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Individualized Family Service Plan: Congruence between professional recommendations and IFSP goal statements

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INDIVIDUALIZED FAMILY SERVICE PLAN: CONGRUENCE BETWEEN PROFESSIONAL RECOMMENDATIONS AND IFSP GOAL STATEMENTS

by

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As members of the Final Examination Committee, we certify that we have read the dissertation prepared by Susan Mustaleski Eck

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and recommend that it be accepted as fulfilling the dissertation requirement for the Degree of Doctor of Philosophy

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STATEMENT BY THE AUTHOR

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SIGNED: Susan Mustaleski Eck

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ABSTRACT

Part H of Public Law 99-457 offered incentives to states to develop services to children, birth through age two, who have or are at risk for developmental delays. A major emphasis is on inclusion of family members as full participants in the design and implementation of services. The Individualized Family Service Plan (IFSP) is a written plan for services to be implemented for the child and family.

This study evaluated critical components of the IFSP document to determine if several assumptions concerning services are substantiated by fact. It is assumed that components specified in the law for content of the IFSP plan will be present on IFSPs, family members will incorporate recommendations made by professional providers into the goals chosen for their child and there will be congruence or match between recommendation and goal statements. It is assumed that all areas of development will be considered when planning programming and that children and their families will receive equitable services regardless of gender, ethnicity or the case manager assisting them.

Data were taken from IFSP documents from November 1, 1992 to May 1, 1993. The data revealed a low rate of compliance with the seven requirements for content of the plan specified in P.L. 99-457. Analysis by developmental area showed an emphasis on physical development. A low rate

of congruence between recommendation and goal statements was found. Difference in congruence was found when analyzed by case manager, but not by gender or ethnicity.

The law enabling services for infants and toddlers with disability incorporates assumptions concerning the development of a plan for services. In this investigation of IFSP documents, several assumptions concerning the IFSP document are not verified by the data.

CHAPTER ONE

INTRODUCTION

This section will provide a brief overview of the requirements in Public Law 99-457 for the Individualized Family Service Plan, including evaluation and goal planning as well as explanation regarding the importance of studying the problem addressed in this investigation. The specific research questions required to address the problem are presented.

Public Law 99-457

Public Law 99-457, the 1986 amendments to the Education of the Handicapped Act (EHA), expanded the educational opportunities for young children with disability. Part H of the law dealt specifically with services for infants and toddlers with disability by offering states incentive to provide services to children from birth through age 2 and their families in need of early intervention services. The Legislative History of the law cited research demonstrating that quality early intervention programs can be effective in improving developmental outcomes for children who are at risk for or who are experiencing developmental delays (Education of the Handicapped Act Amendments of 1986). One of the four stated findings in P.L. 99-457 is "an urgent and substantial need to enhance the capacity of families to meet

the special needs of their infants and toddlers with handicaps (20 U.S.C. § 1471, 1986)." All fifty states have elected to provide services to infants and toddlers and their families (Kochanek, Kabacoff, & Lipsitt, 1990).

States have developed criteria for admission to services, methods for evaluation of infants and a new type of program plan called the Individualized Family Service Plan (IFSP). The goal for such early intervention is improved developmental outcomes for the infant or toddler and enhanced family support (Wayman, Lynch, & Hanson, 1991). To achieve this goal, programming must be tailored to the individual child and family needs (Meisels & Provence, 1989). The Individualized Family Service Plan is only one of the 14 components of the law, but is the heart of the service design. The IFSP is a promise to children and families that can be met only through interagency and interdisciplinary partnerships among parents and professional providers of services (McGonigel, Kaufman, & Johnson, 1992). The professionals who evaluate the child make recommendations for programming and often serve as teachers, resource personnel and supporters of the family. However, the family's informed opinions (by law) should drive the services for their infant or toddler (Healey, Keesee, & Smith, 1985; Wayman et al., 1991).

Statement of the Problem

To meet the principal intent of the law and to be in procedural compliance with the law, the IFSP document is to be in writing and contain seven components designed to enhance and clarify services. Evaluation of compliance with the legal requirements for the IFSP document, while not a qualitative evaluation of services, measures procedural correctness and provides one view of overall functioning of the IFSP process. Inherent in the inclusion of requirements for content of the IFSP plan is the assumption that those who implement the process will comply with the requirements.

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

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

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

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

Unlike the IFSP, other legislated service plans, such as the Individualized Education Plan (IEP) and the Individualized Program Plan (IPP) are professionally driven

and developed through a process where professionals share with parents the evaluation information and desired goals and objectives (Campbell, Strickland, & LaForme, 1992). P.L. 94-142 mandated an active role for families, but reviews suggest the intent envisioned in the legislation has not been realized and that professionals place relatively little value on parents' input (Nash, 1990; Smith & Simpson, 1989; Smith, 1990a; Smith, 1990b). In contrast to P.L. 94-142, P.L. 99-457 and the most recent amendment, P.L. 102-119, The Individuals with Disabilities Education Act (IDEA) place greater emphasis on the requirement of family involvement in the development of the service plan, the IFSP (Bailey, Palsha, & Simeonsson, 1991). The extent to which the family can be involved in an informed and meaningful way is dependent on the extent to which the professionals who evaluate the child are able to make recommendations that can be understood and utilized by the involved family members.

An additional assumption in this process for family involvement is that the recommendations by professionals who evaluate the child will be represented in the goal or outcome statements the parents select for inclusion in the IFSP. Such an assumption needs to be tested because the link between the professional recommendations and the IFSP goal or outcome statements appears to be critical to provision of appropriate services.

Need for Research

Assessments and other programming provided to infants and toddlers need to be evaluated to establish which factors lead to improved outcomes for these children and their families. Yoder (1990) called for research on the assumptions related to family involvement and provision of family supports. Campbell (1991) stated:

> "The link between evaluation and the IFSP process requires flexibility to ensure that early intervention services address the changing needs of infants, toddlers and families (p. 43)."

Rutter (1976) admonished child development professionals because they treat as truths many beliefs that have not been established by the facts. He said it is not our ignorance that is harmful, but rather our "knowing" so many things that are not true. Research must be conducted to compare assumptions concerning aspects of the IFSP document with actual IFSP documents.

Purpose of the Research

This research was designed to study several assumptions that have been made about the IFSP process. They are:

1. The extent to which professionals are meeting documentation requirements for the seven requirements of the law for content of the IFSP.

2. Whether the present levels of development stated on the IFSP are considered when recommendations are made and goals are planned for the child and family.

3. If families are utilizing recommendations made by professionals who evaluate their child when they make goal or outcome choices for their child.

The proposed analysis of procedural compliance in the IFSP document and the relationship between professional recommendations and the goal statements on the IFSP should contribute to understanding of the whole IFSP service delivery process so that researchers and professional providers can implement more exacting and responsive services to infants and toddlers and their families.

