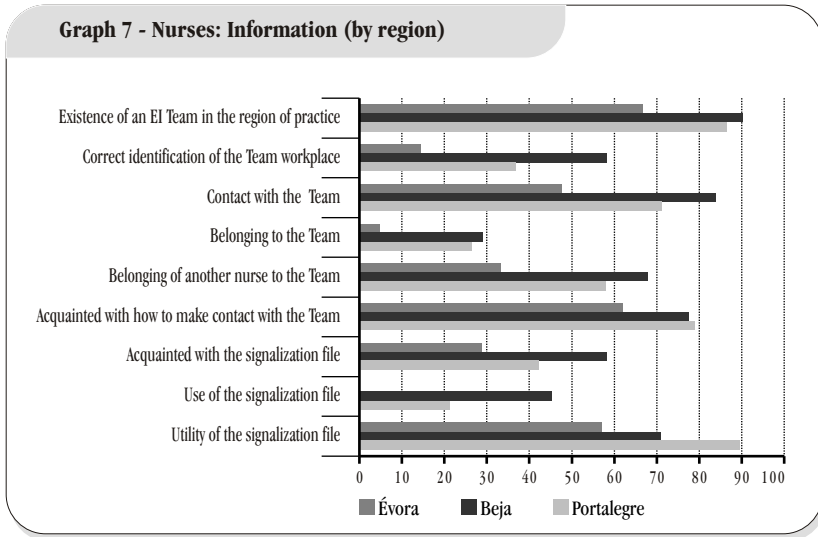
3.4.2.1. Information

The Information dimension, constituted by 9 variables, concerns the information nurses have about the existence and functioning of the Early Intervention services, and also about the instruments for signalization and articulation forms.

We verify that there is a good level of nurses acquaintance with the structure of the Early Intervention. 82% know about the Team existence and over 70% know how to make contact with it, actually contacts it and recognize the utility of the signalization file. However, only 22% belong to the Team and 38,9% identify correctly the Team workplace.

3. Evaluation of the impact on the health system

Comparing the answers between regions, the participation of nurses in the Team and their knowledge of the use of the signalization file is higher in Beja. Évora is the region where the level of information is lower, as already happened with Doctors.



[57]

3.4.2.2. Change

The dimension Change, constituted by 13 variables, concerns the perception about the changes that occurred as a consequence of having an Early Intervention Team in the action field of the Health Centre.

In a general way, Nurses refer changes in a significant frequency. The most important are at these levels: HIGHER SENSIBILITY TO THE CONTRIBUTION OF OTHER PROFESSIONALS (78,9%); HIGHER EASINESS IN THE EVALUATION OF CHILDREN DEVELOPMENT (77,8%); HIGHER CLOSENESS IN THE SUPPORT TO CHILDREN (76,7); HIGHER EASINESS IN THE DETECTION OF CHILDREN DEVELOPMENT PROBLEMS (74,4%); HIGHER EASINESS IN THE DETECTION OF FAMILY PROBLEMS THAT PUT I RISK THE CHILD DEVELOPMENT (73,3%); HIGHER ATTENTION TO FAMILY PROBLEMS (72,2%); HIGHER ATTENTION TO THE FAMILIES CAPACITATION AND AUTONOMY(72,2%); only the items SUPPORT FROM THE HEALTH CENTER TO CHILDREN FROM OTHER SERVICES and LOWER COSTS WITH TRAVELS TO MEDICAL APPOINTMENTS AND TREATMENTS revealed less than 50% of YES answers (although, the I DO NOT KNOW answers prevail).

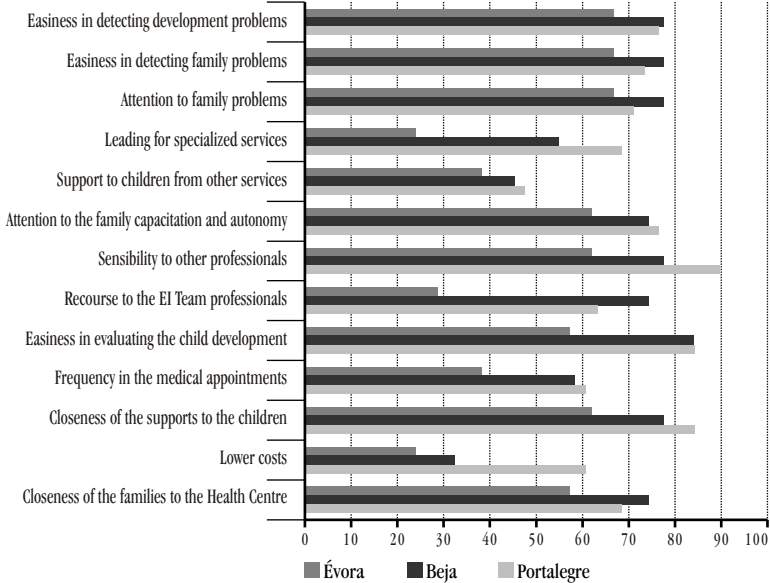
Evaluation of early intervention impact in Alentejo: *child, family and community*

Chart 14 - Nurses: Change

VARIABLES: CHANGE	yes		no		dk/da	
	n	%	n	%	n	%
Easiness in detecting the child development problems	67	74,4	3	3,3	20	22,2
Easiness in detecting family problems	66	73,3	2	2,2	22	24,4
Attention to family problems	65	72,2	3	3,3	22	24,4
Easiness in leading or speed of response from specialized services	48	53,3	11	12,2	31	34,4
Support from the Health Centre to children from other services	40	44,4	25	27,8	25	27,8
Attention to the family capacitation and autonomy	65	72,2	7	7,8	18	20,0
Sensibility to the contribution of other professionals	71	78,9	3	3,3	16	17,8
Recourse to the EI Team professionals	53	58,9	23	25,6	14	15,6
Easiness in evaluating the child development	70	77,8	1	1,1	19	21,1
Frequency in the medical appointments with the child/family	49	54,4	15	16,7	26	28,9
Closeness of the supports to the children	69	76,7	3	3,3	18	20,0
Lower costs with travels to medical appointments and treatments	38	42,2	12	13,3	40	44,4
Closeness of the families to the Health Centre	61	67,8	9	10,0	20	22,2

[52]

Graph 8 - Nurses: Change (by region)



3. Evaluation of the impact on the health system

The region of Portalegre is, again, the one where changes are higher, although Beja shows off and presents higher values concerning the variables related to the family (closeness, attention and detection of problems).

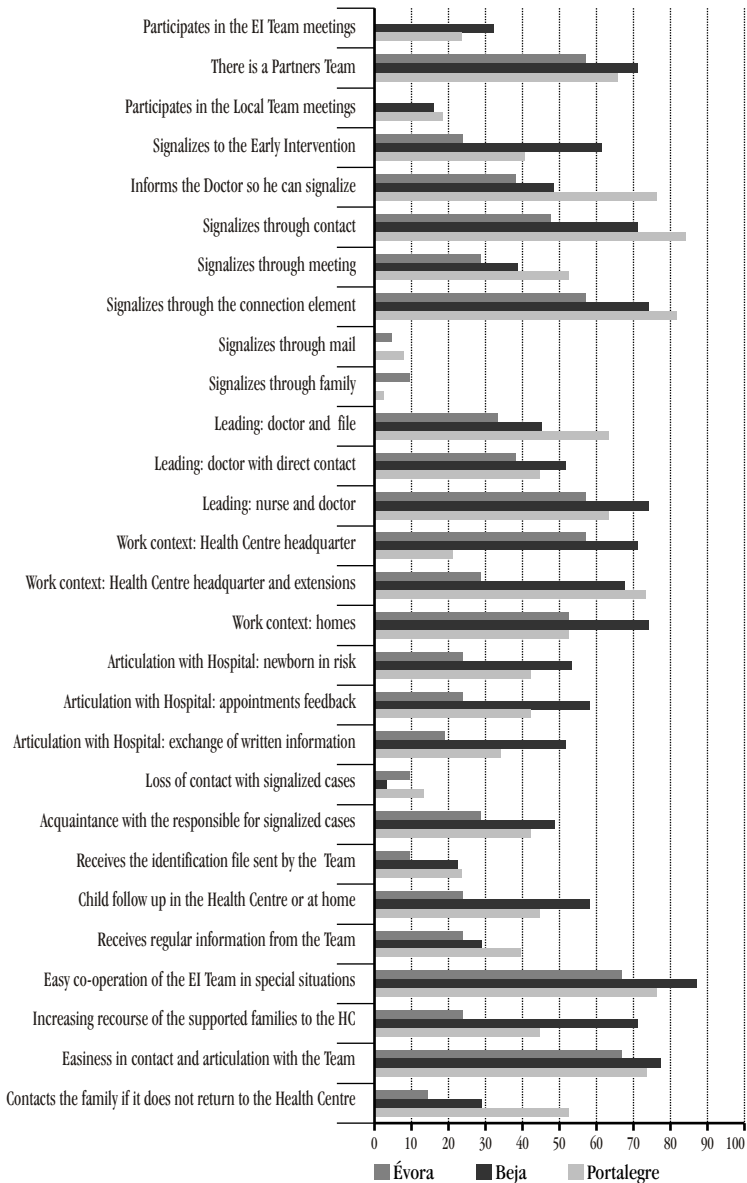
3.4.2.3. Practice

The Practice dimension is the one that integrates more variables: 30. It identifies the forms of articulation between the professional and the EI Team.

Chart 15 - Nurses: Practice

VARIABLES: PRACTICE	yes		no		dk/da	
	n	%	n	%	n	%
Participation in the Direct Intervention Team meetings	19	21,1	61	67,8	10	11,1
Existence of a Local Team (or Partners)	59	65,6	10	11,1	21	23,3
Participation in the Local Team meetings	12	13,3	54	60,0	24	26,7
Signalizes cases for the EI	39	43,8	45	50,6	5	5,6
Signalization of cases through information to the doctor	52	57,8	19	21,1	19	21,1
Signalization of cases through contact with the Team	64	71,1	7	7,8	19	21,1
Signalization of cases through meetings with the Team	38	42,2	32	35,6	20	22,2
Signalization of cases through contact with the connecting element	66	73,3	6	6,7	18	20,0
Signalization of cases through the mail	4	4,4	68	75,6	18	20,0
Signalization of cases through the family	3	3,3	67	74,4	20	22,2
Leading in regular medical appointments - doctor with file	45	50,0	21	23,3	24	26,7
Leading in regular medical appointment - doctor in direct contact with the Team	41	45,6	25	27,8	24	26,7
Leading in regular medical appointment - nurse with doctor	59	65,6	11	12,2	20	22,2
Working context - only in the headquarters of the Health Centre	42	46,7	47	52,2	1	1,1
Working context - in the headquarters of the Health Centre and in extensions	55	61,1	34	37,8	1	1,1
Working context - at homes	54	60,0	36	40,0	0	0,0
Articulation with Hospitals in the leading of newborn in risk	37	41,6	17	19,1	35	39,3
Articulation with Hospitals in the appointments feedback	39	43,3	18	20,0	33	36,7
Articulation with Hospitals in the exchange of written information about the cases	33	36,7	21	23,3	36	40,0
Loss of contact with signalized cases	8	8,9	51	56,7	31	34,4
Acquaintance with those in charge of the signalized cases	37	41,1	19	21,1	34	37,8
Reception of the identification file sent by the EI Team	18	20,0	38	42,2	34	37,8
Follow up of the child/family in the Health Centre or at home	40	44,4	14	15,6	36	40,0
Regular information about the work developed by the Team	29	32,2	47	52,2	14	15,6
Easiness in getting co-operation from the Team in special/urgent situations	70	77,8	3	3,3	17	18,9
Higher recourse to the Health Centre by the supported families	44	48,9	19	21,1	27	30,0
Easiness in the contact and articulation with the EI Team.	66	73,3	6	6,7	18	20,0

Graph 9 - Nurses: Practice (by region)



3. Evaluation of the impact on the health system

The most common practices are: EASINESS IN OBTAINING THE CO-OPERATION OF THE TEAM IN SPECIAL OR URGENT CASES(77,8% and it is remarkable that in only 3% of the cases the answer is NO); SIGNALIZATION OF CASES THROUGH A CONECTING ELEMENT (73,3%) or DIRECTLY WITH THE TEAM (71,1%); and EASINESS IN THE CONTACT AND ARTICULATION WITH THE TEAM (73,3%). They are also common: EXISTENCE OF A LOCAL OR PARTNERS TEAM (65,6%, although only 13,3% claim to participate in those meetings) the most common practice of leading is made in the regular medical appointments, with the presence of the doctor and nurse (65,6%) and seldom by mail or through family. Concerning the context of the nurses work, 61,1% works both in the Health Centre headquarters and in the extensions and 60% also work in homes. Most nurses do not belong to the Intervention teams (67,8%) and there is no loss of signalized cases (only 8,9%). There is no regular information about the work developed by the team (52%) and only 20% receive the identification file.

[55]

We wanted to know a little bit more about who signalizes the cases. Only in 12,2% of the cases they are only doctors and in 10% they are nurses. In 30% of the situations, signalling involves both professionals.

Concerning the place where the detections occur, the most frequent is the Health Centre, although in 10% of the cases that detection occurs in a school.

Concerning the real involvement of the nurses in the net, we verified that 85 of the inquired (over 90%) have already led cases to the Early Intervention Teams, in a total of 146 cases (an average of 1,72 by nurse).

3.4.2.4. Crossing of variables

Crossing the variables and using the same procedure as we did for doctors, we verify that now the differences considering the REGIONS are significant for all the variables of the INFORMATION dimension and for almost of those concerning the PRACTICE. Some related to CHANGE are also significant:

HIGHER EASINESS IN LEADING OR SPEED IN RESPONDING FROM MEDICAL EXPERTS, HIGHER SENSIBILITY TO THE CONTRIBUTION OF OTHER PROFESSIONALS, RECOURSE TO EI PROFESSIONALS, HIGHER FREQUENCY OF MEDICAL APPOINTMENTS WITH THE CHILD/FAMILY, LOWER COSTS.

The TIME OF SERVICE revealed not to be a significant variable if articulated with all the others.

On the other hand, the variable TO BE IN CONTACT WITH THE TEAMS

relates significantly with all the variables of the Change and with almost all of the Practices. The same happens with the variables TO BE ACQUAINTED WITH THE SIGNALIZATION FILE and TO USE THE SIGNALIZATION FILE.

3.5. Discussion

[56]

The data we obtained allow us to conclude that Doctors are well informed about the Early Intervention net. Most of them know the existence of the net and of the Early Intervention Teams. They know how to establish contact, namely the signalization file, even if they have not used it. Usually they are not part of the Early Intervention Teams or Partners or Local Teams and develop their work under an articulation perspective. However they find difficult to identify correctly the place of the team headquarter.

Nurses also prove to be very well informed about the existence of the teams (over 80%) know how to contact them (74%) and actually are in contact with it (70%).

There are significant differences among the levels of information about EI in the three Regions, being lower in Évora and higher in Portalegre in most of the variables.

Doctors mention the strong impact of Early Intervention in changing some situations concerning the assistance to children and families:

- a) families: higher easiness in detecting family problems that put in risk the child development (74,6%) higher attention to family problems (73,6 %) an higher attention to family capacitation and autonomy (64,8%);
- b) higher closeness of the supports to the children (71,8%);
- c) children: higher easiness in detecting development problems (67,6%) and in the evaluation of the child development (63,4%);
- d) work and articulation with other professionals: recognition of higher sensibility to the contribution of other professionals (67,7%) and higher easiness in leading to specialized medical appointments (63,4%).

On the other hand, Nurses emphasize that the impact was stronger and the change more significant in the following aspects:

- a) higher sensibility and opening to the work with other

3. Evaluation of the impact on the health system

- professionals(78,9%);
- b) higher easiness in evaluating the child development (77,8%) and detecting problems of such nature (74,4%);
- c) closeness of the supports (76,7%);
- d) higher attention to the family and its problems (72,2%) and development of its abilities and autonomy (72,2%).

Concerning Changes, results are less significant in Évora Region and point to the need of deeper contacts among the Health Centre Teams.

Concerning the Practice, the most visible aspect in Doctors is the form of signaling they use, usually made through a connection element, which reveals a good understanding and articulation with the Team. It is also important to emphasize that there is no significant loss of cases and the maintenance of feedback on it. Nurses emphasize the easiness in contacting, articulating and obtain co-operation from the Team and also the change of the place where they operate which, in many cases, becomes the home of the supported family.

[57]

Less positive aspects concerning the Practices have to do with the fact that they do not receive the signalized children files or regular information about the Team activities. Articulation with Hospitals seems fragile and functions better when concerning the leading of the newborn.