Evaluation of the degree to which the contents of the IFSP document comply with the seven requirements for content of the plan stated in P.L. 99-457 measures progress toward full implementation of preferred practice as incorporated into the legislation. It tests the assumption that the law will be implemented as written. Following this measure of procedural compliance, qualitative evaluation of the congruence between post-evaluation recommendations recorded on the IFSP and parental goal statements examined the crucial assumption that families incorporate professional provider recommendations into family derived goal statements. For example, several professionals may evaluate an infant or toddler and make recommendations related to

programming for the child. Preliminary reviews of IFSP's suggested that recommendations made by professionals who evaluated the child generally exceeded the number of goal statements on the IFSP. The assumption that families understand and make use of recommendations made it important to determine if congruence exists between recommendation and goal statements recorded on the IFSP, as well as the frequency with which recommendation and goal statements refer to the five developmental areas listed in the law. Further, selected demographics, such as ethnicity or gender, could affect the congruence between recommendation and goal statements recorded on the IFSP. These outcomes should contribute to the understanding of whether or not the critical assumptions regarding the development of an IFSP are accurate.

Research Questions

Answering the following set of research questions was critical in testing major assumptions underlying use of an IFSP.

1. Do the files evaluated contain the seven requirements for an IFSP as stated in P.L. 99-457?
2. Are the five developmental areas specified in the IFSP under present level of development referred to with equal frequency in recommendation and goal statements recorded on the IFSP (using the revised terminology in P.L. 102-119)?

3. Does congruence exist between the recommendation and goal statements made by professional providers that were recorded on the IFSP?
4. Do differences in gender and ethnicity affect the congruence between recommendation and goal statements recorded on the IFSP?
5. Does congruence between recommendation and goal statements recorded on the IFSP vary by case manager?

Definitions

In seeking answers to the research questions above, the following terms and service criteria used in Arizona needed to be understood.

The State of Arizona Early Intervention Program (AzEIP) used the following definitions and criteria for placement of infants and toddlers into programming (March 12, 1993).

Category I: Developmental Delay

A child who has not reached 50 percent of the developmental milestones expected at his/her chronological age in one or more of the following domains:

* physical/fine and/or gross motor/sensory
* cognitive/adaptive
* language/communication
* social/emotional
* self-help/adaptive

Category II: Established Condition

A child whose early development is influenced by a diagnosed physical or mental condition, which based on an informed clinical opinion, has a high probability of resulting in a developmental delay. Currently established conditions include but are not limited to:

* chromosomal disorders
* metabolic disorders
* hydrocephalus
* neural tube defects (i.e. spina bifida)
* intraventricular hemorrhage
* periventricular leukomalacia
* cerebral palsy
* significant auditory impairment
* significant visual impairment
* failure to thrive
* severe attachment disorders

At risk: Children at risk are not included in the current AzEIP definition but are, in certain instances, served by the Department of Developmental Disabilities (DDD).

The AzEIP expects to serve approximately 3% of the estimated 12,000 infants born in Pima County each year, or approximately 360 children each year. (According to Sue Sainz of the vital statistics section of the Pima County Health Department, there were 11,306 births recorded in Pima County in 1991.) Children identified as qualifying for early intervention services might be served through any of the following departments: The Department of Economic

Security, Division of Developmental Disabilities (DES/DDD); Department of Health Services, Children's Rehabilitative Services (DHS/CRS); Department of Health Services, Behavioral Health Services (DHS/BHS); Department of Health Services, Maternal and Child Health (DHS/MCH); or Arizona School for the Deaf and Blind (ASDB) Outreach Program.

District 2 of the Division of Developmental Disabilities (DDD) for Arizona operates under a slightly different set of criteria for services than AzEIP. DDD serves children from birth through 18 months who are (a) at risk for developmental delay or (b) are already showing a delay. Children from 19 months to 3 years must show a significant developmental delay in one or more developmental areas. A six month delay is considered significant (Patsy Conklin, Intake Coordinator, personal communication, December 5, 1991). Those infants and toddlers meeting the AzEIP defined criteria of 50% delay in milestones in at least one area of development are served, but in addition, others are admitted to programming under more informal criteria operationalized by the intake staff and family service coordinators in Child and Family Services.

Professionals Providing Evaluations and Other Services

Qualified professionals who evaluate the child may include special educators, speech and language pathologists and audiologists, occupational therapists, physical therapists, psychologists, social workers, family service

coordinators, nurses, nutritionists, and physicians and other medical personnel. Qualified professionals evaluate the child using a number of methods, write evaluation reports and formulate recommendations. These recommendations are discussed at the IFSP meeting and recorded on or attached to the IFSP document.

Service Providers

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

Individualized Family Service Plan

The Individualized Family Service Plan (IFSP) is required by P.L. 99-457 and P.L. 102-119. The IFSP is a written plan developed by a multidisciplinary team, including the parent or guardian. P.L. 99-457 details the requirements for the IFSP as follows.

(1) Assessment and Program Development. Each handicapped infant or toddler and the infant or toddlers family shall receive:

(a) a multidisciplinary assessment of unique needs and the identification of services appropriate to meet such needs, and

(b) a written individualized family service plan developed by a multidisciplinary team, including the parent or guardian, as required by subsection (d).

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

(3) Promptness after assessment. The individualized family service plan shall be developed within a reasonable time after the assessment required by subsection (1)(a) is completed. With the parent's consent, early intervention services may commence prior to the completion of such assessment. (A reasonable time is defined in the regulations as 45 days following the start of services.)

(4) Content of the Plan. The individualized family service plan shall be in writing and contain:

(a) a statement of the infant's or toddlers present levels of physical development, cognitive development, language and speech development, psycho-social development, and self-help skills, based on acceptable objective criteria (the terminology used for developmental areas was adjusted in P.L. 102-119 to be physical, cognitive, communication, social and emotional and adaptive),

(b) a statement of the family's strengths and needs relating to enhancing the development of the family's handicapped infant or toddler,

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

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

(e) the projected dates for initiation of services and the anticipated duration of such services,

(f) the name of the case manager from the profession most immediately relevant to the infants and toddler's or family's needs who will be responsible for the implementation of the plan and coordination with other agencies and persons, and

(g) the steps to be taken supporting the transition of the handicapped toddler to services provided under Part B to the extent such services are considered appropriate.

The law specifies that the IFSP contain a statement of the major outcomes expected to be achieved for the infant and toddler and the family. These statements of expected outcomes are listed as goal or outcome statements on the written plans used in District 2 of the Division of Developmental Disabilities (DDD) for Arizona. In addition, DDD uses the term family service coordinator for case manager.

Goal or Outcome

A goal may be defined as a stated outcome desired as a result of some action; a change or action intended to benefit the child or family member (The American Heritage College Dictionary, 1993).

"1. Goals help to focus intervention services.
2. Goals communicate.
3. Goals serve a facilitative function.
4. Goals serve an evaluative function.
5. Goal setting contributes to the establishment of ethical and appropriate relationships with families."

(Bailey, Winton, Rouse, & Turnbull, 1990, p. 16).

Recommendation

A recommendation is advice or counsel for something such as a course of action (The American Heritage College Dictionary, 1993). Recommendations are statements made by a professional service provider who has evaluated the child in

one or several areas of development. Following evaluation with either a formal measure or through the use of clinical judgment, the professional formulates recommendations concerning programming for the child. The post-evaluation recommendations are discussed at the IFSP meeting and recorded on the IFSP document.

Congruence

Congruence occurs when a goal or outcome statement agrees or coincides; is the same or very similar to a recommendation.

CHAPTER TWO

REVIEW OF THE LITERATURE

The literature review covers relevant services authorized by Public Law 99-457 (1986) and amendments in Public Law 102-119 (1991) and delineates the history of legislated services for infants and toddlers. Specifically, evaluation and assessment of children with disabilities, requirements for the Individualized Family Service Plan (IFSP), rationales and barriers to provision of family focused services, and assumptions concerning services are the major focus of this review.

Landmark Legislation: Public Law 99-457

Public Law 99-457, which amended the Education of All Handicapped Children Act in 1986, introduced a discretionary program (Part H) to help states develop a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with developmental delays and their families (Trohanis, 1987). In 1991, this legislation was amended and reauthorized as Public Law 102-119, the Individuals with Disabilities Education Act (IDEA). While much of P.L. 99-457 concerned strengthening, clarifying and reauthorizing educational and related services for pre-school children, Part H of the Act was landmark legislation because it

created a new federal program for disabled and at risk children from birth through 2 years (Trohanis, 1987). Meisels and Provence (1989) stated that the Act, P.L. 99-457 (1986), marked an historic turning point in federal and state policy for disabled and developmentally vulnerable young children and their families for two reasons: (1) Infants and toddlers were not included previously in federal educational legislation, and (2) central to the legislation was an emphasis on the family as the primary planner and guider of services for their young child.

The federal legislation defined infants and toddlers with disabilities as:

> "individuals from birth to age 2, inclusive, who need early intervention services because they are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more the following areas: Cognitive development, physical development, language and speech development, psychosocial development, or self-help skills, or have a diagnosed physical or mental condition which has a high probability of resulting in developmental delay" (P.L. 99-457, 20 U.S.C. § 1472 Sec. 672 (1)(A) [1986]).

States may also serve individuals from birth to age 3, who are at risk of having substantial developmental delays if early intervention services are not provided. Public Law 102-119 (1991) revised the terminology referring to developmental areas to include: cognitive development, physical development, communication development, social or emotional development and adaptive development.

In addition to detailing requirements for a multidisciplinary assessment of unique needs and the identification of services appropriate to meet such needs (P.L. 99-457), the legislation required that services to children be guided by an Individualized Family Service Plan (IFSP) that built on family strengths and was driven by the families' identification of needs for their child. The IFSP is to be reviewed periodically. The intent of the law was a proactive, family-centered system of services (Brown, 1991; Johnson, McGonigel, & Kaufmann, 1989).

The legal requirements concerning evaluation of the child and family and planning of services through creation of the IFSP were based on expert testimony, research, and current beliefs and assumptions about what constitutes preferred practice to enhance the developmental outcomes of children and families served. Legislation enabling services for infants and toddlers and their families over the previous 30 years had funded model programs, research and other services. Information from research and model programs led to policies and procedures that currently comprise P.L. 99-457 and P.L. 102-119 (Hebbeler, Smith, & Black, 1991).

P.L. 102-119 was the culmination of an evolutionary process that spanned decades of legislation designed to enhance states' capacity to provide services for young children with disabilities (Hebbeler et al., 1991). P.L.

99-457 altered public policy for children under age 3 and their families. The requirement of an IFSP redefined the service recipient as the child and the family. Procedures to develop the IFSP now require that the child's parent(s)/legal guardian(s), if they so choose, be full, participating members of the multidisciplinary team (Roberts, Wasik, Castro and Ramey, 1991). The team discusses the results of the professional evaluations relative to the child's current developmental status and makes recommendations for programming (Krauss, 1990). This IFSP process was required in an effort to establish collaboration between professionals and family members. Professionals who had been trained to evaluate children and provide services now had to develop methods for evaluation that permitted family involvement, including clear yet sensitive lines of communication to help parents become fully informed participants in planning services for their child with disabilities (Healey et al., 1985; Johnson et al., 1991).

Evaluation and Assessment of Children with Disabilities

Identification of children in need of intervention and services to enhance development or ameliorate delay is complex. P.L. 99-457 requires that qualified professionals conduct a multidisciplinary assessment of unique needs and the identification of services appropriate to meet such

needs. The pertinent rules and regulations define evaluation as:

> "the procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility consistent with the definition of infants and toddlers with disabilities including determining the status of the child in each of the developmental areas" (Federal Register, Vol. 58, No. 145, July 30, 1993, p. 40,971).

Assessment is defined as:

> "the ongoing procedures used by appropriate qualified personnel. . .to identify the child's unique strengths and needs and the services appropriate to meet those needs, and the resources, priorities and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with a disability" (p. 40,971).

Although federal legislation and regulations do not require standardized testing or formulation of an intelligence quotient, stanine or standard deviation score, they do require comprehensive assessment of many child and family variables for use in decision making process (Meisels & Provence, 1989).

A crucial component of the planning and delivery of services to infants and toddlers with disabilities and their families is the ability to accurately distinguish those in need of services from those who will develop well without intervention (Chamberlin, 1987; Kochanek et al., 1990). Professionals must be able to predict future developmental

outcomes from present behavior. Resources describing preferred practice in evaluation and assessment are plentiful (Bailey & Wolery, 1984; Brooks-Gunn & Lewis, 1983; Johnson & Beauchamp, 1987; Meisels & Provence, 1989; Salvia & Ysseldyke, 1988). For example, professionals must be qualified. The reasons for the testing must be considered and the tests used must be appropriate for the child and family. The law indicates that the impact of the child's disabilities on his or her ability to perform must be taken into account and the test must not be culturally biased. Further, the child should be observed in a number of environments including the natural environment and no single measure should be used to determine evaluation results.

Research results indicate that even when administered correctly, measures of infant intellectual ability do not correlate well with future intellectual competence (Chamberlin, 1987; Fewell-DuBose, 1981; Kochanek et al., 1990; Shonkoff, 1983). Practitioners and researchers have criticized the ability of developmental tests to identify children in need of services (Brooks-Gunn & Lewis, 1983; Dunst & Rheingrover, 1981; Meisels, 1992; Shonkoff, 1983; Wolff, 1989). In addition, reliance on measures for which the normative data do not adequately represent the population being tested can lead to biased results and decision making (Bailey & Harbin, 1980). Cultural differences correlated with variations in infant

developmental rate have been documented. Researchers have found advanced development of large motor skills by Ugandan infants and advanced language acquisition by British children. Development of infants in other cultural groups have shown systematic delays (Shonkoff, 1983). Shonkoff cautions that although professionals intend to evaluate infants and toddlers for the purpose of identifying vulnerable children in need of services, they may be attaching stigmatizing labels to children because of culturally related developmental differences.