Both Doctors and Nurses have led children to the EI net in a significant scale (over 70 and 90% respectively).

The acquaintance with the file and its use are the variables that relate significantly with the Change and the Practices, both among Doctors and Nurses. This means they can be good markers of effective changes concerning the articulation between Health Centres and the Early Intervention net.

4. Evaluation of the impact on the education system

4. Evaluation of the impact on the education system

4.1. Objectives

In this second study we intended to evaluate the impact of the functioning of the Early Intervention net in the educative system at the level of the professional practices of Kindergarten Teachers, both those who are in charge of Kindergarten and Nursery classes and those who give specific support to children Special Educational Needs.

[61]

Listening to the Teachers, we tried to identify:

- The kind and level of information Kindergarten Teachers have about Early Intervention;
- When and how do Teachers appeal to the Early Intervention Teams and lead them the children;
- The existence of contact or connection with the Local Teams;
- The acquaintance and use of the signalization files and procedures;
- The changes that occurred at the level of the Teachers practices;
- The changes that eventually occurred in the problems which Teachers have to solve;
- The changes in articulating with other services;
- The changes in the way problems are faced, namely a higher attention paid to development problems, families or other professionals contributions;
- The kind of inter-discipline and inter-institution articulation and the changes that occurred at that level;
- The changes concerning the available resources;
- The changes concerning the specific education practices.

4.2. Instruments and methods

In order to evaluate the Early Intervention impact on the Kindergarten Teachers practices, we decide to build 2 questionnaires, with open and closed questions, that could be answered and sent by mail.

The “Questionnaire for Supporting Kindergarten Teachers” (attachment 3) is constituted by 39 questions, 14 open and 25 closed and it integrates 4 parts (**chart 16**).

Chart 16 - Dimensions and Variables of the Questionnaires for Supporting

DIMENSION	
	<ul style="list-style-type: none"> • Variables
CHARACTERIZATION OF THE TEACHER	
	<ul style="list-style-type: none"> • Local team where he/she belongs; • Total time of service and in the present kindergarten; • Specialized formation.
CHARACTERIZATION OF THE SUPPORTED POPULATION	
	<ul style="list-style-type: none"> • Number of children according to age level; • Diagnosis of supported children.
IMPACT IN THE INFORMATION	
	<ul style="list-style-type: none"> • Quality of the available information about the EI.
IMPACT IN THE EDUCATION PRACTICES	
	<ul style="list-style-type: none"> • Place of intervention; • Schedule and duration of the Intervention; • Focus of the Intervention; • Objectives in the work with families; • Changes occurred in the work as Teacher; • Changes that resulted from the integration in an EI Team.

[62]

During the construction of this questionnaire we considered:

- the legal and organizational frame of the Supporting Kindergarten Teachers that belong to the Early Intervention Teams;
- the information contained in the teams activities reports about these Teachers work, the population involved and the actions that took place;
- everything that bibliography and previous studies point as more relevant in the education work, within the theory perspectives assumed by the net.

Questionnaires were sent by mail, directly to the teams headquarters and using the names of the persons who were supposed to answer them, along with a sheet containing the information about the scope and purposes of the research and a sealed envelope for the answer. This way, the total confidentiality of the answers was assured.

The questionnaires for the Kindergarten Teachers in charge of a classroom (attachment 4) was sent to the Kindergartens along with an instruction sheet so it could be answered by Teachers that have children with Special Needs in their classroom and a sealed envelope to send the answers, also assuring the total confidentiality of its content. These questionnaire contained the same four parts that

4. Evaluation of the impact on the education system

Chart 17 - Dimensions and variables of the questionnaires for kindergarten teachers in charge of a classroom

DIMENSION
• Variables
CHARACTERIZATION OF THE TEACHER
<ul style="list-style-type: none">• Location of the Kindergarten;• Total time of service and in the present Kindergarten;• Formation in Early Intervention;• Children that are in his/her classroom;• Number of children with Special Education Needs (SEN).
CHARACTERIZATION OF THE CHILDREN WITH SEN
<ul style="list-style-type: none">• Age;• Diagnosis of supported children;• Support of the Early Intervention Team: type and place.
INFORMATION CONCERNING EARLY INTERVENTION
<ul style="list-style-type: none">• Information about the Local Intervention Team;• Information about articulation and leading forms;• Opinion about the impact of an EI Team existence.
EDUCATION PRACTICE
<ul style="list-style-type: none">• Impact of the EI in the education practice.

[63]

were described for the Supporting Teachers and had several common questions.

The answers to the questionnaires constituted the two data basis that allowed its analysis.

4.3. Population and sample

To this study were considered the Kindergarten Teachers that belong to two groups: Supporting Teachers that work with the Early Intervention Teams and Teachers in charge of kindergarten classrooms where there is one or more children with SEN in an area covered by the Early Intervention net.

The Supporting Teachers sample was constituted according to the total number of Supporting Teachers that exists in the 3 regions that comprehend the Early Intervention net, 154. Of the 79 casually selected, 63 answers were received (79,75%).

The sample of Teachers in charge of the classrooms was built by the same

number of Teachers, distributed by the same Regions. Only 42 answers arrived (53,16%) which reveals the difficulties that happened, especially in the Regions of Beja and Portalegre.

4.3.1. Geographic distribution

In the Chart 18 we present the distribution of the samples by Regions and also the total population of Teachers. The highest concentration of Teachers in charge of a classroom in Évora is only due to the fact that there is a higher level of responses in this Region.

Chart 18 - Samples of kindergarten teachers

REGIONS	total: education supports	sample: education supports	sample: teachers in charge of a classroom
	N	n	n
Beja	50	16	6
Évora	59	36	29
Portalegre	45	17	7
Total	154	63	42

[64]

4.3.2. Age and duration of service

The average age in the Teachers in Charge is 39,48 years old; half of the inquired were under 40 and the other half was 40 or over 40.

Teachers in Charge have an average of total time of service of 15,81 years, although with a very enlarged distribution (s.d. 8, 278) ; the average of time of service in the present Kindergarten is 5,94 years.

Supporting Teachers present a higher duration of service (17,55 yrs) and have worked in this role for the an average of 5,57 yrs. We realise that we are facing a well consolidated group of experimented professionals, both globally and at the level of specialized education supports.

Chart 19 - Duration of service

AGE	teachers			
	in charge		supporting	
	n	%	n	%
Until 5 years old	5	11,9	1	1,6
5 - 9 years old	6	14,3	1	1,6
10-14 years old	7	16,7	12	19,0
15-19 years old	8	19,0	25	39,7
20 24 years old	7	16,7	19	30,2
+ 25 years old	9	21,4	4	6,3
DA	0	0	1	1,6
N	42	100	63	100
Mean	15,81		17,55	
SD	8,279		4,810	

4.3.3. Formation and specialization

All the Supporting Teachers refer they have some kind of formation in Early Intervention, namely at the level of formation in service. Half of them refers specialization and only 14,3% has initial formation on this area.

Considering the specialization area, 25,4% of the Supporting teachers refer they specialized in body and/or cognitive handicap, although some of them have a more comprehensive formation in SEN, Early Intervention or other areas of specialization. The group of Teachers in charge of a classroom reveals that only 22% has formation on Early Intervention, which seems to point for the need of formation in this area.

Chart 20 - Formation in EI: supporting teachers

FORMATION	n	%
Initial Formation on EI	9	14,3
Complementary Formation (specialization)	34	54,0
Formation in service about EI	62	100,0

Chart 21 - Specialization areas: supporting teachers

SPECIALIZATION AREAS	n	%
Special Education Needs	5	7,9
Early Intervention	4	6,3
Body and /or cognitive handicap	16	25,4
Others	8	12,7
DA	30	47,6
Total	63	100,0

Chart 22 - Formation in EI: teachers in charge

FORMATION	n	%
Yes	9	22,0
No	32	78,0
Total	41	100,0

4.4. Results

4.4.1. Supporting teachers in the EI teams

4.4.1.1. Supported population

The supporting Teachers that are considered in this study are in charge of a total number of 579 children, in an average of 9,2 children for each teacher; of these, 183 are less than 3 yrs old and 345 between 3 and 5 yrs old. There are

Chart 23 - Age of the supported children

AGES	n
0 - 2 years old	183
3 - 5 years old	345
6 and more years old	51
Total	579

also 51 children over 6 years old, mainly due to a delay in entering school.

Considering the population characteristics, 213 of these children are in “Risk of Severe Retardment due to social or family causes”, 93 reveal a serious development retardment and 89 present some kind of handicap. There are also 56 in risk due to biological causes.

Chart 24 - Diagnosis of the supported children

DIAGNOSIS	n	%
Established Handicap	89	15,37
Severe Development Retardment	93	16,06
Risk of Severe Retardment due to Biological Causes	56	9,67
Risk of Severe Retardment due to Social/Family Causes	213	36,79
Other	50	8,64

[66]

4.4.1.2. Impact at the level of information

The first dimension we tried to approach was about the information these teachers have while members of an Early Intervention Team. We asked them to classify their information in a scale from 1 to 5, where the lowest level would correspond to “no information” and the highest to “all the necessary information”.

All the teachers refer they have high levels of information. Concerning the theory framing of EI, information is enough and, in 31,7% of the cases, professionals even consider that it fully corresponds to their needs and they do not feel they need more formation. On the other hand, they refer that they need more information about the development problems and the education practice in the Early Intervention field. The information concerning the families functioning models and the functioning of other services that deal with the child and the family are the ones where the average level is lower, being this last one the only one where the mode is in the category “some”.

Chart 25 - Information: supporting teachers

INFORMATION AVAILABLE	N	\bar{x}	d.p.					
				none	little	some	enough	all the necessary
				%	%	%	%	%
Theory framing of the Early Intervention	63	4,19	0,644	0,0	0,0	12,7	55,6	31,7
Early Intervention as a service	63	3,94	0,644	0,0	0,0	23,8	58,7	17,5
Development problems of supported children	63	3,90	0,530	0,0	1,6	14,3	76,2	7,9
Families functioning models	63	3,60	0,685	0,0	3,2	41,3	47,6	7,9
Education practice in Early Intervention	63	3,92	0,548	0,0	1,6	14,3	74,6	9,5
Functioning of other services that deal with the children/families	63	3,35	0,765	0,0	12,7	44,4	38,1	4,8

4. Evaluation of the impact on the education system

4.4.1.3. Impact on the interventional practices of the teachers

When these teachers describe their practices, we verify that most of them (82,5%) develops their action both in Kindergarten/Nursery and in Homes. Only a small part works exclusively in a Kindergarten (9,5%) or in the Homes (6,4%). This means that the home of the supported families is considered as an intervention place for almost 90% of the professionals.

Concerning the frequency of appointments or work with the child, we can see that the intervention is more common twice a week (47,6%) or once a week (39,7%) and that the cases with a different schedule are rare.

There seems to be an appointment model, so the average duration of each session is usually over 60 minutes (60,3%).

In most cases these Teachers consider that the target of their intervention is both the child and the parents. A high rate (76,2%) considers that the Teacher in charge of the classroom is also a target of their intervention. 57,1% also consider that other professionals as potential targets.

Concerning the work with the families, these Teachers consider as goals the transmission of information (92,1%) the work with the family

Chart 26 - Place of intervention

PLACE	n	%
Only in homes	4	6,3
Only in the Kindergarten	6	9,5
Homes and Nursery	12	19,0
Homes and Kindergarten	40	63,5
Other	1	1,6
Total	63	100,0

[67]

Chart 27 - Frequency of intervention

SCHEDULE	n	%
Twice a week	30	47,6
Once a week	25	39,7
Twice a month	2	3,2
Other	6	9,5
Total	63	100,0

Chart 28 - Average time of the working sessions

DURAÇÃO	n	%
Around 30 minutes	1	1,6
30 - 60 minutes	24	38,1
+ 60 minutes	38	60,3
Total	63	100,0

Chart 29 - Teacher intervention target

SUBJECTS OF INTERVENTION	n	%
Child	63	100,0
Parents	60	95,2
Teacher	48	76,2
Nanny	6	9,5
Other professionals	36	57,1

(90,5%) the leading of situations (90,5%) and the counselling (82,5%).

We tried to see the changes that have occurred in the Supporting Teachers practices as a consequence of their participation in an EI net. In a general way, they refer significant changes in all the 5 evaluated dimensions. The most significant are the use of proper EI instruments (for evaluation and intervention planning) in which 74,6% say they changed deeply and in the evaluation of the children and families needs (76,2%).

Chart 30 - Purpose of the intervention with the family

PURPOSE	n	%
Counselling	52	82,5
Information	58	92,1
Leading of situations	57	90,5
Organization of groups of parents	0	0,0
Organization of parents meetings	3	4,8
Organization of formation for parents	6	9,5
Work with the family	57	90,5
Work with the family and the community	37	58,7
Others	7	11,1
Usually I do not work with the families	0	0,0

[68]

Chart 31 - Changes in the practice as a teacher

CHANGES	N	x̄	d.p.	none	few	some	much	very much
				%	%	%	%	%
Evaluation of the children and families needs	63	3,89	0,743	0,0	4,8	19,0	58,7	17,5
Work articulation with the Teachers in charge of the classroom	61	3,23	0,824	1,6	14,8	47,5	31,1	4,9
Use of instruments	63	3,92	0,789	0,0	4,8	20,6	52,4	22,2
Place where the intervention occurs	63	3,60	1,040	1,6	12,7	33,3	28,6	23,8
Transition process to other education structures	61	3,23	0,973	4,9	14,8	41,0	31,1	7,9
Other aspect	4	5,00	0,000	0,0	0,0	0,0	0,00	100,0

The less significant changes occurred in the articulation with the Teachers in charge of the classroom and in the transition process to other education structures (here, almost 20% says that the changes were insignificant or did not happen). However, the higher level of change is in the item PLACE WHERE THE INTERVENTION OCCURS.

We also wanted to evaluate the utility and benefits that the integration in an Early Intervention Team brought to the Teachers. We asked them to sign in which way the integration in a Team helped them considering 8 aspects. In a general way, Teachers refer that the integration was very helpful in the evaluated dimensions and the average level of the positioning was always over point 3,8 (close to the category MUCH).

4. Evaluation of the impact on the education system

The largest benefit comes from working according to an approach that is centred in the family (82,5% consider that the integration in the Team helped MUCH or VERY MUCH) or that considers the family as an intervention unit. Working under a trans-disciplinary perspective (the only variable where the average of MUCH equals the average of VERY MUCH) to be able to recognize the strengths and abilities of the child and family and to improve the capacity to detect cases were the other aspects that were most helpful to the Supporting Teachers.

Chart 32 - Impact of the integration in the EI team

BENEFITS	N	x̄	d.p.	none	few	some	much	very much
				%	%	%	%	%
To have access to the needed information	63	3,84	0,700	0,0	3,2	23,8	58,7	14,3
To perspective the family as an intervention unit	63	4,11	0,721	0,0	0,0	20,6	47,6	31,7
To recognize strengths and abilities in the child and in the family	63	4,08	0,789	0,0	1,6	22,2	42,9	33,3
To know how to deal with the families	63	3,89	0,863	0,0	4,8	28,6	39,7	27,0
To improve the capacity to detect and signalize cases	63	4,06	0,840	0,0	4,8	17,5	44,4	33,3
To work according to a family centred approach	63	4,21	0,722	0,0	0,0	17,5	44,4	38,1
To articulate with other professionals/services	63	3,98	0,772	0,0	3,2	20,6	50,8	25,4
To work according to a trans-disciplinary functioning model	63	4,11	0,845	0,0	3,2	20,6	38,1	38,1
To be more effective in the evaluation of the children development	63	3,84	0,846	0,0	6,3	25,4	46,0	22,2
Other	3	4,67	0,577	0,0	0,0	0,0	33,3	66,7

[69]

4.4.2. Kindergarten and nursery teachers in charge of a classroom

4.4.2.1. Supported population

These teachers work both in the public net of the Education Office (54,8%) as in non profitable private institutions (40,5%). They work with groups that have a variable number of children and 57,1% have 20 or more children in their classroom. Most of these children are part of heterogeneous groups from 3 to 6

Chart 33 - Kind of kindergarten

KINDERGARTEN	n	%
Public net (E.O.)	23	54,8
Solidarity net (N.PL.)	17	40,5
Other	2	4,8
Total	42	100,0

years old, in some cases because the Kindergarten is too small to justify more classes and, in other cases because that was the option made.

Concerning the children with Special Educational Needs, in the present moment half of the inquired is working with just one, although there are 26,2% that work with three or even more. In terms of age, most of these children are in the 4 years old classroom.

Concerning the diagnosis of the development disturbances, it was only possible to make one to 51 of the 76 children; the most common are Development Global Retardment (25,9%) and Language Disturbances (24,1%).