In a thorough and long-term study, Kochanek et al. (1990) found that results of developmental and intellectual testing with children before age four were not predictive of later delay. They studied the developmental histories of 268 adolescents who were receiving special education services in Rhode Island and compared them with 268 adolescents who were not receiving special education services. All of the adolescents had been included in the National Collaborative Perinatal Project and were indistinguishable in terms of health and development at birth. Kochanek et al. analyzed data taken at birth, 4 months, 8 months, 12 months, 3 years, 4 years and 7 years. Until the age of four, the level of maternal education was the factor that correlated most significantly with placement in special education at adolescence. This corroborates the

findings of other research (Chamberlin, 1987 and Ramey in Brooks-Gunn & Lewis, 1983).

In addition to child-centered evaluation, P.L. 99-457 required that the IFSP contain a statement of the family's strengths and needs relating to enhancing the development of their family's handicapped infant or toddler. The additional requirement to evaluate the family's ability to support and aide their child assumed a sophisticated and accurate technology that has not been developed and further required professionals to make complicated predictions (Meisels & Provence, 1989). P.L. 102-119 amended the wording in this section to require a family-directed assessment of the resources, priorities, and concerns of the family and the identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with a disability. It further limited family directed assessment to qualified professionals and stated family-centered considerations must be included.

Ideally, assessment tools, naturalistic observation, arena assessment and clinical judgment all factor into the decision- making process that qualifies a child for services and contributes to the information utilized in the development of the IFSP and then into the services for the child and family (Fewell, 1991). Meisels and Provence (1989) recommended that the multidisciplinary evaluation and

on-going assessment include medical information, information from standardized assessment tools, analysis of the child's environment through checklists and information gathered from parent interviews.

Professionals who participate in the evaluation of infants and toddlers with disabilities and the development of the IFSP must be trained not only in assessment skills, but be knowledgeable about the handicapping conditions of the child, evaluation of family strengths, communication skills and collaboration skills (Stayton & Johnson, 1990). Professionals who evaluate infants and toddlers must know how to use the information accurately and work with members of a team to use the evaluative data and their judgment to reach decisions concerning services to the child. Campbell (1991) stated that information from evaluation is frequently used as the sole basis for determining goals and objectives for an infant or toddler. A strong emphasis of the legislation is the family's right to determine goals or outcomes and to accept or decline any early intervention services for their child. Campbell (1991) stated that assessment data are generated using traditional approaches but then follow family generated outcome determination. Ideally, this outcome determination is part of an ongoing process but occurs formally at the IFSP meeting. The link between evaluation and the IFSP process requires flexibility and strong communication to ensure that early intervention

services address the needs of infants and toddlers with disabilities and their families (Bailey et al., 1990).

The Individualized Family Service Plan for Arizona

Arizona, in accordance with section 677 of P.L. 99-457, developed a definition and declaration of purpose for the Individualized Family Service Plan (IFSP).

> The IFSP is an agreement reflective of the current needs, wants, and desires of the family in relation to their child who has special needs. This agreement is formulated and implemented as a result of a dynamic, collaborative, cooperative team process involving the family and professionals from multiple disciplines and agencies. The core of this team is the family.
>
> The individualized family service plan documents the efforts of the team to meet the global developmental or quality of life needs of the infant or toddler. It is designed to (1) aid the family with defining the child's strengths and abilities; (2) be maintained as a "living" document at all times, reflecting the families current desires for information, supports and services; and (3) offer the family support and assistance in identifying and accessing resources (formal and informal) and services (home based and community based whenever possible) on behalf of their child and or family (Walker, J., Arizona's IFSP Principles, Policy and Procedures, February 8, 1990, by the Arizona IFSP Task Force).

The IFSP is a major mandate of the new legislation to provide programming for infants and toddlers and their families (Brown, 1991; McGonigel et al., 1991). The IFSP is only one of the 14 components of the statewide

multidisciplinary interagency program of early intervention services, but is noteworthy because it is a pro-active family-centered system of services (Johnson et al., 1989). The law establishes parents as educational decision-makers and recognizes the critical role parents and families assume in the development of a child (Roberts, 1993). It requires multidisciplinary team members to collaborate with families to develop the IFSP, allows family members to become full team members, and makes it clear that the ultimate decision-making authority rests with the family (Nash, 1990). Team goals are to be based directly on the wishes and needs of the eligible child and the family (Nash, 1990). The legislative history of P.L. 99-457 stressed respect for family preferences for involvement, use of family concerns to guide assessment and planning of service delivery to the needs and wishes of the family (United States Code, Congressional and Administrative News, 99th Congress, 1986).

The Federal Rules and Regulations governing implementation of P.L. 102-119 (Federal Register, July 30, 1993) which was not in force at the initiation of this study, detail current requirements for the IFSP. The initial IFSP meeting must be conducted within 45 days after a child has been determined to be eligible for services. Federal regulations specify IFSP development, review, evaluation processes, as well as who must attend the IFSP

meeting. Section 303.344 specifies the content of an IFSP, which must include:

> (a) A statement of the child's present level of development (including vision, hearing and health status), cognitive development, communication development, social or emotional development, and adaptive development, based on professionally acceptable objective criteria.
>
> (b) With the concurrence of the family, a statement of the family's resources, priorities, and concerns related to enhancing the development of the child.
>
> (c) A statement of the major outcomes expected to be achieved for the child and family, and the criteria, procedures and time lines used to determine progress made and modifications necessary.
>
> (d) A statement of the specific early intervention services necessary to meet the unique needs of the child and the family to achieve the outcomes identified in paragraph (c) including:
>
> i. frequency, intensity, and method of delivering the services;
> ii. the natural environments in which early intervention services will be provided;
> iii. the location of the services; and
> iv. payment arrangements, if any.
>
> (e) Other services: Medical and other services including the funding sources for these services.
>
> (f) The projected dates for initiation and anticipated duration of services.
>
> (g) Name of the service coordinator.
>
> (h) The steps to be taken to support the transition of the child to preschool or other appropriate services (pp. 40,972-40,974).

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

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

Rationales and Barriers

Bernheimer, Gallimore and Weisner (1990) stated that the family emphasis of P.L. 99-457 not only makes intuitive and conceptual sense, but reflects best practice in early intervention. Emphasis on family goals is consistent with abundant literature supporting the view of the child within the family and involved family members as decision-makers (Bailey et al., 1990). Families have established their own relationships, daily routines and particular place in the environment. They are at a strategic, pivotal point to effect child change because they know their child best and typically spend more one to one time with the child than anyone else (Cartwright, 1981). Bernheimer et al. (1990) believed that, in the past, professionals made decisions about what services were necessary and at times created additional stress for families. For example, a professional might have believed that a mother would benefit from attendance at a support group when the mother did not feel such a need.

McGonigel et al. (1991) stated that the IFSP has the potential to guide professionals as they move from child centered to family centered planning and services.

Although the IFSP component of the law provides the most potent vehicle for redefinition, reshaping and redirection of early intervention (McGonigel et al., 1991), legal, fiscal and structural barriers exist that inhibit

full implementation of the IFSP requirements and ideals (Nash, 1990; Brown, 1991). A shortage of qualified personnel prevents full implementation of a comprehensive system of services and many professionals now delivering services have not been trained to work with families (Bailey et al., 1991). The prevailing paradigm for service development and training of professionals prior to P.L. 99-457 was designed by developmental psychology and was child centered. Professionals, now, must become prepared to understand and work within the family niche and eco-cultural context, including family beliefs and values to assist in the writing and implementation of the IFSP (Bernheimer et al., 1990).

Even in programs where the IFSP process is meeting technical requirements, Nash (1990) reported barriers to family participation. He said that the most influential member of the inter-disciplinary team is the individual perceived to have the most power and expertise. Typically, this individual is not the parent. Nash (1990) and Smith (1990a) stated that, in the past, the family members on a planning team carried little power or influence. Nash (1990) suggested that when family members are involved in assessment, their participation can increase the expertise professionals perceive them to possess. Some authors have suggested a common language must be developed so that all members of the team agree on the meanings of terms and

information should be shared in such a way that families are able to evaluate alternatives and options (Nash, 1990; McGonigel et al., 1991). Bailey, et al. (1992) reported results of their survey indicated that professionals do not believe families have the skills necessary to participate fully. Nash (1990) suggested professionals must honor the individual characteristics of each family and accept parents as the experts on their child.

With this new, family-driven system, family members who so desire are to be included at all levels of planning and assessment. Professional's and parent's ability to communicate with one another and work as partners on the multidisciplinary team are crucial to implementation of the ideal discussed in the legislative history of P.L. 99-457 (McGonigel et al., 1991). Bailey et al. (1990) stated if communication between families and professionals does not occur, the IFSP or goal document is likely to have little meaning. McGonigel and Garland (1988) asserted that professionals should be less concerned with making a place for parents on the multidisciplinary team than with developing skills and strategies that will enable professionals to become successful members of the family's team.

Assumptions Concerning Services to Infants and Toddlers

The decision on the part of the federal government to provide services to young children with disabilities is based on several assumptions resulting from the information gathered prior to writing the legislation. The information included testimony by witnesses at seven hearings, discussions with experts from around the country, a review of reports submitted by the Department of Education, a report Toward Independence issued by the National Council on the Handicapped and a review of the literature (Legislative History for P.L. 99-457, p. 5). The legislative history lists seven benefits accomplished by early intervention. Early intervention can:

1. help enhance intelligence in some children;

2. produce substantial gains in physical development, cognitive development, language and speech development, psycho-social development and self-help skills;

3. help prevent the development of secondary handicapping conditions;

4. reduce family stress;

5. reduce societal dependency and institutionalization;

6. reduce the need for special class placement in special education programs once the children reach school age; and

7. save substantial costs to society and our nations schools (Legislative History, p. 6).

Gallagher (1992) said the requirements of P.L. 99-457 express a mix between facts and values. Further, "every piece of legislation that affects people is essentially a series of assumptions or hypotheses about human behavior" (Gallagher, 1992, p. 2). He lists some of the major assumptions embedded in P.L. 99-457.

1. The earlier the treatment the better, since the legislation focuses on early intervention to enhance later outcome in development for the child.

2. The more professional disciplines that participate, the better, because the legislation requires multidisciplinary participation in planning and implementation of services.

3. Families are important because the law is strongly worded to empower families in the planning and implementation of services for their child. Values inherent in requirements of the legislation are that the more often parents participate in programming for their child the greater likelihood of progress for the child. Further, the empowerment of families in the legislation expresses acceptance of the family as the keystone of society.

4. Qualified personnel are needed because the legislation supports the development of a well-prepared group of personnel. The value statement inherent in this wording is that loving care is not enough to obtain observable improvement in development.

5. Children who are at risk should be helped. The legislation supports identification and provision of services to children who do not qualify for services because of a specific, existing developmental delay, expressing the value that all children who need help should be assisted (Gallagher, 1992, p. 2).

Yoder (1990) explored assumptions concerning delivery of services to infants and toddlers. He identified three models of infant intervention: (1) direct intervention with the infant, as when therapeutic toys are provided, (2) intervention through an interventionist, as when a trained therapist provides skill training, and (3) provision of social support to the family to indirectly enhance infant development. Although P.L. 99-457 enabled intervention at all three levels, Yoder concluded that assumptions made by professionals underlie all three approaches to infant intervention. Efficacy research is needed concerning services intended to facilitate infant development to determine which levels of intervention services yield the greater benefits.

Bailey, Buysse, Edmondson and Smith (1992) have listed four assumptions regarding improved child outcomes as a result of family centered services.

1. Intervention with the support and participation of families influence children.

2. Interventions that involve families will be more powerful than exclusively child focused interventions.

3. Family members should be able to choose their own level of involvement in the child's intervention program.

4. Professionals should attend to family priorities and goals even when they differ substantially from professional priorities. (p. 299)

Summary

Chamberlin (1987) reviewed research concerning professionals' ability to identify infants and toddlers who will exhibit developmental delay at school age. He then examined research concerning the benefits children and families might expect because of participation in early intervention programs. Finally, he reviewed psychological research concerning the negative impact of identification of an infant or toddler as at risk for developmental delay. From his research and review, Chamberlin acknowledges that early intervention programs can be of considerable benefit to children experiencing delays. However, he also concludes that professionals cannot accurately predict which infants and toddlers are likely to exhibit developmental delay with the use of existing assessments and that parents perception of their child's abilities can be influenced negatively when their child is labeled as delayed or at risk for delay. Therefore, professionals involved in early intervention must operate with caution to assure that they enhance the development of infants and toddlers experiencing delays or being at risk for delay without negatively impacting the child and family.

Knowledge and services in early childhood education have expanded substantially in the past thirty years at considerable cost. The presumption is that outcomes for infants and toddlers and their families will be enhanced and

thereby save federal expenditures for remediation services when: (1) services are family centered; (2) services include family members in the planning process; and (3) provision of services adhere to family desires and goals (Toufexis, 1991). Gallagher (1992) and Yoder (1990) called for study of legislative implementation and how assumptions are substantiated in the design and implementation of services. Bailey et al. (1990) stated that implementation of the law must be studied to extend our knowledge and to facilitate improvement in delivery systems. Baer (1993) said that the planners of services often fail to study the ways in which programs are implemented. He said we must study the "stitchers and weavers" who bring planned programs into practice to evaluate our progress. Such recommendations for research to examine the assumptions inherent in P.L. 99-457 as they are implemented serve as impetus for the present study.

CHAPTER THREE

METHODOLOGY

This chapter describes the process used in obtaining approval for the study, the subjects, and the procedures followed for data collection and analysis.