Almost all the Teachers indicated that they received support from the Local EI Team. There is only one situation where that support does not exist. This gives us a good idea on how effectively the net seems to cover all the region needs.

The kind of support most commonly received by the children is the one provided by the Speech Therapist (61,9%) and by a Kindergarten Teacher (57,1%). Other kinds of supports are provided, like: Psychologist, Physiotherapist and, in a lower percentage, Social Workers, Occupational Therapist and Nurse.

Chart 34 - Number of children per room

QUANTITIES	n	%
Up to 10 children	4	9,5
10 - 19 children	13	31,0
20 and + children	24	57,1
DA	1	2,4
Total	42	100,0
Mean		18,78
SD		5,251

Chart 35 - Children age

AGES	n	%
3 years old	6	14,3
4 years old	6	14,3
5 years old	6	14,3
Variable (3 to 5 years old)	24	57,1
Total	42	100,0

Chart 36 - Children with SEN per room

CHILDREN PER ROOM	n	%
0	2	4,8
1	21	50,0
2	8	19,0
3	8	19,0
4	2	4,8
7	1	2,4
Total of integrated children	76	

Chart 37 - Age of the children with SEN

AGES	n
3 years old	9
4 years old	30
5 years old	22
6 and + years old	15
Total	76

4. Evaluation of the impact on the education system

These supports are usually received in the Kindergarten or at Home and all the professionals work in both spaces (except for the Occupational Therapist that, however, only works with 2 children). Both Speech Therapists (84,6) and Psychologists (90%) work more often in the Kindergarten than the Supporting Teacher that only does it in 79,1% of the cases he works with.

The person in charge of the case is usually the Team Kindergarten Teacher (38,1%); but it can also be the Psychologist, the Physiotherapist or other member of the Team. There is around 10% that can not identify the person responsible for the case.

Chart 38 - SEN Diagnosis

DIAGNOSIS	n	%
Development Global Retardment	14	25,9
Risk of Severe Retardment	3	5,5
Social/Family Risk	1	1,8
Language disturbances	13	24,1
Disturbances of the Autism Spectrum	3	5,5
Behaviour disturbances	6	11,1
Hyperactivity/ Deficit of Attention	2	3,7
X-Fragile Syndrome	2	3,7
Cerebral Palsy	3	5,5
Other Disturbances	4	7,4
Total	51	100,0

Chart 39 - Early Intervention Support

SUPPORT	n	%
Yes	39	92,9
No	1	2,4
NA	2	4,8
Total	42	100,0

Chart 40 - Received Supports

PROFESSIONAL	received supports			
	total		kinder.	
	n	%	n	%
Kindergarten teacher	24	57,1	19	79,1
Social worker	2	4,8	1	50,0
Psychologist	11	26,2	10	90,0
Physiotherapist	7	16,7	2	28,6
Speech therapist	26	61,9	22	84,6
Occupational therapist	2	4,8	2	100,0
Nurse	1	2,4	0	0,0
Other	2	4,8	0	0,0

[77]

Chart 41 - Responsible for the case

RESPONSIBLE FOR THE CASE	n	%
Kindergarten Teacher	16	38,1
Social Worker	1	2,4
Psychologist	6	14,3
Physiotherapist	2	4,8
Speech Therapist	5	11,9
DN/DA	8	19,0
NA	4	9,5
TOTAL	42	100,0

4.4.2.2. Impact at the level of information

Concerning the information that Kindergarten Teachers have, the acquaintance with the existence of a Local Team, how to establish contact with it and the recognition of the utility of the signalization file is clearly significant (all have 97,6% of the answers). The existence of contact with the Team and the easiness of that contact are also referred by over 90% of these Teachers. The values related with the easiness of articulation and more attention to family problems are also very high. The information about the use of the signalization file is the one that shows the lower level (69%).

Chart 42 - Information: Teachers in Charge of the Classroom

VARIABLES: INFORMATION	%
Existence of an EI Team in the local where he/she teaches	97,6
Acquaintance with the way to establish contact	97,6
Utility of the signalization file	97,6
Contact with the Team	92,9
Easiness in contact with the EI Team	92,9
Easiness in articulating with the EI Team	82,9
Higher attention to the family problems	82,5
Acquaintance with the signalization file	80,5
The EI Team helped in the integration process of children with SEN	77,5
Improvement in the early detection of development problems	75,0
Use of the signalization file	69,0

[72]

Concerning the information they received from the Early Intervention Team, we verify that (instead of what happened with the Supporting Teachers) the lower value refers to the THEORY FRAMING OF THE EARLY INTERVENTION. Concerning the issue WORK WITH FAMILIES, 31,7% claims that the help provided was almost null or even null. The higher value refers to the information about the development problems of the supported children, the development and needs of the supported families and the relevance of the received information for the inclusive education of these children with special needs.

Chart 43 - Help of the EI at the Information level

THE EI HELPED TO HAVE INFORMATION ABOUT	N	x̄	d.p.	none	few	some	much	very much
				%	%	%	%	%
The theory framing of the Early Intervention	40	3,25	1,428	5,0	22,5	42,5	12,5	15,0
The education inclusion of children with special needs	41	3,56	1,433	4,9	14,6	34,1	22,0	22,0
The development problems of the supported children	41	3,61	1,394	4,9	7,3	46,3	14,6	24,4
Development and needs of the families	41	3,59	1,533	9,8	9,8	31,7	19,5	26,8
How to work with the families	41	3,27	1,628	14,6	17,1	29,3	14,6	22,0

4. Evaluation of the impact on the education system

4.4.2.3. Impact in the education practices

We also pretended to verify in which way the articulation with the EI Team has been helpful to the Teachers in Charge in their education practice.

The highest impact was in the growth of knowledge concerning the problems of the integrated children (45% say that it was MUCH or VERY MUCH helpful) in the articulation with other professionals or services that are also involved with the child and the family (42,5% MUCH or VERY MUCH).

The lower values concern the acquaintance with the functioning of the Early Intervention Teams and the development of new work strategies in the community (20,5% say the help was null).

[73]

Chart 44 - Impact in the Education Practices of the Teachers in Charge				none	few	some	much	very much
THE EI HELPED TO	N	\bar{x}	d.p.	%	%	%	%	%
Know the problems of the integrated children	40	3,60	1,297	2,5	10,0	40,0	30,0	15,0
Articulate with other professionals and services	40	3,35	1,442	10,0	12,5	32,5	32,5	10,0
Have access to the necessary information	40	3,30	1,265	2,5	15,0	52,5	20,0	7,5
Improve the detection and signaling of development problems	40	3,30	1,344	2,5	22,5	40,0	22,5	10,0
Develop individual work with the child	39	3,28	1,432	5,1	23,1	35,9	20,5	12,8
Create strategies that promote the education inclusion	40	3,25	1,428	7,5	20,0	35,0	25,0	10,0
Know the families better	40	3,15	1,511	12,5	20,0	30,0	25,0	10,0
Plan the group work, considering the child needs	40	3,13	1,399	7,5	22,5	40,0	20,0	7,5
Know the functioning of the EI Teams	40	3,00	1,301	2,5	35,0	37,5	20,0	2,5
Create new strategies for working with the community	39	2,82	1,485	20,5	12,8	48,7	10,3	5,1

4.5. Discussion

The Supporting Teachers are rather experienced professionals; half of them did specialization and Early Intervention formation. They all work directly with children in a Kindergarten/Nursery and/or in Homes, following an average of 9 children. Most of the cases are children IN RISK DUE TO SOCIAL/ FAMILY CAUSES (36,8%).

The Supporting Teachers say that the EI helped them to reach very good levels of information, specially about the theory framing of the early Intervention, about its understanding as a service and about the education practice it stimulates. They also

refer they have good information about the child and family development. The information subjects where the EI help was lower were about the family functioning and other services functioning, seeming that it is possible to improve the knowledge these teachers have about those subjects.

This information is relevant at the level of promoting these professionals formation, since that the initial formation of Kindergarten Teachers seldom mentions the intervention with the families. The work profile of the professionals that work in the EI emphasizes the need of a solid formation about the functioning and family dynamics and about the education processes and the change within a family context.

[74]

From the point of view of the practices, the work in the supported children homes seems to be generally present in the Teachers activities, since 90% of them work there, while only 9,5% works exclusively in the Kindergartens. This work perspective in the “natural contexts” (Thurman, Cornwell & Gottwald, 1997) is coherent with the intervention model. Most of the work happens, in fact, both in the family context and in the Kindergarten/Nursery, which indicates that there must be some malleability in order to adequate the work to the child and family needs and to face the constraints that eventually may occur.

Teachers seem to use a certain appointment pattern, with one or two weekly sessions that frequently last over 60 minutes.

In spite of that, they have a clear notion that the target of their intervention is both in the child, in the parents and in the Teacher that works daily with the child. Over half refers also that works with other professionals. This perspective represents a significant change in the mere educational perspective of the work with pre-school children and points to a strong coherence with an intervention model that is contextual and ecological.

The work they develop with the families has new and distinctive objectives: to give information, leading, counselling, requiring a direct involvement with the family. Some dimensions are functional, some are relational, but they all point to a relationship model of help, with the objective of promoting the change in the family, which demands a kind of work that is adequate to this purpose.

The Supporting Teachers mention they deeply changed their practice as a consequence of working with the Early Intervention Team. That change is particularly felt at the level of using instruments for: evaluation, intervention planning and the evaluation of the child and family needs. A significant group emphasizes the change of the place of intervention from the Kindergarten to the children Homes. Lower changes

4. Evaluation of the impact on the education system

occurred at the level of articulation with the Teachers in Charge of the classrooms and in the transition process to other structures.

The higher profits for working in the Early Intervention as part of a team materialize in a) they started to work centred in the family considering it as an intervention unit; b) higher capacity to detect the difficulties and to recognize the strengths and capacities ; and c) to work with a trans-disciplinary team model, which means that the Teachers say that it was their integration in the Team that allowed them to work in a different way, under a different pattern of the traditional ones.

On the other side, the Teachers in Charge show to have effective support from the EI Teams, which points to a real efficacy of the net. Those supports are usually given through the Team Speech Therapist and Kindergarten Teacher. The language disturbances are the principal difficulty of the supported children with SEN; however the nature of the needs remains open because it is not clear, since the categories are vague and comprehend different problems (Development Global Retardment, Language Disturbances). The supports are received specially in the Kindergarten.

[75]

The Teachers in charge have wide information about the Early Intervention: most of them know about the existence of the Teams and know how to contact them, consider that contact as easy and recognize the role of the signalization file in the articulation of the contacts.

In the information level, they consider that the best help is related to the education inclusion of the children with Special Education Needs. The lowest level of help relates to the Theory Framing of the Early Intervention. This result is totally opposite to the one provided by the Supporting Teachers and shows as a clue for future work the importance of giving that level of information to these Teachers, too. The same happens with the knowledge to work with the families, that also reflects the need for help/formation.

Concerning the way how the articulation with the Early Intervention helped the Teacher in Charge in his/ her education practice, the most significant results are in these issues: acquaintance with the children problems and articulation with other professionals. They are very tenuous , below the average level, concerning the acquaintance with the internal functioning of the teams and the development of new work strategies with the community.

5. Evaluation of the impact on the development of the child and the family

5. Evaluation of the impact on the development of the child and the family

5.1. Objectives

In this third study we will, at the end, evaluate the impact of the function of the Early Intervention system with regards to the development of the child and the family.

Being as it is not possible, at this moment, to conduct a longitudinal study in which the different dimensions of the development of children can be evaluated in different moments, we opted to consider the opinion and evaluation of those that are most directly linked to the child: the children, on one hand; those responsible for the case, representative of the team, on the other.

In the evaluation of the impact of Early Intervention in the development of the child we operated with a collection of dimensions that correspond to the specific objectives of this study:

- a) Verify the form in which the initial detection of difficulties in the child occurred;
- b) Discover how, by whom, and when the diagnosis of difficulties in the child was done;
- c) Discover how, and at what time, the referral of the case to the Early Intervention team was done;
- d) Verify the speed of the process from the first detection until the beginning of action of the Early Intervention type;
- e) Verify the type of problems and necessities of the accompanied children;
- f) Discover where the support of the teams occurred and who supplied it;
- g) Evaluate in what way changes in the development of the child can be observed and how they can be related to the process of intervention.

In the evaluation of the impact on the function of the family and the development of the family, we have the following objectives:

- a) Verify the knowledge of the EI services;
- b) Verify the existing knowledge of the intervention services in health, education, and protection of children with disturbances of development or at-risk;
- c) Verify the way in which it articulated with the services;

- d) Observe how the families resort to the services and what they hope for;
- e) Verify what was the support obtained by families;
- f) See in what way the families related to the help received;
- g) Verify in what form the support/intervention responded to the needs of the family;
- h) Identify the verified changes in the development of the family and its functionality.

This collection of objectives does not include any direct indicator of satisfaction of the families in relation to the services, or, as we stated, any indicator of direct observation of the child.

[80]

5.2. Instruments and methods

For the collection of the data two similar procedures were followed, 2 questionnaires having been constructed, one for the families and the other for those responsible for the case. In the questionnaire for the families three dimensions were considered: CHARACTERISATION OF THE FAMILY, CHARACTERISATION OF THE DEVELOPMENT OF THE CHILD, and IMPACT ON THE DEVELOPMENT OF THE FAMILY, with the variables that were integrated presented on the **chart 45**.

In the questionnaire for those responsible for the case the same dimensions were considered, although there were alterations in the variables, as shown in the **chart 46**.

To collect from the questionnaire the same procedure was followed for both groups, though two distinct processes were followed, with care taken so that neither of the groups knew the answers of the other. After the selection of the sample, the team that accompanied the child was contacted, an interview with the one responsible for the case was scheduled, contact was obtained with the family and an interview was also scheduled with them. In the cases in which it was impossible to directly interview the family, the child selected for the sample was substituted by another, previously selected in an equally random way, by the same municipality. In any case the substitution of children was only permitted by the contact faculty or by the suggestion of the team.

The opinion of the parents was collected through a direct and personal interview given to one or both the parents of the child. The interview took the form of the filling in of the “Questionnaire for the supported families” (Attachment 5), which was complemented by open questions or by additional information offered by the parents. This interview was done by those licensed in Psychology or Social Services,

5. Evaluation of the impact on the development of the child and the family

rightly prepared for the effect, and, as a general rule, was conducted in the household or in one of the sites where the child receives regular support (kindergarten, hospital, institution, etc.).

The opinions of those responsible for the case were collection equally in a direct and personal interview that took the form of filling in the “Questionnaire for those responsible for the case” (Attachment 6).

Chart 45 - Dimensions and variables of the questionnaires for the families

[87]

DIMENSION
<ul style="list-style-type: none">• Variables
CHARACTERISATION OF THE FAMILY <ul style="list-style-type: none">• Characterisation of the parents: age, profession, education;• Type of family;• Constitution of the household;• Familial income;• Residence and living conditions.
DEVELOPMENT OF THE CHILD <ul style="list-style-type: none">• Characterisation of the child: age, sex, kindergarten attended, and position in the family;• Reasons for support of the team;• Diagnosis;• First concerns: at what age and how they manifested themselves;• First diagnosis: who made it and when;• Referral: age and waiting time;• Difficulties of the child (by areas);• Support received (by areas);• Beginning of support: time, place, and techniques involved;• Current support: professionals, responsible for the case and frequency;• Place of intervention;• Other support;• Global evaluation of the support received.
IMPACT ON THE DEVELOPMENT OF THE FAMILY <ul style="list-style-type: none">• Information;• Global evaluation of the information received;• Social Network and Inclusion in the community: who helped and support of EI;• Familial function;• Global evaluation of the adequacy of the support.

Chart 46 - Dimensions and variables of the questionnaires for the responsible for the case

DIMENSION	
• Variables	
CHARACTERISATION OF THE CHILD AND FAMILY	
<ul style="list-style-type: none"> • Characterisation of the child: age, sex, kindergarten attended, support team; • Characterisation of the parents: age, profession, education. 	
DEVELOPMENT OF THE CHILD	
<ul style="list-style-type: none"> • Reasons for support of the team; • Diagnosis; • First concerns: at what age and how they manifested themselves; • First diagnosis: who made it and when; • Referral: age and waiting time; • Beginning of support: time, place, and techniques involved; • Difficulties of the child (by areas); • Registered processes (by areas); • Current support: Professionals, Responsible for the case and frequency of support; • Place of intervention; • Other support; • Global evaluation of the results of the support supplied. 	
IMPACT ON THE DEVELOPMENT OF THE FAMILY	
<ul style="list-style-type: none"> • Information; • Global evaluation of the information supplied; • Social Network and Inclusion in the community: support of EI; • Familial function; • Global evaluation and adequacy of support. 	