Approval Process

In July, 1992, contact was made with Mr. Ronald Barber, Program Manager for Division 2 of the Division of Developmental Disabilities and the coordinator for child and family services, Tucson, Arizona. A presentation of the proposed research was made to all family service coordinators (case managers) and an informed consent document was developed for parents or guardians to grant access to the confidential files of involved children. The student researcher, Ms. Susan Eck, was granted access to the confidential files of children who were receiving services following written permission from their parents or guardians.

Initially, the family service workers were requesting permission from the families, but response rate was very low. In November, 1992, a second procedure to obtain informed consent was implemented. Intake coordinators who met with families to determine service eligibility for their child explained the procedure and goals of the research and

sought participation. Families who indicated willingness to participate were asked to sign an informed consent document. Following receipt of permission, the secretary for child and family services phoned the researcher and gave her the name of the family, the name of the family service coordinator and the location of the child's confidential file. The researcher then made arrangements to obtain the file and record relevant information.

Subjects

The sample population for this research was comprised of family members who received services through the Division of Developmental Disabilities (DDD) in District 2, Pima County, Arizona between November 1, 1992 and May 1, 1993, and who, with the IFSP team, created the IFSP goal or outcome statements. A family might be referred to DDD by a physician or other medical professional, social worker, case worker, or any community member who has concerns about the development of the infant or toddler in the family. Following contact with DDD, a staff member in the Program for Child and Family Services meets those family members involved with the child to conduct an intake interview. Evaluations are then scheduled to determine if the child meets the current criteria for services. The criteria for services are explained in the previous section.

Subjects in this study included all children and families served within the DDD system in District 2 who:

1. Signed a consent form to have data taken from the file of their child.
2. Had their first IFSP written prior to May 1, 1993.

From November 1, 1992 to May 1, 1993, 136 children aged birth through 2 and their families were determined to be eligible for services through DDD. Sixty families signed an informed consent permission for their files to be used in this study. Of the sixty families, 49 had files containing whole or partial IFSP documents and were analyzed for procedural compliance with the seven required components for an IFSP. An IFSP was counted if it was in the child's file and labeled as the IFSP. The remaining 11 families who signed permission for their files to be used did not have an IFSP written prior to May 1, 1993. The regulations require that the IFSP be written within 45 days of the start of services. In all 11 cases, 45 or more days had passed since the start of services, with a mean duration of services of 158 days as of May 1, 1993. (In one case, the case manager reported that the family was no longer at the address listed and she had been told that the family left the country.)

Fourteen of the 49 files containing IFSP's were eliminated because they did not contain both recorded recommendation statements and goal statements. Seven of these files contained recorded recommendation statements, but no recorded goal or outcome statements. Six of these files contained recorded goal or outcome statements, but no

recorded recommendation statements. One file was written prior to the birth of the child and therefore contained no recommendations related to the child and the goal statements addressed activities for the prospective mother to complete prior to the birth of her child. To review the number of IFSP files used for the two evaluations included in the study:

> 49 IFSP documents were examined for procedural compliance.
>
> 35 IFSP documents were evaluated by developmental area and for congruence between goal statements and professional provider recommendations.

Twenty case managers served as coordinators for the 60 families included in the total sample. However, in the analysis of congruence by case manager, the families of only 15 case managers were represented. Five case managers were eliminated from the sample because either their files did not contain an IFSP or the IFSP did not contain both recommendation and goal statements.

The gender and ethnicity for the sample population were as follows:

Table 1. Gender of Children Included in the Study

	Male	Female
136 DDD eligible children	75 (55%)	61 (45%)
60 who signed permission	27 (45%)	33 (55%)
49 whose files were analyzed for compliance	24 (49%)	25 (51%)
35 whose files were evaluated by developmental area and congruence	18 (51%)	17 (49%)

Table 2. Ethnicity of Children Included in the Study

	Caucasian	Hispanic	Native Amer.	Black	Asian	Unknown
136 DDD Eligible Children	64 (47%)	48 (35%)	9 (7%)	8 (6%)	2 (1%)	5 (4%)
60 Who Signed Permission	26 (43%)	32 (53%)	1 (2%)	1 (2%)	0	0
49 Whose Files Were Analyzed For Compliance	22 (45%)	25 (51%)	1 (2%)	1 (2%)	0	0
35 Whose Files Were Evaluated By Developmental Area and Congruence	14 (40%)	19 (54%)	1 (3%)	1 (3%)	0	0

The mean ages for the sample population at the start of services and at the time of the IFSP are as follows:

Table 3. Ages of Children Included in the Study

	Mean Age at Start	Mean Age at IFSP
Compliance Sample	237 days (7.8 months)	339 days* (11.1 months)
Congruence Sample	261 days (8.6 months)	365 days* (12 months)

***Note:** Two IFSP's were undated and one was written prior to the birth of the child and therefore were not included in this distribution.

Table 4. Distribution of Ages at Time of IFSP

	0-6 mos.	6-12 mos.	12-18 mos.	18-24 mos.	24-30 mos.	30-36 mos.
Compliance Sample *	12	17	9	3	3	2
Congruence Sample *	7	13	7	2	2	2

***Note:** Two IFSP's were undated and one was written prior to the birth of the child and therefore were not included in this distribution.

Procedures

File Access

Data obtained from individual files were used in this analysis. Data collection was scheduled to begin in August of 1992, but because of delays in obtaining informed consent from parents, data collection did not begin until November 1, 1992. The original proposal for research stated that data would be collected for three months. However, only about one-half of the eligible families granted permission

to collect data from the confidential file of their child. To obtain an adequate sample, data collection was extended from three to six months. During the six months of data collection, 136 families were admitted to services and 60 families agreed to allow their child's file to be included in the study.

The researcher collected data from 60 files beginning November 1, 1992 to May 1, 1993. The files were stored in four locations and included families served by 20 case managers. Each file was obtained from the case manager or secretary and relevant data from the IFSP's were typed into a laptop computer. The file was then evaluated for procedural compliance with the requirements for content of the IFSP plan.

Data Collection

Data were collected for 6 months, from November 1, 1992 to May 1, 1993. Data recorded from each file were as follows:

1. The child's gender;
2. The child's ethnicity;
3. The name of the family service coordinator;
4. The date of birth;
5. The start date for DDD services;
6. The date of the IFSP;
7. The recommendations for programming recorded on or attached to the IFSP document; and

8. Outcomes or goals chosen by the parent or guardian and the IFSP team and recorded on the IFSP document.
9. The IFSP document was examined for compliance with the seven requirements for content of the plan listed in P.L. 99-457.

Data Coding

Data coders were needed to make judgements concerning the developmental areas referred to in recommendation and goal statements and whether or not goal statements were congruent with recommendation statements. Skill requirements for the position included ability to read Spanish and English and familiarity with developmental areas. Two data coders were hired and trained by the student investigator. James Boyless, the primary data coder, is the father of a child who is being served through the Department of Developmental Disabilities. Myrna Munguia, the reliability data coder, is a teacher of young children with disability. In addition, Deni Cunningham, an intake coordinator for the Division of Developmental Disabilities, served as reliability evaluator for procedural compliance.

1. Procedural Compliance (n=49). The seven requirements for written information as specified in P.L. 99-457 were listed and each child's IFSP document was read to determine when such information was recorded on the IFSP document. The seven requirements were evaluated as follows:

a) *A statement of the infant's or toddler's present levels of physical development, cognitive development, communication development, social/emotional development and adaptive development, based on acceptable objective criteria.*

A mark of **yes** was given when any statement(s) of the infant's or toddler's present development was recorded on the IFSP document, regardless of whether all developmental areas or objective criteria were noted.

b) *A statement of the family's strengths and needs related to enhancing the development of the family's infant or toddler.*

A mark of **yes** was given when any statements of the family's strengths or needs were recorded on the IFSP document.

c) *A statement of the major outcomes expected to be achieved for the infant and toddler and the family, and the criteria, procedures, and time lines used to determine the degree to which progress toward achieving the outcomes are being made, and whether modifications or revisions of the outcomes or services are necessary.*

A mark of **yes** was given when any statement regarding major outcomes was recorded on the IFSP document.

d) *A statement of specific early intervention services necessary to meet the unique needs of the infant or toddler and the family, including the*

frequency, intensity, and the method of delivering services.

A mark of **yes** was given when any statement regarding specific early intervention services was recorded on the IFSP document. Services were counted as recorded whether or not the frequency, intensity and method of delivering services were included.

e) *The projected dates for initiation of services and the anticipated duration of such services.*

A mark of **yes** was given when both the dates of initiation and duration of services were recorded on the IFSP document.

f) *The name of the case manager from the profession most immediately relevant to the infant's and toddler's or family's needs who will be responsible for the implementation of the plan and coordination with other agencies and persons.*

A mark of **yes** was given when the name of the case manager was recorded anywhere on the IFSP document.

g) *The steps to be taken supporting the transition of the toddler to services provided under Part B to the extent such services are considered appropriate.*

A mark of **yes** was given when any information about transition was recorded anywhere on the IFSP document.

2. Congruence Coding. This study involved examination of recommendations made by professionals who evaluated the child. Recommendations were recorded on or attached to the IFSP document along with the goal or outcome statements for the IFSP. To be included in the analysis of congruence between professional recommendation and goal statements, the IFSP had to contain both recommendation and goal statements.

Step 1. The recommendations made by professional providers recorded on the IFSP were listed by the primary data coder.

Step 2. The goal or outcome statements recorded on the IFSP were listed by the primary data coder.

Step 3. Two data coders categorized the data. The primary data coder and the reliability data coder were trained to evaluate the recommendation statements and the goal or outcome statements in the following ways:

(a) They determined if statements referred to the developmental areas described in P.L. 102-119 as defined in the Battelle Developmental Inventory. They recorded **yes** when the statement related to the area or **no** when it did not and **none** when the statement did not relate to any developmental area). The developmental areas are:

1. physical development
2. cognitive development
3. communication development

4. social/emotional development

5. adaptive development

Statements could refer to development in more than one area; therefore, the primary data coder evaluated each statement to determine each developmental area referred to in the statement. Statements coded as **none** included primarily recommendation and goal statements that referred to activities for adults to carry out such as monitoring a child's weight, making medical appointments, obtaining training for parents or modifying the home environment.

(b) Each goal or outcome statement on the IFSP was compared for congruence to the statements made in the recommendations. Each statement on the IFSP was coded as follows:

1. A **yes** was recorded when the statement addressed the same or very similar issue or task stated in a recommendation (congruence).

2. A **no** was recorded when the goal statement on the IFSP did not relate to a recommendation statement (no congruence). An example was that a child learn to sleep in the crib instead of the carseat. The professionals who evaluated the child did not evaluate the child's sleeping behavior and made no recommendations addressing that concern. From the parent's perspective, however, sleeping in the crib was a primary concern. Therefore, the goal

statement on the IFSP was to teach the child to sleep in the crib.

Step 4. Intercoder reliability:

1. Procedural Compliance. Forty-nine files were examined for procedural compliance. Six files (12.5%) were examined by an intake coordinator for Division for Developmental Disabilities to determine reliability of the procedural compliance evaluation. The reliability coder for procedural compliance was given a list of the seven required components for the IFSP. The researcher and reliability coder evaluated a practice file together. The reliability coder was instructed to count a component as present (yes) when a whole or partial statement or piece of data met one of the seven requirements for content of the plan. The reliability coder was also instructed that when uncertain about whether to count a statement as being in compliance, to give "the benefit of the doubt" in favor of compliance. The agreement between the researcher and the reliability evaluator was 100% for the seven requirements for content of the plan.

2. Congruence Coding. The primary data coder categorized recommendation and goal statements for all children's files used in the study. The reliability data coder reviewed 24 of the 35 (68%)

IFSP files used for the analysis. Reliability was calculated for those files categorized by both data coders. The percent reliability was calculated as the number of agreements divided by the number of agreements plus disagreements. The primary data coder and the reliability data coder experienced difficulty in reaching an acceptable level of intercoder agreement as to what developmental areas should be included for some recommendation and goal statements. Even when practicing together, the data coders could not reach 100% agreement on decision-making concerning coding by developmental area. For example, for the recommendation to "continue visual tracking", one coder marked physical and the other marked cognitive. For the recommendation "imitate familiar gestures", one marked cognitive and communication and the other marked physical. "Play with cause and effect toys" was rated as physical and cognitive by one coder and as social/emotional by the other. Initially, the agreement concerning coding for developmental area resulted in 85.4% agreement for recommendation statements and 89% for goal statements. To improve agreement in decision-making, the primary data coder and the reliability data coder reviewed the definitions and practiced coding together on files that were not to be used

for reliability evaluation. Following this second practice session, the primary data coder reviewed his coding decisions and the reliability data coder, using blank coding forms, re-coded all 24 files. For this second reliability measure, the coders achieved 89% agreement for recommendation statements and 92% agreement for goal statements, for an average agreement of 90% for coding by developmental area.

The primary data coder and the reliability data coder also made decisions concerning whether or not goal statements were congruent with recommendation statements. They achieved 93% agreement.

Step 5. The results of the data coding were organized and summed by child and by category to obtain understanding of the implications of the data. Those results are reported in Chapter Four.

CHAPTER FOUR

RESULTS

The results of this study are reported for each of the five research questions.

To review the number of files used in this study, permission was given to take data from 60 files, 49 of which contained IFSP documents. Of the 49 IFSP documents examined, 35 contained both recommendation and goal statements. Research question 1 concerning compliance with the seven requirements for content of the plan was answered using information from 49 IFSP documents. Research questions 2, 3, 4 and 5 concerning developmental areas referred to in recommendation and goal statements and congruence between recommendation and goal statements used information from 35 IFSP documents.