[82]

5.3. Population and sample

The studied population is constituted of supported children, in a regular form, by a service or Early Intervention team and their respective families, in accordance with the data supplied by the regional coordination. In the 3 districts of Alentejo there are a total of 1,164 supported children, with some type of developmental disturbance or in

Chart 47 - Sample by regions

REGION	population	sample
	N	n
Beja	235	21
Évora	601	52
Portalegre	328	29
Total	1164	102

5. Evaluation of the impact on the development of the child and the family

an at-risk situation, with more than half of those in the municipalities in the region of Évora.

Among these a random selection was made of 102 children that constituted the sample studied, in a distribution that respects the differences between regions and covers all the municipalities in which the Early Intervention network functions. For the constitution of the sample we took into account the relative numbers from the 2005/2006 school year, though the collection of data only was realised throughout the following year.

The response to the questionnaire was done only by the mother in the great majority of the cases (85.3%) and in the remaining by the father, by both parents together, grandparents, or aunts and uncles.

5.3.1. Characterisation of the children

The distribution of the supported children grows very unexpectedly in the class of 6 year olds and up, the maximum age limit for eligibility for Early Intervention, with two identical groups in the classes up to 3 years and from 3 to 5 years. The use of a selected sample in a previous school year to the one when the data was collected contributed to this growth in the age level. 61.8% of the children are boys and 38.2% are girls.

Of the 102 children studied, 86 attend a kindergarten in the public system or private nurseries/kindergartens (including the independent system of establishments pertaining to IPSS and other situations of private establishments). Only 15.7% are

Chart 48 - Interviewed family

INTERVIEWED	n	%
Mother	87	85,3
Father	5	4,9
Grandparents	7	6,9
Aunts/Uncles	1	1,0
Both parents	2	2,0
Total	102	100

[83]

Chart 49 - Age distribution

AGES	n	%
< 3 years old	23	22,5
3 - 5 years old	23	22,5
6 and + years old	56	54,9
Total	102	100
Mean	55,80 months	
SD	20,580 months	
Minimum	4 months	
Maximum	84 months	

Chart 50 - Sex

SEX	n	%
Masculine	63	61,8
Feminine	39	38,2
Total	102	100

not in any educational establishment. In the responses of those responsible for the case there are slight variations (with there being only referred 48 integrated children) that owe themselves only to the new entries in the kindergarten that have not yet been registered by the team.

Around a third of the children are only children. After that, 27.5% are second children, 19.6% third and 15.7% are the oldest child in the family.

[84]

It is worth noting further that in 15% of the cases considered there are other siblings that are also supported by Early Intervention.

In the interview with the family we opted to solicit the information as to whether the support of the Early Intervention team is just to the development problems of the child, with the alternative YES or NO. We do not inquire as to the differentiation between handicap and social risk due to ethical concerns, because it could be too intrusive or threatening, and there was no information about the way in which the family and the team had justified the received support.

In 58.8% of the cases the family indicated the existence of a developmental problem of the child. In these cases in which the response was YES the following question asked for the diagnosis of the child, following the form of an open question, which was later categorised. Asked about the nature of the development problems, the families mostly referred to disturbances in speech

Chart 51 - Education situation

ESTABLISHMENT	n	%
Public kindergarten	51	50,0
Private nursery/kindergarten	35	34,3
No attendance	16	15,7
Total	102	100

Chart 52 - Position in the family

POSITION	n	%
Only child	32	31,4
Oldest	16	15,7
Second	28	27,5
Third	20	19,6
Fourth	3	2,9
Fifth	3	2,9
Total	102	100

Chart 53 - Global diagnosis of developmental problems

PROBLEMS	n	%
Yes	60	58,8
No	42	41,2
Total	102	100

Chart 54 - Type of developmental disturbance

DIAGNOSIS	n	%
Global developmental delay	9	15,0
Grave risk of delay	3	5,0
Disturbance within the spectrum of autism	3	5,0
Cerebral Palsy	4	6,7
Down Syndrome	3	5,0
Hyperactivity and Attention Deficit	2	3,3
Disturbance of language	17	28,3
Other	13	21,7
DK/DA	6	10,0
Total	60	100

5. Evaluation of the impact on the development of the child and the family

(28.3%) and global delay in development (15.0%) with the rest of the disturbances being quite dispersed or described in a form that could not be categorised.

In the cases in which those inquired responded that there were no disturbances in development (41.2%), they were asked for what reason they were being supported by Early Intervention. The families once again referred to difficulties in language and altered behaviour (26.2%) as well as the existence of a situation of social or familial risk (21.4%).

5.3.2. Characterisation of the family

As far as the characterisation of the family goes, with regard to ages, the fathers are, on average, older (35.72 years), registering only one case of age of less than 20 years, while 5 mothers are younger than this age.

Regarding the professional activity of the parents it is true that there are many unemployed, especially among the mothers. The fathers are mostly unqualified workers and operators.

More than a third of the fathers have only the first cycle of basic education and 70.7% have qualifications equal to or inferior to the 6th year. In mothers there is more predominance of the second cycle, as well as the 9th year of education.

Chart 55 - Diagnosis without developmental disturbance

DIAGNOSIS	n	%
Behavioural changes	11	26,2
Difficulties in attention/concentration	1	2,4
Difficulties in language	11	26,2
Risk of delay	4	9,5
Social/familial risk situation	9	21,4
DK/DA	6	14,3
Total	42	100

[85]

Chart 56 - Ages of the parents

AGE	father		mother	
	n	%	n	%
< 20 years old	1	1,0	5	4,9
20 - 29 years old	17	16,7	32	31,4
30 - 39 years old	52	51,0	52	51,0
40 - 49 years old	28	27,5	12	11,8
50 and + years old	2	2,0	0	0,0
DK/DA	2	2,0	1	1,0
Total	102	100,0	102	100
N	100		101	
Mean	35,72		31,47	
SD	7,589		6,945	
Minimum	19		17	
Maximum	64		48	

Chart 57 - Professional activity of the parents

PROFESSIONAL ACTIVITIES	father		mother	
	n	%	n	%
Member of the Armed Forces	2	2,1	0	0,0
Superiors in Administration and Careers	2	2,1	1	1,0
Specialists of intellectual and scientific professions	4	4,2	7	7,0
Technicians in intellectual and scientific professions	2	2,1	2	2,0
Administrative personnel and similar	4	4,2	4	4,0
Service personnel and sellers	11	11,6	13	13,0
Farmers and qualified farm/fishing workers	3	3,2	0	0,0
Operators, craftsmen, and similar work	17	17,9	2	2,0
Other qualified workers	6	6,3	0	0,0
Unqualified workers	27	28,4	15	15,0
Students, unemployed, and similar	17	17,9	56	56,0
Total	95	100,0	100	100

[86]

In the most part of cases (67.6%) the family consists of a couple, married or in a civil union, although in 13.7% there is a situation of reconstitution familiar, and in 10.8%, single parent families.

The family, aside from the parents and the children, also includes the grandparents in 11.8% of the situations and, sometimes, aunts/uncles, cousins, or other elements of the extended family.

There is a lot of variability as far as the number of elements in the aggregated family, the most typical being the situation of 4 elements (34.3%).

The familial income is, as a general rule, extremely low: almost 40% of the families live with incomes

Chart 58 - Educational qualifications of the parents

EDUCATIONAL QUALIFICATIONS	father		mother	
	n	%	n	%
Cannot read nor write	2	12,0	4	4,0
Can read and write	7	7,1	4	4,0
Primary School/1st Cycle	33	33,3	19	19,0
Preparatory Cycle	28	28,3	36	36,0
9th school year	10	10,1	16	16,0
11th/12th school year	10	10,1	9	9,0
Professional studies	1	1,0	2	2,0
University graduate	8	8,1	10	10,0
Total	99	100,0	100	100

Chart 59 - Type of family

FAMILY	n	%
Parents married/legal union	69	67,6
Reconstructed family (second marriage)	14	13,7
Single-parent family	11	10,8
Other	8	7,8
Total	102	100

5. Evaluation of the impact on the development of the child and the family

lower than 500 euros and close to 90% lower than 1,500 euros per month.

The families were asked if the house they live in corresponds to their needs. In the great majority of the cases, the response was positive. The negative responses were justified by the lack of space and an insufficient number of divisions. In many of the cases they also referred to problems of humidity, illumination, or basic sanitation.

Chart 60 - Constitution of the aggregated family

FAMILY	n	%
Parents	96	94,1
Children	97	95,1
Grandparents	12	11,8
Uncles/aunts	7	6,9
Cousins	4	3,9
Other elements	2	2,0

Chart 61 - Number of elements of the family

ELEMENTS	n	%
2	6	5,9
3	29	28,4
4	35	34,3
5	18	17,6
6	11	10,8
7	3	2,9
Total	102	100

[87]

Chart 62 - Familial income

MONTHLY INCOME	n	%
< 385€	14	14,1
385€ - 500€	25	25,3
500€ - 1000€	33	33,3
1000€ - 1500€	17	17,2
1500€ - 2000€	5	5,1
> 2000€	5	5,1
Total	99	100

Chart 63 - Satisfaction with house

SATISFACTION	n	%
Yes	84	82,4
No	18	17,6
Total	102	100
REASONS FOR NO		%
Insufficient number of divisions		72,2
Problems with humidity		44,4
Too little space for children		38,8
No basic sanitation		16,6
Little light		11,1
Other reasons		11,1
Has some/many stairs		0,0

5.4. Results

We will present the results obtained in 4 large groups: a) the characterisation of the development of the child, b) the characterisation of the support, c) the impact of the early intervention on the development of the child, d) impact on the development of the family, and e) global evaluation of the impact.

5.4.1. Characterisation of the development of the child

[88]

5.4.1.1. Signalizing and diagnosis of the child

As was referred to previously, in 60 of the 102 cases the parents said there were developmental problems with the child that justified the support of the Early Intervention network. Those responsible for the case characterised the children in another form, pointing out 21.6% as bearers of handicaps, 42.2% as having (other) developmental problems and 23.5% as living in a situation of developmental risk. They also referenced 13 more cases in which the accompaniment in EI did not occur in any of these situations.

In a more concrete explanation of the type of problems of the supported children, those responsible for the case identified 22 cases of disturbances of language, 19 cases of global delay in development, 11 of other delays (aside from the cases of Cerebral Palsy, Down Syndrome, or disturbances in the spectrum of autism). In 11 cases the motive of the accompaniment occurred in the situation of social/familial risk, and there was no other additional problem. There are 8 cases in which it was not possible to make a diagnostic identification.

Chart 64 - Justification of support: responsible for the case

JUSTIFICATION OF THE SUPPORT	n	%
Bearer of a handicap	22	21,6
Has developmental problems	43	42,2
Lives in a situation of risk for development	24	23,5
Other reason	13	12,7
Total	102	100

Chart 65 - Diagnosis: responsible for the case

DIAGNOSIS	n	%
Global delay in development	19	18,6
Risk of grave delay of development	8	7,8
Situation of social/familial risk	11	10,8
Disturbances of language	22	21,6
Auditory problems	1	1,0
Visual problems	2	2,0
Changes in behaviour	9	8,8
Disturbances in the Autistic Spectrum	3	2,9
Cerebral Palsy	5	4,9
Down Syndrome	3	2,9
Other delay	11	10,8
No diagnosis	8	7,8
Total	102	100

5. Evaluation of the impact on the development of the child and the family

The difficulty in making a clear diagnostic identification is notable, appearing classes essentially descriptive and symptomatic, that don't necessarily represent changes in development, simultaneous with definitions that are clearly etiological. Refer to the use of the very broad categories 'GLOBAL DEVELOPMENTAL DELAY', 'RISK OF GRAVE DEVELOPMENTAL DELAY', 'CHANGES IN BEHAVIOUR', 'OTHER DELAY' and in cases in which there is no diagnosis.

5.4.1.2. From the emergence of the problem to the beginning of the EI process

We looked to find out, alongside the families and those responsible for the case, the way in which the problem emerged and how the detection, the diagnosis, the referral, and the beginning of intervention were done.

Referring to the moment in which the first concerns with the development of the child emerged, the parents, in an elevated percentage (42.2%) said that they don't know at what age is occurred (or simply did not respond). This response is understandable considering that, as we have seen, only in a part of cases is there a clear identification of a disturbance.

Those responsible for the case situated the emergence of the first concerns at up to 1 year of age in 36.6% of cases and then 25% for the periods between 1 - 2 years and 3 - 5 and 8.8% from 6 years on. We can then verify that the majority of difficulties linked with the disturbances of development emerge fairly early, on average around one year and a half of age, though with a strong variability.

Chart 66 - Emergence of problem

AGE	parents	res. case
	%	%
< 1 year	27,5	36,3
1 - 2 years	14,7	25,5
3 - 5 years	15,7	26,5
6 and +years	0	8,8
NS/NR	42,2	2,9
Total	100	100
Mean	17,36 months	23,36 months
SD	17,841 months	20,163 months

[89]

Chart 67 - Identification of the problem

WHO IDENTIFIED IT	parents	res. case
	%	%
Family	28,4	25,5
Kindergarten teacher	9,8	25,5
EI team	1,0	2,9
Health Centre	2,0	10,8
Hospital	16,7	22,5
Social Security	0	4,9
CPCJ	0	2,0
Other	0	2,0
DK/DA	2,0	0
NA	40,2	0
Total	100	100

These first concerns began to be identified by the family (between 28.4% according to them and 25.5% according to those responsible for the case). Second to the family in the detection of these difficulties was the hospital, although the technicians of kindergarten teachers appeared as some of the principals responsible for the initial identification of the problem. Once more we call your attention to the fact that the responses of the family refer only to the cases of disturbance in the development while the numbers of those responsible for the case also include those children at social or familial risk, which can bring us to think that the identification of the latter is essentially done by educators.

[90]

Considering the age of the child when the first diagnosis was made, the parents point to an average of 23 and a half months, though also with great variability. During the first year of life 23.5% are diagnosed (or 39.8% in cases with disturbance of development). Compared with the previous chart we can conclude that there is an average gap of around 6 months between the first concerns and the first diagnosis. Also considering the responses of those responsible for the case we can verify a decrease of 3 and 4% in the younger ages and an increase in the diagnosis in the older ages. These are situated before the end of the 1st year in 33.3% of cases, plus 21.6% between 1 and 2 years and 32.4%

Chart 68 - Age of child at the time of diagnosis

	parents	res. case
AGE	%	%
< 1 year	23,5	33,3
1 - 2 years	10,8	21,6
3 - 5 years	23,5	32,4
6 and + years	0	10,8
DK/DA	42,2	2,0
N	102	102
Mean	23,56 months	25,92 months
SD	19,744 months	20, 715 months

Chart 69 - Origin of diagnosis

	parents	res. case
WHO MADE THE DIAGNOSIS	%	%
Health centre	1,6	4,9
Hospital	54,0	34,3
Specialised centre	3,2	1,0
Social Security	1,6	2,0
EI team	31,7	38,2
Education	0	3,9
CPCJ	0	3,9
Other professionals	1,6	2,0
DK/DA	6,3	8,8
N	63	101

5. Evaluation of the impact on the development of the child and the family

between 3 and 5 years. 10.8% of cases are only diagnosed at 6 years or after.

The diagnosis of the problematic situation (or risk) in the development of the child was made predominantly by the EI team (38.2%) and by the hospital (34.3%). Considering only the cases referred to by the parents, the percentage of the hospital increases understandably (as well as the specialised centre) in detriment of education and of organisations of social protection.

Considering the time at which the child was referred to the Early Intervention network, the average age stands at 29.65 months, according to the parents. Those responsible for the case put the figure at 20.6% in the 1st year, 48.1% before 3 years and the rest after 3 years of age, including 10.8% with 6 years or more.

Between the first concerns and signs and the referral to an intervention program the time passed was, on average, one year, which, without a doubt, is too much.

The referral to Early Intervention was made mostly by educators (kindergartens, teachers, etc.) and by the hospital. In the description made by those responsible for the case the number of cases sent by Health Centres, Social Security, CPCJ and specialised centres is greater, but without significant differences.

Chart 70 - Time of referral

	parents	res. case
AGE	%	%
< 1 year	19,6	20,6
1 - 2 years	28,4	27,5
3 - 5 years	46,1	39,2
6 and+ years	1,0	10,8
DK/DA	4,9	2,0
N	102	102
Mean	29,65 months	30,14 months
SD	19,402 months	18,774 months

[97]

Chart 71 - Entity of referral

	parents	res. case
WHO SENT	%	%
Health centre	6,9	11,8
Hospital	24,5	20,6
Educators	36,3	28,4
Social Security	9,8	11,8
Specialised centre	0	5,9
Family	4,9	7,8
CPCJ	0	4,9
Other situation	10,8	6,9
DK/DA	6,9	2,0
N	102	102

Chart 72 - Time between referral and intervention

	parents	res. case
TIME	%	%
< 1 week	13,0	28,7
1 - 2 weeks	29,0	21,8
< 1 month	15,0	19,8
1 - 3 months	10,0	14,9
3 and+ months	6,0	8,9
DK	27,0	5,9
N	100	101

The time elapsed between the referral and the first contact was less than 1 month in 70.3% of the cases. Even though the parents in 27% of the cases could not identify the time elapsed, they always considered it to be very short.

Regarding the hosting of cases by the Early Intervention team, the first contact was most frequently made by the kindergarten teacher or by the psychologist, though all the other technicians intervened in reception situations in new cases.

This first contact was made in the home of the child in 45.1% of the cases, at the headquarters of the team (26.5%) or in the nursery/ kindergarten attended by the child (19.6%).

Chart 73 - Professional in the first contact of EI team

PROFESSIONAL	n	%
Educator	22	21,6
Psychologist	22	21,6
Technician of Social Security	9	8,8
Therapist	15	14,7
Nurse	1	1,0
Educator + Therapist	6	5,9
Educator + Psychologist	3	2,9
Educator + Social worker	11	10,8
Psychologist + Therapist	1	1,0
Psychologist + Social worker	5	4,9
Social worker + Therapist	1	1,0
Other	2	2,0
DK/DA	4	3,9
Total	102	100

Chart 74 - Place of the first contact with EI team

PLACE	n	%
Household	46	45,1
Nanny's house	1	1,0
Nursery/kindergarten	20	19,6
Team headquarters	27	26,5
Other place	3	2,9
DK/DA	5	4,9
Total	102	100,0

5. Evaluation of the impact on the development of the child and the family

5.4.2. Characterisation of the intervention

Consistent with the functioning period of the teams and the network, the average time of accompaniment of the children was close to 2 years, with 80.4% of children accompanied for less than 3 years.

The one responsible for the case of the children and families accompanied is most frequently the teacher, though there is some discrepancy between the identification done by families and the reality described by the teams, which points to the tendency of families to attribute this responsibility to therapists that have direct intervention in the case.

As we did with the teachers, now we also look for where the intervention took place, verifying that it is divided between the nursery/kindergarten and the household. The most frequent situation is that it occurs only in the nursery/kindergarten (36% according to the families and 24.5% according to those responsible), but many times it is divided between the two, although almost always in the kindergarten.

In that which refers to the type of support that is given to the children and families, we can verify that there can be regular support among the different professionals of the teams. The kindergarten teacher is the one that is most present, in more than a half of the cases of regular support, with their biweekly appearance 50% of the cases. The speech therapist also intervenes in 50% of the cases, the psychologist in 35% and the Social Worker in 26%. The differences between the responses of the technicians and of the families are more significant with regards to the teachers, speech therapists, and physiotherapists, which make up 4%, which one can attribute to the difficulties of identification of the technicians having different understandings of

Chart 76 - Responsible for the case

	parents	res. case
TECHNICIAN	%	%
Kindergarten teacher	30,4	36,3
Social worker	5,4	6,9
Psychologist	19,6	21,6
Physiotherapist	7,6	9,8
Speech therapist	20,7	18,6
Occupational therapist	6,5	3,9
Other	2,2	2,9
Don't know/don't remember	7,6	0
N	92	102

Chart 75 - Current duration of accompaniment

TIME	n	%
< 1 year	17	16,7
1 - 2 years	65	63,7
3 - 5 years	18	17,6
6+ years	1	1,0
DK/DA	1	1,0
Total	102	100
Mean	24,42 months	
SD	15,066 months	
Minimum	2 months	
Maximum	81 months	

Evaluation of early intervention impact in Alentejo: *child, family and community*

Chart 77 - Where the intervention took place

PLACE	parents	res. case
	%	%
Always in the home	14,0	12,7
Always in nursery/kindergarten	36,0	24,5
Always in team headquarters	10,0	8,8
Almost always in the home, some times in nursery/kindergarten	2,0	2,9
Almost always in the home, sometimes in team headquarters	2,0	4,9
Almost always in nursery/kindergarten, sometimes in the home	14,0	20,6
Almost always in the team headquarters, sometimes in the home	1,0	1,0
Alternating between the home, nursery/kindergarten, and team headquarters	7,0	7,8
Other situation	14,0	16,7
N	100	102

[94]

what constitutes regular intervention, principally an elevated lack of knowledge of the parents regarding the eventual involvement of some technicians in the process.

Chart 78 - Characterisation of Intervention

INTERVENTION	N	regular intervention		intervention							
		n	%	daily	biweekly	weekly	bimonthly	monthly	monthly ^	monthly dk	
Kindergarten teacher	responsible for the case	102	60	58,8	10,0	50,0	30,0	5,0	5,0	0,0	
	parents	100	54	54,0	11,1	29,6	40,7	0,0	1,9	1,9	11,1
Speech therapist	responsible for the case	102	53	52,0	0,0	13,2	77,4	3,8	3,8	1,9	
	parents	100	48	48,0	0,0	20,8	66,7	6,3	2,1	2,1	2,1
Psychologist	responsible for the case	102	35	34,3	0,0	8,6	42,9	11,4	20,0	22,9	
	parents	100	35	35,0	0,0	2,9	57,1	8,6	11,4	11,4	11,4
Social worker	responsible for the case	102	26	25,5	0,0	7,7	34,6	11,5	15,4	38,5	
	parents	100	26	26,0	0,0	7,7	34,6	3,8	11,5	11,5	7,7
Physiotherapist	responsible for the case	102	22	21,6	0,0	59,1	27,3	4,5	0,0	9,1	
	parents	100	17	17,0	0,0	41,2	58,8	0,0	0,0	0,0	0,0
Occupational therapist	responsible for the case	102	12	11,8	0,0	8,3	83,3	0,0	0,0	0,0	
	parents	100	12	12,0	0,0	33,3	58,3	0,0	0,0	0,0	16,7
Nurse	responsible for the case	102	3	2,9	0,0	33,3	66,7	0,0	0,0	0,0	
	parents	100	2	2,0	0,0	0,0	0,0	0,0	50,0	50,0	50,0
Other technician	responsible for the case	102	8	7,8	12,5	25,0	25,0	25,0	0,0	12,5	
	parents	100	7	7,0	28,6	14,3	0,0	14,3	0,0	0,0	14,3

5. Evaluation of the impact on the development of the child and the family

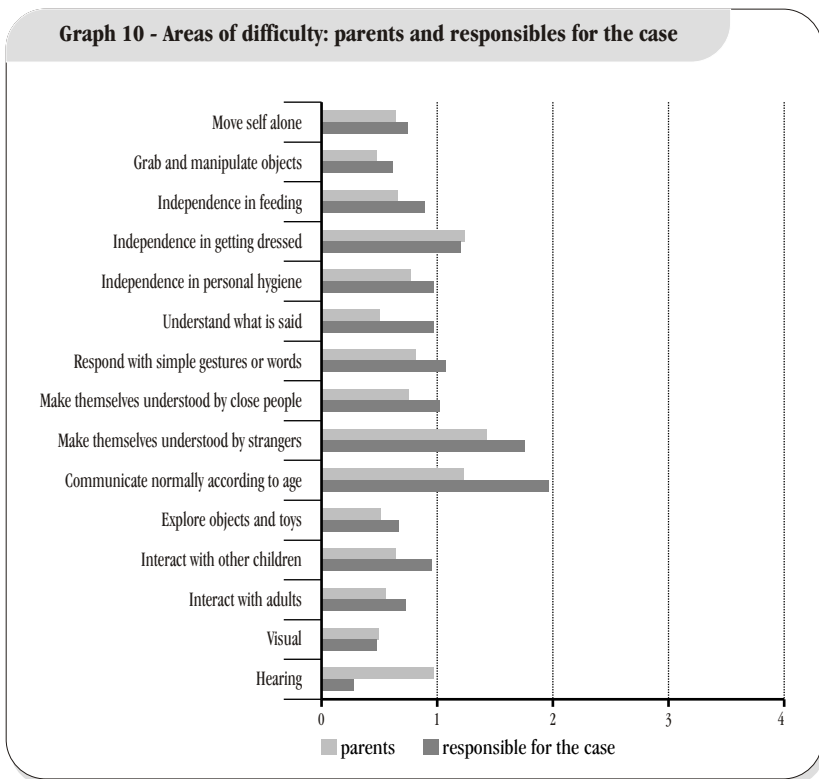
5.4.3. Impact on the development of the child

Concerning ourselves with having a perspective of evaluation regarding what the parents and those responsible for the case make of the changes occurring in the development of the child we started by identifying the areas in which some considered there to be difficulties. This evaluation was done in 5 areas: a) Mobility, b) Personal independence, c) Communication and language, d) Social interaction, e) Sensorial deficit (visual and auditory). For each of the first for we used some of the most frequent difficulties, in a way in which the parents could understand and respond to all of the questions.

In the **charts 79 and 80** we present the perspective of the parents, of those responsible for the case and a comparative representation of the two. In a general way, those responsible for the case accentuated the existence of difficulties more, while the parents presented numbers greater only in INDEPENDENCE IN GETTING DRESSED, VISION, and HEARING.

[95]

Graph 10 - Areas of difficulty: parents and responsables for the case



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[96]

Chart 79 - Areas of difficulty: parents				none	few	some	much	very much			
AREAS OF DIFFICULTY OF THE CHILD				N	\bar{x}	d.p.	%	%	%	%	%
Motor skills	Move self alone			101	0,64	1,285	77,2	2,0	7,9	5,0	7,0
	Grab and manipulate objects			101	0,48	0,986	78,2	4,0	11,9	4,0	2,0
Personal independence	Independence in feeding			101	0,66	1,125	68,3	9,9	12,9	5,0	3,9
	Independence in getting dressed			101	1,24	1,358	47,5	9,9	19,8	16,8	5,9
	Independence in personal hygiene			100	0,77	1,325	70,6	2,9	6,0	14,0	5,0
Communication language	Understand what is said			101	0,50	0,986	76,2	5,0	11,8	5,9	1,0
	Respond with simple gestures or words			101	0,81	1,155	61,4	9,9	16,8	9,9	2,0
	Make themselves understood by people close to them			101	0,75	1,004	58,4	14,9	19,8	6,9	0,0
	Make themselves understood by strangers			101	1,43	1,322	37,6	11,9	27,7	15,8	6,9
	Communicate normally according to age			9	1,23	1,361	47,5	10,1	21,2	14,1	7,1
Social interaction	Explore objects and toys			100	0,51	1,059	79,0	2,0	10,0	7,0	2,0
	Interact with other children			100	0,64	1,177	73,0	6,0	9,0	8,0	4,0
	Interact with adults			100	0,55	1,019	74,0	6,0	12,0	7,0	1,0
Vision			100	0,49	1,040	79,0	4,0	8,0	7,0	2,0	
Hearing			100	0,97	1,480	85,0	6,0	4,0	4,0	1,0	

Chart 80 - Areas of difficulty: responsables for the case				none	few	some	much	very much			
AREAS OF DIFFICULTY OF THE CHILD				N	\bar{x}	d.p.	%	%	%	%	%
Motor skills	Move self alone			102	0,74	1,193	67,6	7,8	10,8	10,8	2,9
	Grab and manipulate objects			102	0,61	1,091	71,6	12,9	12,9	2,9	3,9
Personal independence	Independence in feeding			101	0,89	1,272	59,4	12,9	12,9	8,9	5,9
	Independence in getting dressed			101	1,20	1,379	49,5	8,9	22,8	9,9	8,9
	Independence in personal hygiene			101	0,97	1,323	58,4	8,8	22,8	9,9	8,9
Communication language	Understand what is said			102	0,97	1,301	57,8	10,8	11,8	15,7	3,9
	Respond with simple gestures or words			102	1,07	1,315	52,9	9,8	21,6	8,8	6,9
	Make themselves understood by people close to them			102	1,02	1,235	50,0	16,7	20,6	6,9	5,9
	Make themselves understood by strangers			102	1,75	1,410	31,4	7,8	26,5	22,5	11,8
	Communicate normally according to age			101	1,96	1,414	24,8	9,9	26,7	21,8	16,8
Social interaction	Explore objects and toys			101	0,67	1,167	69,3	9,9	8,9	7,9	4,0
	Interact with other children			102	0,95	1,308	58,8	9,8	14,7	10,8	5,9
	Interact with adults			102	0,72	1,164	67,6	7,8	12,7	8,8	2,9
Vision			102	0,48	1,035	80,2	2,0	10,9	4,0	3,0	
Hearing			102	0,28	0,849	88,2	2,0	4,9	2,9	2,0	

5. Evaluation of the impact on the development of the child and the family

Chart 81 - Evaluation of the help of EI:parents

				none	some	much	very much			
SUPPORT RECEIVED				%	%	%	%			
				N	\bar{x}	d.p.				
Motor skills	Move self alone			33	2,94	0,294	6,1	24,2	39,4	30,3
	Grab and manipulate objects			31	2,84	0,735	0,0	35,5	45,2	19,4
	Independence in feeding			38	2,66	0,847	10,5	26,3	50,0	13,2
Personal independence	Independence in getting dressed			51	2,29	0,879	19,6	39,2	33,3	7,8
	Independence in personal hygiene			40	2,35	0,864	15,0	45,0	30,0	10,0
	Understand what is said			49	2,88	0,781	4,1	24,5	51,0	20,4
Communication language	Respond with simple gestures or words			55	2,89	0,854	7,3	20,0	49,1	23,6
	Make themselves understood by people close to them			61	2,74	0,835	8,2	26,2	49,2	16,4
	Make themselves understood by strangers			72	2,58	0,868	8,3	41,7	34,3	16,7
	Communicate normally according to age			68	2,81	0,815	4,4	30,9	44,1	20,6
	Explore objects and toys			43	2,74	0,693	4,7	25,6	60,5	9,3
Social interaction	Interact with other children			43	2,65	0,870	11,6	25,6	48,8	14,0
	Interact with adults			43	2,53	0,960	16,3	30,2	37,2	16,3
	Vision			17	2,24	1,200	41,2	11,8	29,4	17,6
Hearing			12	2,83	1,267	25,0	8,3	25,0	41,7	

[97]

Chart 82 - Evaluation of the development of the child according to those responsible for the case

				none	some	much	very much			
CHILD DEVELOPMENT				%	%	%	%			
				N	\bar{x}	d.p.				
Motor skills	Move self alone			40	2,83	0,657	0,0	32,5	52,5	15,0
	Grab and manipulate objects			35	2,63	0,690	2,9	40,0	48,6	8,6
	Independence in feeding			47	2,26	0,736	12,8	53,2	29,8	4,3
Personal independence	Independence in getting dressed			49	2,08	0,607	12,2	69,4	16,3	2,0
	Independence in personal hygiene			47	2,23	0,729	14,9	48,9	34,0	2,1
	Understand what is said			55	2,53	0,690	1,8	52,7	36,4	9,1
Communication language	Respond with simple gestures or words			56	2,64	0,749	3,6	41,1	42,9	12,5
	Make themselves understood by people close to them			60	2,53	0,676	3,3	46,7	43,3	6,7
	Make themselves understood by strangers			73	2,41	0,723	5,5	56,2	30,1	8,2
	Communicate normally according to age			80	2,49	0,693	5,0	47,5	41,3	6,3
	Explore objects and toys			47	2,66	0,635	0,0	42,6	48,9	8,5
Social interaction	Interact with other children			51	2,49	0,731	5,9	47,1	39,2	7,8
	Interact with adults			46	2,54	0,721	2,2	52,2	34,8	10,9
	Vision			17	2,19	0,834	23,5	29,4	41,2	0,0
Hearing			11	2,67	1,073	9,1	54,5	9,1	36,4	

Evaluation of early intervention impact in Alentejo: *child, family and community*

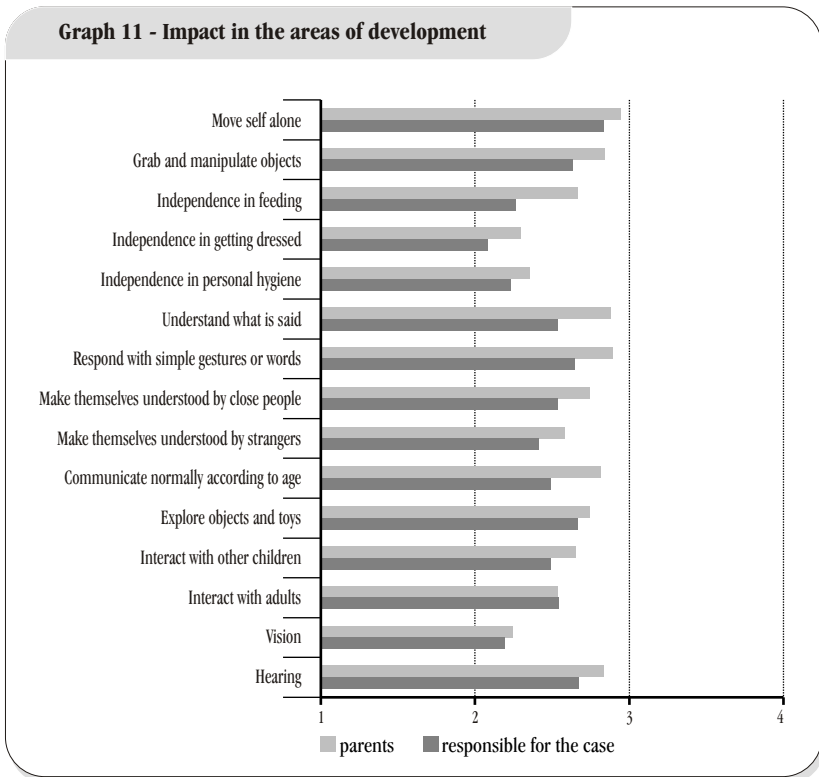
The first difficulties identified by the parents are INDEPENDENCE IN GETTING DRESSED, MAKE THEMSELVES UNDERSTOOD BY STRANGERS and COMMUNICATE NORMALLY ACCORDING TO AGE. The smallest incidence of difficulties was found in the visual and motor dimensions, GRAB AND MANIPULATE OBJECTS, UNDERSTAND WHAT IS SAID, EXPLORE OBJECTS AND TOYS and INTERACT WITH ADULTS.

The technicians identified the greatest difficulties on the level of oral communication (COMMUNICATE NORMALLY ACCORDING TO AGE, MAKE THEMSELVES UNDERSTOOD BY STRANGERS) and INDEPENDENCE IN GETTING DRESSED. The smallest incidence of difficulties is in the HEARING and VISUAL dimensions, GRAB AND MANIPULATE OBJECTS, EXPLORE OBJECTS AND TOYS, and MOVE SELF ALONE.

[98]

Passing now the evaluation of the impact of intervention on these difficulties of development, we are taking into account only the cases in which difficulties were referred. When asking in what way Early Intervention will help in the face of these difficulties, the responses were given in 4 categories: DIDN'T HELP AT ALL, HELPED SOME, HELPED A LOT, HELPED VERY MUCH.

Graph 11 - Impact in the areas of development



5. Evaluation of the impact on the development of the child and the family

In a general way of speaking the parents greatly valued the support received from Early Intervention, in all areas, more than those responsible for the case. They accentuated particularly the help on the level of motor skills (MOVE SELF ALONE, GRAB AND MANIPULATE OBJECTS) in which almost 70% referred to the help received as very or extremely helpful, and on the level of language (RESPOND WITH GESTURES OR SIMPLE WORDS and UNDERSTAND WHAT IS SAID) in which this percentage surpasses 70%.

The lowest numbers appear in PERSONAL INDEPENDENCE (INDEPENDENCE IN GETTING DRESSED and INDEPENDENCE IN PERSONAL HYGIENE) in which the percentage in which the support received is considered little or not at all helpful reaches 60% and in Vision, in with 41.2% of the families did not refer to any help.

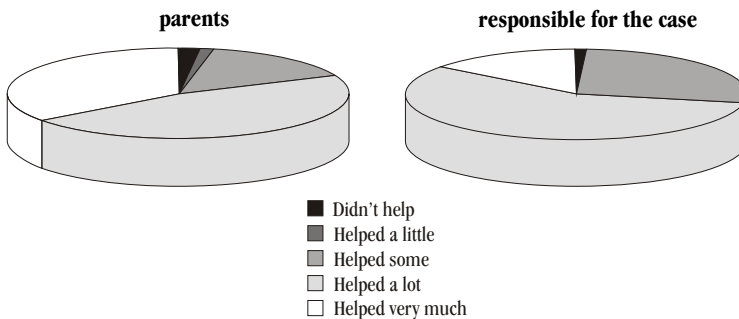
Those responsible for the case also value most the success in MOTOR SKILLS (MOVE SELF ALONE, with almost 70% saying VERY or EXTREMELY, and GRAB AND MANIPULATE OBJECTS) as well as RESPOND WITH GESTURES OR SIMPLE WORDS and HEARING (this with a distribution with two distinctive bars between SOME and VERY MANY). The least successes were registered in Vision (52.9% saying little or no help) and in the three dimensions of personal independence.

Chart 83 - Global evaluation of the impact of EI on the development of the child

	parents	res. case
HELP RECEIVED	%	%
Didn't help	2,0	1,0
Helped little	1,0	0,0
Helped some	14,9	26,5
Helped a lot	47,5	57,8
Helped very much	34,7	14,7
N	101	102
Mean	4,12	3,85
SD	0,840	0,695

[99]

Figura 12 - Global evaluation of EI impact: parents and res. for the caso



We also asked the families and those responsible for the case to do a global evaluation of the registered progress in the development of the child.

The parents evaluated in a very favourable way the all-around impact of EI in the development of the child, once again with values more positive than those collected from those responsible for the case. 82.2% said that the support contributed by EI towards the registered progress was MUCH or VERY MUCH and only 3% said it was FEW or NONE. Those responsible for the case registered less cases in which they thought that the help of EI in the progress of the child was VERY MUCH, using as evidence the categories MUCH (57.8%) and SOME (26.5%).

[100]

5.4.4. Impact on the development of the family

Early Intervention defines itself as being centred on the child and the family (Despacho 891/99, art. 2) - that is to say, assume that the family, with a context close to development, has a predominant role in its promotion. It is challenged, for this reason, to verify the type and profundity of the impact that the actions of the Early Intervention network has on the families themselves.

5.4.4.1. Impact at the level of information

We presented to the families, and to those responsible for the case, a collection of 8 items related to the information, in relation to the fact that the investigation about Early Intervention shows that this can drive the results: information about the process of development and the learning of children, about their problems and their capacities, information about the therapies and supports that exist and the most adequate, and information about the rights of the family.

Chart 84 - Impact about the information: parents				none	few	some	much	very much
THE SUPPORT OF EI HELPED TO	N	\bar{x}	d.p.	%	%	%	%	%
Get to know the way in which the children develop and how they learn	98	3,41	1,120	11,2	4,1	29,6	42,9	12,2
Understand better the developmental problems of the child	98	3,43	1,121	11,2	6,1	21,4	51,0	10,2
Get to know better the capacities of the child	98	3,49	1,048	8,2	6,1	25,5	49,0	11,2
Have more information about the therapies and support that exist	98	3,41	1,073	10,2	4,1	30,6	44,9	10,2
Know what therapies and support the child needs	98	3,37	1,187	14,3	4,1	23,5	46,9	11,2
Know where to find the support	97	3,18	1,283	20,6	3,1	23,7	43,3	9,3
Have information about the existing financial support	97	2,34	1,376	45,4	7,2	20,6	20,6	5,2
Have information about the rights as the family of a child with developmental problems	96	2,46	1,421	43,8	4,2	20,8	25,0	6,3

5. Evaluation of the impact on the development of the child and the family

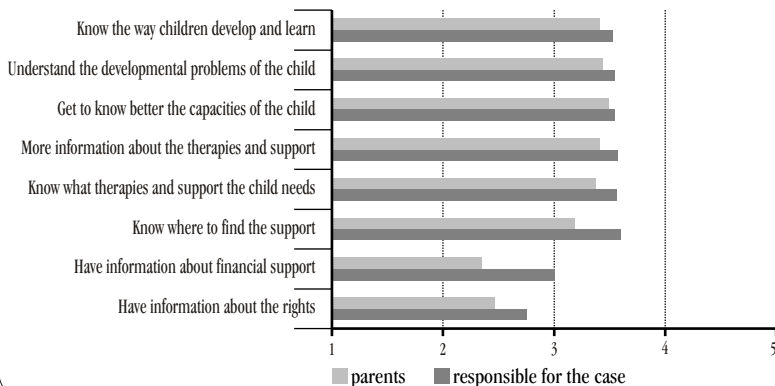
The responses of the parents are concentrated for the most part in the categories VERY, except in the last two points (HAVE INFORMATION ABOUT THE EXISTING FINANCIAL SUPPORT and HAVE INFORMATION ABOUT THE RIGHTS AS THE FAMILY OF A CHILD WITH DEVELOPMENTAL PROBLEMS) between which they were distributed more uniformly between VERY and SOME. The categories chosen most were: GET TO KNOW BETTER THE CAPACITIES OF THE CHILDREN (60.2% of A LOT or VERY MUCH), UNDERSTAND BETTER THE DEVELOPMENTAL PROBLEMS OF THE CHILDREN (61.2%), GET TO KNOW THE WAY IN WHICH THE CHILDREN DEVELOP AND HOW THEY LEARN (55.1%) and HAVE MORE INFORMATION ABOUT THE THERAPIES AND SUPPORTS THAT

Chart 85 - Impact about the information: res. for the case

THE SUPPORT OF EI HELPED TO	N	\bar{x}	d.p.					
				none	little	some	much	very much
				%	%	%	%	%
Get to know the way in which the children develop and how they learn	102	3,52	0,767	2,9	1,0	44,1	45,1	6,9
Understand better the developmental problems of the child	101	3,54	0,781	3,0	3,0	36,6	51,5	5,9
Get to know better the capacities of the child	102	3,54	0,829	3,9	2,0	38,2	48,0	7,8
Have more information about the therapies and support that exist	102	3,57	0,885	4,9	2,9	31,4	52,0	8,8
Know what therapies and support the child needs	102	3,56	0,939	5,9	3,9	28,4	52,0	9,8
Know where to find the support	102	3,60	0,836	2,9	4,9	30,4	52,9	8,8
Have information about the existing financial support	100	3,00	1,333	23,0	8,0	26,0	32,0	11,0
Have information about the rights as the family of a child with developmental problems	100	2,75	1,184	23,0	12,0	36,0	25,0	4,0

[101]

Graph 13 - Impact about the information: parents and res. case



EXIST (55.1%). The categories in which they considered EI to have helped the least were: HAVE INFORMATION ABOUT THE EXISTING FINANCIAL SUPPORT and HAVE INFORMATION ABOUT THE RIGHTS AS THE FAMILY OF A CHILD WITH DEVELOPMENTAL PROBLEM, in which 52.6% and 48.0%, respectively, considered that the support was none or little.

[102]

Comparing the responses of the parents with those of those responsible for the case, we can verify that these placed more value on KNOW WHERE TO FIND THE NECESSARY SUPPORT, HAVE MORE INFORMATION ABOUT THERAPIES AND SUPPORT THAT EXIST, and KNOW WHAT THERAPIES AND SUPPORT THE CHILD NEEDS. We can verify that, generally, those responsible for the case tend to value more positively than the families the support of EI on the level of information, in all the sections assessed.

Because we asked for a global evaluation of the way in which the information supplied through EI corresponds with the needs of the family, we can see that those responsible for the case tend to consider that this information responds MUCH to the needs of the family (63.6%), with a global average of 3.86 on a scale of 1 to 5, while with regards to the families, although they have an identical average, presented more responses of VERY MUCH (20.6%).

Chart 86 - Response to the need for information

?	parents		res. case	
	n	%	n	%
None	0	0,0	0	0,0
Few	5	4,9	0	0,0
Some	23	22,5	25	25,3
Much	49	48,0	63	63,6
Very much	21	20,6	11	11,1
Mean	3,88		3,86	
SD	0,803		0,589	

5. Evaluation of the impact on the development of the child and the family

5.4.4.2. Support of the social network and inclusion in the community

Another one of the aspects we looked to find was the elements of the social network that the family considers contributed most to helping and resolving the identified problems. Their responses attributed the most positive value to the Early Intervention team: 71.4% considered that they helped MUCH or VERY MUCH, with an average value that only the support of the family nears. All the other elements of the social network, formal or informal, have average values less than 3, with the kindergarten presenting an average of 2.98. Those pointed out as having contributed the least to the resolution of the problems of the family are: Red Cross/Firefighters, Parent groups, Authorities, and Local associations of rehabilitation or special education. Distinguished from those that didn't help only the intervention teams have a value of 2%, then we find the family (17.2%), family doctors (27.6%), and kindergarten (20.9%).

[103]

We also would like to see in what way EI had an impact on the inclusion of the family into the community. The results are much lower than those found relating to the information, situated always below the average level of 2.50 in the evaluation of families.

The great help mentioned by the families was the direction of help in FINDING PEOPLE THAT CAN HELP WHEN NECESSARY, to help THE COMMUNITY TO GET TO

Chart 87 - Support of the social network				none	few	some	much	very much
HELP IN THE RESOLUTION OF PROBLEMS	N	̄	d.p.	%	%	%	%	%
Family	99	3,40	1,399	17,2	7,1	20,2	29,3	26,3
Friends	98	2,69	1,424	34,7	7,1	20,6	27,6	9,2
Neighbours	98	2,21	1,246	44,9	9,2	28,6	14,3	3,1
Family doctor/Nurse Health Centre	98	2,71	1,300	27,6	12,2	28,6	24,5	7,1
Hospital doctors/private doctors	98	2,81	1,397	30,6	6,1	25,5	27,6	10,2
Municipal government	97	1,60	1,115	74,2	4,1	12,4	6,2	3,1
Parent groups	97	1,57	0,989	72,2	6,2	14,4	7,2	0,0
Rehabilitation or special education associations	96	1,58	1,220	79,2	2,1	5,2	8,3	5,2
Nursery/kindergarten	97	2,98	1,472	29,9	3,1	21,6	29,9	15,5
Firefighters/Red Cross	97	1,53	1,081	77,3	6,2	5,2	9,3	2,1
Early Intervention team	98	3,94	0,940	2,0	4,1	22,4	40,8	30,6

Evaluation of early intervention impact in Alentejo: *child, family and community*

[104]

Chart 88 - Support of EI for the inclusion into the community: parents				none	few	some	much	very much
IN WHAT WAY EI HELPED	N	\bar{x}	d.p.	%	%	%	%	%
Get to know well neighbours and people close	98	1,73	1,089	64,3	8,2	18,4	8,2	1,0
Participate in organised activities in the community	98	1,61	1,022	70,4	6,1	15,3	8,2	0,0
Find people that can help when necessary	98	2,44	1,324	41,8	2,0	29,6	23,5	3,1
Relate with members of the extended family	98	1,64	1,105	71,4	5,1	12,2	10,2	1,0
Feel more integrated in the community they live in	98	1,95	1,271	57,1	11,2	16,3	10,2	4,1
The community to know and integrate the child	97	2,29	1,330	45,4	7,2	25,8	16,5	4,1
Get to know other families with children with developmental problems	98	1,69	1,090	68,4	5,1	17,3	8,2	1,0
Have more ease in access to consults and treatments at the Health Centre	97	2,18	1,407	53,6	6,2	15,5	18,6	6,2
Have more ease in scheduling specialty consults	98	2,29	1,492	52,0	6,1	12,2	20,4	9,2
Have more ease in doing tests/treatments that the child needs	98	2,00	1,462	61,2	3,1	9,2	19,4	7,1
Have necessary technical help	98	1,45	1,066	83,7	1,0	4,1	9,2	2,0
Enter into nursery/kindergarten	98	1,93	1,459	69,4	1,0	4,1	18,4	7,1
Have fewer displacements to get the care necessary	98	2,20	1,399	53,1	3,1	20,4	17,3	5,9
Have more ease in access to other services	98	1,86	1,201	62,2	5,1	19,4	11,2	2,0
Find responses to problems in the community	98	2,21	1,326	49,0	5,1	26,5	14,3	5,1

Chart 89 - Support of EI for the inclusion into the community: responsables for the case				none	few	some	much	very much
IN WHAT WAY EI HELPED	N	\bar{x}	d.p.	%	%	%	%	%
Get to know well neighbours and people close	100	2,11	1,063	38,0	25,0	26,0	10,0	1,0
Participate in organised activities in the community	101	2,21	1,080	32,7	27,7	28,7	7,8	2,9
Find people that can help when necessary	101	3,00	0,980	10,9	10,9	49,5	24,8	4,0
Relate with members of the extended family	100	2,07	1,057	38,0	29,0	23,0	8,0	2,0
Feel more integrated in the community they live in	101	2,62	1,094	21,8	16,8	41,6	16,8	3,0
The community to know and integrate the child	101	2,76	1,184	20,8	15,8	35,6	21,8	5,9
Get to know other families with children with developmental problems	100	2,06	1,171	48,0	14,0	23,0	14,0	1,0
Have more ease in access to consults and treatments at the Health Centre	101	2,83	1,327	24,8	14,9	20,8	31,7	7,9
Have more ease in scheduling specialty consults	101	3,08	1,301	19,8	9,9	23,8	35,6	10,9
Have more ease in doing tests/treatments that the child needs	102	2,85	1,316	25,5	9,8	26,5	30,4	7,8
Have necessary technical help	98	1,84	1,290	65,3	9,2	5,1	17,3	3,1
Enter into nursery/kindergarten	101	2,49	1,534	46,5	4,0	15,8	21,8	11,9
Have fewer displacements to get the care necessary	102	2,88	1,444	29,4	8,8	18,6	30,4	12,7
Have more ease in access to other services	102	2,89	1,281	23,5	9,8	27,5	32,4	6,9
Find responses to problems in the community	102	3,01	1,156	16,7	9,8	35,3	32,4	5,9

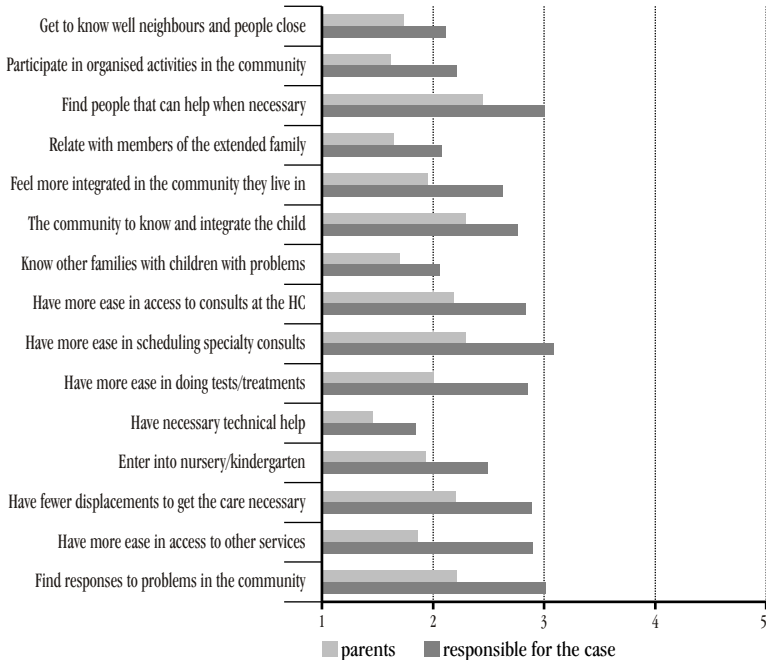
5. Evaluation of the impact on the development of the child and the family

KNOW AND INTEGRATE THE CHILD and HAVE MORE EASE IN SCHEDULING SPECIALTY CONSULTS. In all the other variables the responses DID NOT HELP surpass 50%, with the exception of FIND RESPONSES FOR THE PROBLEMS IN THE COMMUNITY.

Those responsible for the case once again had an evaluation more undervalued in relation to that of the families in that which refers to the way Early Intervention helps the inclusion of the families into the community. We found average values greater than 3.00 in HAVE MORE EASE IN SCHEDULING SPECIALTY CONSULTS, FIND RESPONSES TO PROBLEMS IN THE COMMUNITY, FIND PEOPLE THAT CAN HELP WHEN NECESSARY. The dimensions in which the help was considered virtually none were: HAVE NECESSARY TECHNICAL HELP, GET TO KNOW OTHER FAMILIES WITH CHILDREN WITH DEVELOPMENTAL PROBLEMS, ENTER INTO NURSERY/KINDERGARTEN, GET TO KNOW WELL NEIGHBOURS AND PEOPLE CLOSE, PARTICIPATE IN ORGANISED ACTIVITIES IN THE COMMUNITY, RELATE WITH MEMBERS OF THE EXTENDED FAMILY.

[105]

Graph 14 - Support for the inclusion into the community: parents and res. case



5.4.4.3. Familial function

We are still looking to see the way that parents and technicians evaluation the help given by EI on the level of variables relative to the familial function. Once again the evaluation of the technicians tends to be more favourable than that of the families.

The responses of the families presented values more elevated in two large groups. The first was more focused on the child: HAVE NEW IDEAS FOR THE EDUCATION AND DEVELOPMENT OF THE CHILD (3.54) and UNDERSTAND THE BEHAVIOUR OF THE CHILD (3.42). The second concentrated on emotional well-being, security, and confidence: HAVE SOMEONE WITH WHICH TO DISCUSS QUESTIONS AND DOUBTS THAT EMERGE (3.33), HAVE MORE CONFIDENCE IN THE FUTURE OF THE CHILD (3.31), FEEL MORE SECURE DEALING WITH THE CHILD (3.28). The areas in which the help received was considered to be none were: GIVE ATTENTION NECESSARY TO THE OTHER MEMBERS OF THE FAMILY (54.1%), HAVE MORE MOMENTS OF LEISURE TIME AND FREE TIME (53.1%), DEAL WITH PAPER AND BUREAUCRACY

[106]

Chart 90 - Support of EI for the familial function: parents

IN WHAT WAY EI HELPED	N	x̄	d.p.	none	few	some	much	very much
				%	%	%	%	%
Have new ideas for the education and development of the child	98	3,54	1,194	11,2	5,1	21,4	42,9	19,4
Include the child in the daily routines of the family	98	2,81	1,455	33,7	5,1	18,4	32,7	10,2
Have more nice moments with the child	98	2,71	1,421	35,7	3,1	23,5	29,6	8,2
Understand the behaviour of the child	98	3,42	1,268	15,3	2,9	24,5	38,8	18,4
The other family's members understand how to interact with the child	98	2,77	1,456	34,7	4,1	22,4	27,6	11,2
Give attention necessary to the other members of the family	98	2,17	1,400	54,1	4,1	18,4	17,3	6,1
Feel more secure dealing with the child	98	3,28	1,338	19,4	4,1	22,4	37,8	16,3
Have more confidence in the future of the child	98	3,31	1,255	15,3	5,1	29,6	33,7	16,3
Have more confidence in the future of the family	98	2,81	1,375	29,6	7,1	25,5	28,6	9,2
To talk with someone else about the child difficulties	97	2,45	1,339	40,2	6,2	25,8	23,7	4,1
Know how to handle emotions	98	2,89	1,428	28,6	7,1	25,5	24,5	14,3
Improve the quality of life of the family	95	2,67	1,364	33,7	4,2	31,6	22,1	8,4
Have someone with which to discuss questions and doubts that emerge	98	3,33	1,199	14,3	5,1	26,5	41,8	12,2
Find responses to the basic needs of the child and the family	98	2,87	1,344	27,6	5,1	29,6	28,6	9,2
To relate and work with different professionals	97	2,60	1,412	36,1	7,2	28,9	16,5	11,3
Know how to defend the interests of the child	98	3,10	1,461	26,5	3,1	22,4	29,6	18,4
Deal with paper and bureaucracy	98	2,34	1,421	46,9	6,1	21,4	17,3	8,2
Have more moments of leisure time and free time	98	2,19	1,375	53,1	2,0	22,4	17,3	5,1

5. Evaluation of the impact on the development of the child and the family

(46.9%), and TALK WITH OTHER PEOPLE ABOUT THE DIFFICULTIES OF THE CHILD (40.2%).

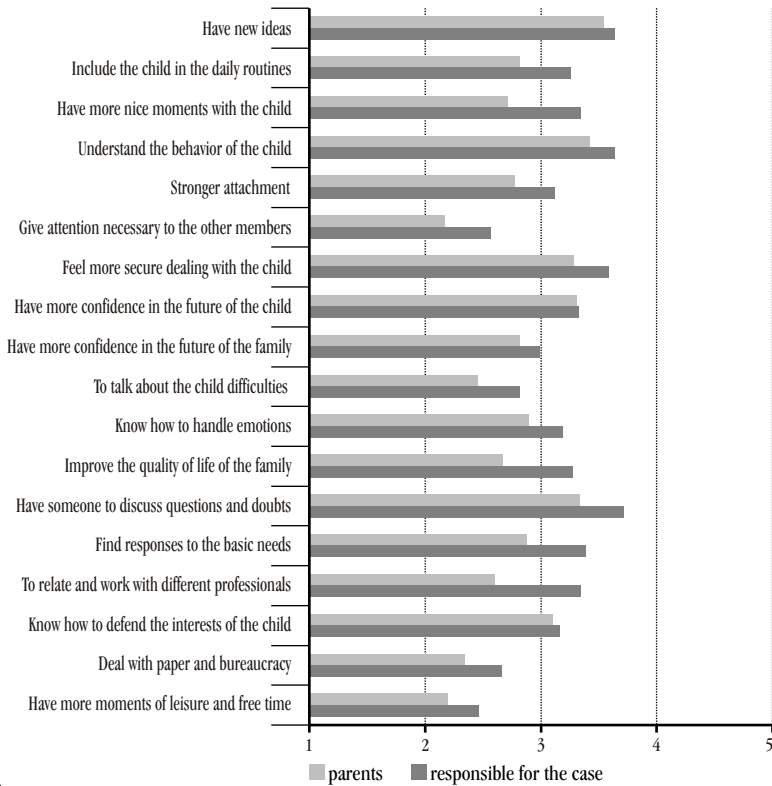
The responses of those responsible for the case show a clear valorisation of the help in all the dimensions analysed of familial function. They considered that Early Intervention helped especially in: HAVE SOMEONE WITH WHICH TO DISCUSS QUESTIONS AND DOUBTS THAT EMERGE (average value of 3.71), HAVE NEW IDEAS FOR THE EDUCATION AND DEVELOPMENT OF THE CHILD (3.64), UNDERSTAND THE BEHAVIOUR OF THE CHILD (3.63), and FEEL MORE SECURE DEALING WITH THE CHILD (3.58). The help of EI was most frequently NONE or LITTLE in the categories of: HAVE MORE MOMENTS OF LEISURE TIME AND FREE TIME (49.0%), GIVE ATTENTION NECESSARY TO THE OTHER MEMBERS OF THE FAMILY (40.8%), and DEAL WITH PAPER AND BUREAUCRACY (43.6%).

[107]

Chart 91 - Support of EI for the familial function: res. case

IN WHAT WAY EI HELPED	N	\bar{x}	d.p.	none	few	some	much	very much
				%	%	%	%	%
Have new ideas for the education and development of the child	102	3,64	0,806	2,9	2,9	30,4	54,9	8,8
Include the child in the daily routines of the family	102	3,25	0,941	6,9	9,8	38,2	41,2	3,9
Have more nice moments with the child	101	3,34	0,875	5,9	5,0	42,6	42,6	4,0
Understand the behaviour of the child	102	3,63	0,716	1,0	2,9	36,3	52,0	7,8
To have a stronger attachment with the child	100	3,12	1,183	15,0	11,0	29,0	37,0	8,0
Give attention necessary to the other members of the family	98	2,56	1,236	30,6	10,2	36,7	17,3	5,1
Feel more secure dealing with the child	102	3,58	0,763	2,9	2,9	32,4	56,9	4,9
Have more confidence in the future of the child	102	3,32	0,977	8,8	5,9	33,3	48,0	3,9
Have more confidence in the future of the family	102	2,99	1,058	14,7	10,8	36,3	37,3	1,0
To talk with someone else about child difficulties	102	2,81	1,078	17,6	13,7	40,2	26,5	2,0
Know how to handle emotions	101	3,19	0,997	8,9	9,9	39,6	36,6	5,0
Improve the quality of life of the family	102	3,27	1,006	8,8	7,8	36,3	41,2	5,9
Have someone with which to discuss questions and doubts that emerge	102	3,71	0,885	4,9	2,0	22,5	58,8	11,8
Find responses and basic needs of the child and the family	102	3,38	0,934	6,9	6,9	31,4	51,0	3,9
To relate and work with different professionals	101	3,34	0,941	8,9	2,0	39,6	45,5	4,0
Know how to defend the interests of the child	100	3,16	1,051	11,0	11,0	33,0	41,0	4,0
Deal with paper and bureaucracy	101	2,66	1,194	21,8	21,8	30,7	19,8	5,9
Have more moments of leisure time and free time	100	2,46	1,077	24,0	25,0	34,0	15,0	2,0

Graph 15 - Impact of EI on the familial function



[108]

5.4.5. Global evaluation of impact

When we change the evaluation of the help of EI in its different dimensions into a global evaluation, asking how the respondents think the support of the EI team has helped their family to deal with a child with developmental problems, we can verify that this appreciation is always more favourable than what we found in the different dimensions described previously.

The average response of families surpasses the value 4.00 (HELPED A LOT) with 36.1% considering the support of EI to have helped VERY MUCH and 41.2% A LOT (total of 77.3%).

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The evaluation of those responsible for the case was a little lower, but in any case 73.5% considered the support of EI to have helped the family to deal with the problems of development or with difficulties A LOT or VERY MUCH.

Chart 92 - Global evaluation of EI

HELP	parents	res.case
	%	%
Did not help	2,1	0,0
Helped a little	0	0,0
Helped some	20,6	26,5
Helped a lot	41,2	65,7
Helped very much	36,1	7,8
N	97	102
Mean	4,09	3,81
SD	0,867	0,558

[109]

5.5 Discussion

In the sample of children accompanied by the Intervention Teams we quickly found a large discrepancy between the responses of the families, of those responsible for the case, and of the educators (studied in the previous chapter) with regards to the reasons that lead to intervention. 41.2% of parents do not realise that there may be a development problem, although there may be difficulties in speaking or behaviour; those responsible for the case note that they found social or family risk in only 23.5% of accompanied children (even though some of these cases end in a diagnosis of some type of difficulty, there remains 10.8% that do not present them). We recall that the support educators, in the previous study, marked 36.79% of children as being at risk simply for social or family reasons. This difference between the obtained indications points in two directions: the elevated number of social at-risk cases on the way to EI and notable difficulties on the level of the eligibility criteria and of diagnoses or characterisation of situations, and the fact that it appears that there does not exist common or uniform criteria.

The majority of supported families have a low social-professional level, education rates below that which is obligatory and income that puts them in conditions of poverty, with half of the families earning below the threshold of 500 euros a month. These conditions certainly challenge the work of the teams, knowing, from investigation, that the conditions of poverty interfere in the intervention programmes of the development of children, and that to resolve of

these types of difficulties different entities and structures must be mobilised that may or may not be articulated in the EI system.

The children's difficulties emerge, on average, around the age of one and a half, with 36.3% manifesting themselves during the first year of life. These early signals that something may not be right in the development of the child are usually detected by the family; then the hospitals; and, in cases of social or family risk, kindergartens also have a reflective role in this detection. The responses of those responsible for the case, given an elevated number of children without development pathologies, tend to identify the problems much too late, bringing the average closer to 2 years.

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Already the first diagnosis of effectively existent difficulties was made, on average, around two years (23.56 months), with more than half before 3 years. This means that there is an average gap of 6 months between the detection of the first difficulties and the diagnosis of the situation. The role of hospitals is reflective in the realisation of this diagnosis of the situation, attributing to it this function in 54% of responses of parents (in which a difficulty of development is identified) and 34.3% of all cases reported by those responsible for the case. Considering handicapped children or those with some disruption of development, hospitals were involved in the diagnosis in 63.8% of cases, which continues to be a number certainly below that which would be desirable or hoped for. The role of the Health Centres is also very small, with far lower percentages appearing in cases in which the centres were responsible for the diagnosis of the situation. In the cases of problematic situations of elevated social risk, the participation of the EI teams, educated establishments, and CPCJ is increased.

Between the diagnosis of the situation and the referring of the child to an intervention team pass, on average, 6 more months, the average age at which children are sent for intervention being 29.65 months (that is, almost two and a half years) with 50% of the total referrals happening after the age of 3, with up to 10% of children over 6 years old.

From here we can conclude that between the detection of the first signals that are cause for worry until the referral for intervention occurs a period of around 1 year, nearing the beginning of this at 3 years of age, which should be the acceptable limit in order for intervention to take an effect that is beneficial and expected of its quick nature or in time.

Between the referral to the team and the first contact with the family the

5. Evaluation of the impact on the development of the child and the family

length of time is generally short, being less than one month in 70% of cases, which gives us an idea of the efficiency of the host teams in the cases that are sent to them. This first contact is frequently done in the home of the family (45.1%) and only 24.5% is done in kindergarten.

With regards to the place where the intervention is done, we are now finding very different results from those that were calculated together with the support educators. These stated, as we saw previously, that only in 9.5% of cases was this accompaniment done in an educational establishment. In the cases currently studied, we can verify that this number has risen to 36%, according to the parents (or 24.5% according to those responsible for the case). This difference is very significant and can point us towards a generalisation of responses of educators in agreement with the desirable theoretic model, or in concordance with the ideal. We must not ignore, however, the rise of a change in the nature of the approach to the family in the context of their lives.

The accompaniment in more than 50% of cases is done by the educator and, in the same percentage, by the speech therapist. This last number seems quite elevated against the developmental problems described since only 28.3% in disturbances of development, according to the parents, and 21.6% in total, according to those responsible for the case, presented difficulties on the level of language. This input, on the other hand, can point to developmental difficulties on the level of communication.

In the description of difficulties there is, in fact, a highlight of difficulties on the level of communication: COMMUNICATE NORMALLY ACCORDING TO AGE (in which 24.8% according to those responsible for the case and 47.5% according to the parents didn't possess some difficulty at this level) and MAKE THEMSELVES UNDERSTOOD BY STRANGERS (in which equally 31.4% and 37.6% according to those responsible for the case and parents, respectively, said there were no difficulties). Generally those responsible for the case accentuated the existing difficulties more than the families. In the case of the parents, together with difficulties on the level of communication, INDEPENDENCE IN GETTING DRESSED is also valued (average value 1.24).

In that which refers to the evaluation of the impact of EI in the development of children, the position of parents is very favourable, with those that consider this support VERY or EXTREMELY important tallying 82.2% and only 3% saying that it helped LITTLE or NOT AT ALL. This evaluation is much more favourable to the importance of the support provided by the team than that done by those

[112] responsible for the case, in which only in 72.5% of cases was the support considered VERY or EXTREMELY important. The parents accentuated the importance of the support of EI in all the areas of development, with special emphasis in the area of mobility (around 70% answered VERY and EXTREMELY in MOVE THEMSELVES ALONE and GRAB AND MANIPULATE OBJECTS) and in language (in which these values surpassed 70%). Areas of less impact of support are VISION, INDEPENDENCE IN GETTING DRESSED, and INDEPENDENCE IN FEEDING (53%, 40%, and 40% answered NOT AT ALL or LITTLE). Those responsible for the case accentuate the contributions in the area of Mobility (MOVE THEMSELVES ALONE) and in that of Communication (RESPOND WITH GESTURES AND SIMPLE WORDS with 67.5%, 55.9% of responses VERY and EXTREMELY) and still in HEARING (with a maximum value of EXTREMELY, 36.4%, but with most answering SOME). Therefore we can understand that the impact on the development of the child is globally quite elevated, corresponding almost always to levels above the middle point and being more valued by the families themselves.

Taking into account now the development of the family, it was found that EI was especially useful in the support that it gave on the level of information and in a special way to the information involving the child and their development. The main impact in information is highlighted in the various UNDERSTAND BETTER DEVELOPMENTAL PROBLEMS OF THE CHILD, KNOW BETTER THE CAPACITIES OF THE CHILD, KNOW THE WAY THE CHILD DEVELOPS AND LEARNS, HAVE MORE INFORMATION ABOUT THERAPIES AND SUPPORT THAT EXIST, KNOW WHAT THERAPIES AND SUPPORT THE CHILD REQUIRES (with answers of VERY and EXTREMELY of 61.2%, 60.2%, 55.1%, 55.1%, and 58.1%). The information was weaker in HAVE INFORMATION ABOUT THE RIGHTS AS THE FAMILY OF A CHILD WITH DEVELOPMENTAL PROBLEMS (52.6% and 48% of responses NOT AT ALL or LITTLE). In this evaluation of the impact on the information the responses of those responsible for the case presented values greater than those of the parents in all the variables. They placed more value on the more pragmatic information related with the supply of information about therapies and support.

Comparing the support of the system of Early Intervention with the support supplied by other entities and elements of the social system of the families, we can verify that the parents, in 71.4% of cases say that EI helped VERY or EXTREMELY (with an average value of 3.94 on a scale of 1 to 5), while as far as the support to the family goes only 55.6% of the responses were of this type, 31.6% of family doctors and 45.4% of kindergartens. In respect to inclusion in the community, the values

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of responses of the parents regarding the way EI helped them are generically low, with responses of NOT AT ALL always greater than 40%. What this shows is that this may be a dimension that still needs to be worked on by the teams. Those responsible for the case have an opinion more favourable than that of the families in this respect. The variables that presented higher values are: HAVE MORE EASE IN SCHEDULING SPECIALTY CONSULTS, MEET PEOPLE WHO CAN HELP WHEN IT IS NECESSARY, THE COMMUNITY KNOWING AND INTEGRATING THE CHILD, and FINDING ANSWERS FOR THE PROBLEMS/NECESSITIES IN THE SERVICES OF THE COMMUNITY.

One last dimension referring to the impact on the family has to do with the form that EI helped in the functioning of the family itself. The more significant responses of the parents are grouped into two blocks: one that focuses on the child and the other on their emotional aspects. In the first the variables that stood out were HAVE NEW IDEAS FOR THE EDUCATION AND DEVELOPMENT OF THE CHILD and UNDERSTAND THE BEHAVIOUR OF THE CHILD. In the second the more relevant variables included: HAVE SOMEONE WITH WHOM TO DISCUSS THE QUESTIONS AND DOUBTS THAT ARISE, HAVE CONFIDENCE IN THE FUTURE OF THE CHILD, and FEEL SECURE HANDLING THE CHILD. The support was less on the level of: GIVE THE ATTENTION NECESSARY TO THE OTHER MEMBERS OF THE FAMILY, HAVE MORE LEISURE TIME AND FREE TIME, COPE WITH PAPERS AND BUREAUCRACY, and SPEAK WITH OTHER PEOPLE ABOUT THE DIFFICULTIES OF THE CHILD.

The global evaluation of support that EI brought to help the family deal adequately with the difficulties of the child or with the child itself is quite positive, with the evaluation of the parents even more favourable than that of those responsible for the case. While these consider the support to have helped VERY or EXTREMELY in 73.5% of cases, those reached 77.3%, which is a very favourable indicator of the good acceptance of intervention in the way that the parents feel that it has been effective in the situation they live in.

Conclusions

Conclusions

The collecting of information about the functioning of the Early Intervention net in the region of Alentejo and the data that were possible to obtain, allow us to know better its impact on all its major actors and agents. We can point out some aspects that characterize the results of the first net that was possible to establish in such an enlarged way and in such a wide territory.

At the level of the Health System, the impact of the EI net in the three Regions seems to be significantly important; there are several aspects we would like to mark out:

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1. Both the Doctors and the Nurses that work in the Health Centres are well informed about the Early Intervention: they know there is a Local EI Team and know where and how they can establish contact with it.
2. Around 75% of the Doctors have already signalized cases (in an average superior to 3 cases) and inform they have others to lead, which seem to constitute a positive indicator that Doctors and Health Centres are fundamental elements in the net at the level of detecting, signalization and leading. Nurses are also involved in the practice of signalizing, in an articulated way with Doctors, and most of them have already led cases to the EI Team.
3. The EI has created a strong impact in the change of the Doctors practices at three levels: support to the family; higher easiness in detecting and making diagnosis; and in the proximity of the supports and articulation among services.
4. In the Nurses practice, there is a significant change at the level of working with the families, with more attention paid to their problems and an increasing of the support given in the homes.
5. Although usually Doctors are not members of the EI Teams or of the Local or Partners Teams, it is particularly important the existence of a connecting element that will lead the cases from the Health Centre to the Teams.
6. There are important differences among the 3 Alentejo Regions; Évora shows the lowest results for most of the variables, both at the information level, and also of the change and practice.

7. Almost half of the Health Centre professionals do not receive regular information about the Team activities, namely through the child identification file, which means that the way the Team maintain and consolidates its permanent connection with the Health Centre must be improved.
8. To be in touch with the Team, to be acquainted with the case signalization file and know how to use it, seem to be the most important indicators of a significant impact at the levels of information, changes and practices, both in Doctors and in Nurses.

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Evaluating the impact of the Early Intervention net at the level of the Education System, the data obtained from the Supporting Teachers and the Teachers in Charge of a classroom in Kindergartens or Nurseries allow us to conclude that:

1. In a general way, the children with education needs have the support of an EI Team and there seems to be an effective covering of the net.
2. The Supporting Teachers that are part of the EI Teams are experienced professionals, with a wide time of service, half of them has done specialized studies and they all have some kind of formation in Early Intervention.
3. Most of the Teachers in Charge have not done any formation in Early Intervention; this is certainly one of the areas of development for the net itself.
4. The Supporting Teachers work with an average of nine children each, usually in the age level from 3 to 5 years old. There seems to be an improvement in what concerns an increasingly earlier intervention with a higher relative number of children below the three years old.
5. Children supported by their Teachers usually arrive at the EI because of being in risk due to social or family causes (36,79%). The situations of handicap or of severe retardment of development are significantly less. However, when we look at the Teachers answers, we realise that is difficult to make groups according to the difficulties children present; the diagnosis made is essentially syndromatic with a strong emphasis in the language disturbances (24,1%) and in the global retardment of development (25,9%).

6. This difficulty to clarify the diagnosis and the mixture of the functional, syndromatic and etiological levels leads to situations like this: for example, in the case of the language disturbances, there are only 24,1% of cases identified; however, the Speech Therapists respond to 61,9%. This situation reveals that there are three fundamental needs: a) define a coherent and homogenous to make the diagnosis and characterize the situations; b) overcome and materialize general and undifferentiated characterizations that do not clarify anyone about the intervention needs (like Global Retardment of the Development); and c) differentiate between developmental aspects (for example, of the language, to be worked in the education activity and the pathological situations that need specialized therapies.
7. Another problem that the data show us is the one of the transition to other structures. First of all to the Primary School, when there are many children, possibly handicapped that maintain the EI support beyond the 6 years old; but also the problem of the follow up by other entities that also have responsibilities in the protection of the child or in the social support to the family.
8. The Supporting Teachers consider they have a very high level of information about EI, both in theory and in practice and assume they raised their knowledge about the development problems.
9. Their practices reflect the changes that themselves say are related with the fact that they are working in the circuit of the EI. They refer as most significant changes the use of specific instruments for evaluation and intervention planning, higher capacity to evaluate the child and family needs and new places for developing their intervention. In fact, in over 80% of the situations their intervention is made in the children homes and in the Kindergarten/Nursery in a once or twice a week meeting that lasts over 60 minutes.
10. Another change at the level of the Supporting Teachers practice concerns the focus of their intervention, that is no longer only on the child but also on the parents, teachers and other professionals.
11. The family centred intervention is considered as one of the most significant benefits that the EI brought to the Supporting Teachers practice, along with the higher ability to recognize the strengths and capacities of the child and

of the families. Their work with the families consist, above all, in providing information, leading and counselling, which demands a kind of relationship with the family that is challenging.

12. It is also valued the transdisciplinary perspective and the increase of competences to detect difficulties.
13. According to the Teachers in Charge, the most frequent supports to the children in their classrooms are given by the Supporting Teacher (57,1%) and the Speech Therapist (61,9%).
14. The level of information about the EI functioning is also high among the Teachers in Charge. They are all acquainted with the net functioning and present very high values in all the variables related with the information: they know how to establish contact with the team and actually do it, they say the articulation is easy and they are acquainted with the signalization system and know how to use it.
15. Concerning the profit of information brought by the EI, this occurs essentially at the level of the child development problems and of the development and needs of the family. The information about the activities of the EI Teams and the theory foundations are the less explored aspects.
16. The EI had impact in the Teachers in Charge education practices: they recognize better the children problems and they have improved the articulation with other professional and services. The impact has been weaker in the development of strategies to work in the community.

When we centre the impact evaluation on the children development and their families, made upon the answers that the professionals in charge of cases and the families themselves, we realize that:

1. Most of the families supported by the EI belong to a social and economic group with low resources and qualifications:
 - a) Low professional and social level, being that a large part is constituted by unskilled workers (among the fathers) and unemployed (specially among the mothers; over half of them are in this condition).
 - b) Both parents do not have much studies (in over two thirds of the cases they only studied till the 9 th grade).
 - c) The family income is very low; almost half of the families have a monthly income below the 500 euros.

d) A high sense of satisfaction about the house where they live.

These characteristics correspond to a situation profile of social and/or family risk, and constitutes necessarily a restraint to the teams actions and the nature of the results they want to achieve.

2. Between the first concerns with the existence of an eventual development problem in a child and the first diagnosis there is an average break of 6 months, even in those cases of handicap or development disturbance. Between the identification of the child problem and its leading to the Early Intervention there is another average break of 6 months. The period between the detection of difficulties and the leading to the Early Intervention sums, this way, around 1 year, contributing to the fact that 50% of the children arrive there when they are over 3 years old and 10% even over 6 years old.
3. The participation of the Hospitals in the Diagnosis is not so high as it should, even in situations of development disturbance or handicap, where its intervention hardly goes beyond the 50% of the cases. The Health Centre role in that diagnosis is very short, almost residual, and does not reach the 5%.
4. The EI Teams show an adequate speed when they start an intervention, since the break between the reception of the cases and the beginning of the work usually is not longer than 1 month.
5. Contradicting what the Support Teachers say, the rate of interventions that take place in the Kindergarten/Nursery is, in this study, of 36% (or 24,5%, in the opinion of those in charge of cases) and in 50% of the cases takes place in the Kindergarten , although occasionally it may occur at home. This makes us conclude that, although the intention was to make a home intervention, frequently she ends up happening in the education place.
6. The Kindergarten Teachers and the Speech Therapists are the professionals that interfere more frequently in the signalized cases; their intervention is superior to the diagnosis identification of speech or language problems. This rises again the issue of the nature of the diagnosis, identification and operation of the child difficulties in its development context.
7. The incidence in specific areas of difficulty in the supported children development is relatively low. Only the variables AUTONOMY TO GET

DRESSED, MAKE ONESELF CLEAR TO STRANGERS and COMMUNICATE NORMALLY ACCORDING TO AGE there are difficulties in over 50% of the cases.

8. The impact on the development of the children that have actual difficulties is high, and the parents value the help from the EI very much, considering it MUCH or VERY MUCH important. That evaluation of the impact of the EI in the children development is higher in the families answers than in those given by the professionals in charge of cases.
- 9- The impact of the net in the information the family has about the EI is very positive. Parents value essentially the information that they now have concerning the development process, learning, children capacities and therapeutic supports. They refer the needs of information that were not fulfilled concerning their rights as a family and financial supports.
10. The social basis of the families supported by the EI is low and the functioning of the social nets is poor. However, to these families, the EI is, clearly, the most important resource, even more than the family itself, which gives us a fundamental indicator of the importance it has from the family perspective.
11. The inclusion in the community seems to be the dimension where the EI less support has brought to the family, although some aspects are underlined in the fight to the exclusion and that induce the sense of contextualized intervention in the community: organizing medical appointments, helping to find answers within the community. However, in this aspect the evaluations of the families are very distant from what the Professionals in Charge of cases seem to think that was achieved. Considering the EI purposes, it seems that a therapeutic view is better accomplished than an answer to the inclusion.
12. In terms of the impact in the family functioning, the EI help is also far from the evaluation that was made by those in charge of cases and the Team intentions. However the families value what has got to do with the child functioning and with the personal safety and welfare. The careless elements in the family functioning are: the attention to the other members of the family (pointing to a focalization on the child problem) the existence of leisure periods (demanding another kind of responses and support , “family breathing “ type) have to deal with papers and bureaucracy (that,

even considering the low study level of the families would demand activities that could give effective bureaucratic support) and talking to other people (pointing out the great need of informal social nets within the community).

13. The global evaluation of the impact in the family is very good, especially the one made by the families, in which almost 80% consider that the received support helped them MUCH or VERY MUCH with the development difficulties of the child and even of the family.

Summarizing, the data we obtained point to a strong impact of the Early Intervention net in the activity of the systems, of the services and of the professionals. All the changes that occurred and were recognized lead to the principles that the Early Intervention stands for and wants. There are still some difficulties or aspects that need improvement in order to obtain even better results, namely at the level of defining and identifying the problems and the nature of the interventions, which resolution will improve even more the effects of the net functioning.

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The impact evaluated in terms of the children development and their families is also very positive, and the EI corresponds to most of their needs.

This investigation has its limits. By not analyzing the processes but only the impact, it does not allow a global vision of the net functioning. Yet, these informations can be obtained through the consultation of the activities reports produced by the Regional Team. Also, not having done the direct evaluation of the actual functioning it depends on the representations that the inquired have about their practice or other professionals practice. The case of the children goes even further: it was not possible to evaluate their real development or the profits obtained during the Team support period.

All those aspects can be object for future studies and, crossed with others concerning the practices and the quality of the services, will allow to develop better practices and take the best out of a wide net of services and professionals.

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