The requirements of P.L. 99-457 for content of an IFSP plan were used for the evaluation of compliance in research question 1. P.L. 102-119, a more recent amendment to the law, adjusted the requirements for content of the plan. However, the requirements of P.L. 102-119 were not used because the regulations detailing such requirements were published after completion of data collection. The headings for developmental areas also were changed in P.L. 102-119. These new labels were used for the analysis of data by developmental area in research question 2 because

the changed terminology was being used in conversations at the Division of Developmental Disabilities and was not dependent on information in the regulations for clarification.

Research Question 1

Do the files evaluated contain the seven requirements for an IFSP as stated in P.L. 99-457?

Only eight (16%) of the 49 files evaluated contained all seven requirements for content of the IFSP plan.

The data were analyzed in two ways to obtain information concerning compliance for each file and compliance by requirement. First each IFSP file was examined to determine if information regarding every requirement was included. This provided a perspective of the number of requirements met in each child's IFSP document. Second, results for all IFSP's were summed by requirement to pinpoint areas of greater or lesser compliance.

The requirements for content of the IFSP plan are that a statement of the child's present level of development, family strengths and needs, major outcomes expected, specific services planned, initiation and duration of services, the responsible case manager, and the steps to be taken for transition to preschool or other services must be included.

For the first analysis, the data were reported as the number and percentage of IFSP documents meeting all 7, 6, 5, 4, 3, or 2 of the requirements. These numbers refer only to the total number of requirements included in any individual IFSP file. As can be seen in Figure 1, of the 49 IFSP documents examined, eight (16%) met all seven requirements for content of the IFSP plan. Three (6%) IFSP's met six of the seven requirements; 17 (35%) met five, nine (18%) met four, ten (21%) met three and two (4%) met two requirements for content of the IFSP plan (see Figure 1). The mean number of requirements met was 4.8 and the median and mode were five requirements met.

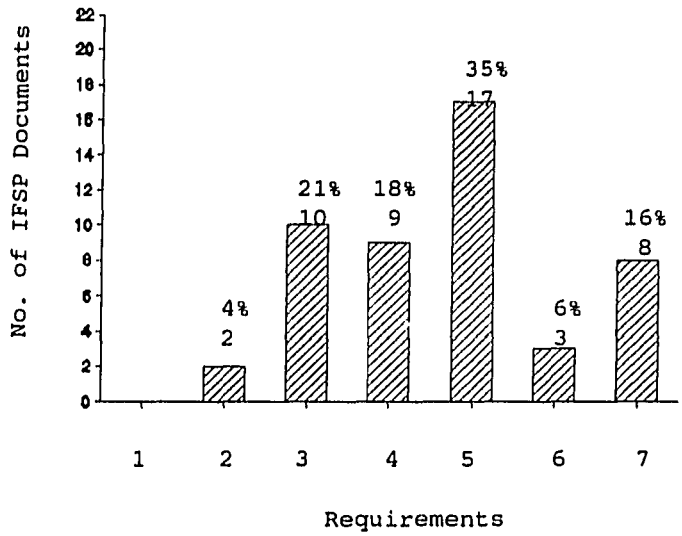

Figure 1. Distribution of IFSP documents by the number of requirements for content of the IFSP plan (n=49).

A second way the data were analyzed was by the number of IFSP's on which information relevant to each requirement was recorded. For example, of the 49 IFSP's examined, how many

contained a transition plan? This analysis provided an overview of how well the IFSP teams were meeting the requirements for what was to be recorded on the IFSP document.

Table 5. Percent of IFSP Documents that Recorded Information Pertaining to Each Content Requirement

	Content Requirements	Percentages
a.	Present Level of Development	86% (n=42)
b.	Family Strengths & Needs	57% (n=28)
c.	Major Outcomes Expected	80% (n=39)
d.	Specific Services	80% (n=39)
e.	Initiation and Duration	49% (n=24)
f.	Case Manager	92% (n=45)
g.	Transition Plan	24% (n=12)

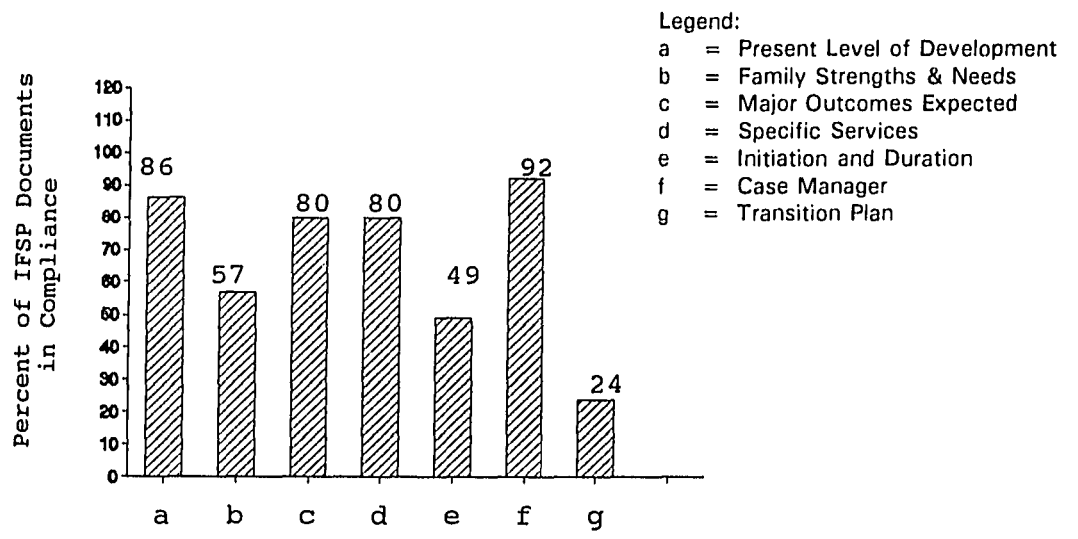

Figure 2. Percent of IFSP documents containing recorded information pertaining to each of the seven requirements for content of the plan in P.L. 99-457.

From the data presented in Table 5 and Figure 2, the requirement that achieved greatest compliance (92%) was the name of the case manager recorded on the document. Lowest compliance (24%) was the requirement for the IFSP to include steps to be taken to support the transition of the child to preschool or other services. Eighty-six percent of the files included some statement of present level of development. Major outcomes expected and specific services planned for the child and family were recorded in 80% of the files. Fifty-seven percent of the IFSP documents recorded information concerning family strengths and needs. Fewer than half of the IFSP documents (49%) specified dates for initiation and duration of services (see Figure 2).

Research Question 2

Are the five developmental areas specified in the IFSP under present level of development referred to with equal frequency in recommendation and goal statements recorded on the IFSP (using the revised terminology in P.L. 102-119 of physical, cognitive, communication, social/emotional and adaptive development)?

The five developmental areas were not addressed with equal frequency. Of the 49 files containing IFSP documents, 35 contained both recorded recommendation and goal statements. A by-child analysis of the IFSP documents was done to determine the number of developmental areas referred to in each child's recommendation and goal statements. This

is a measure of whether or not the developmental area was referred to at all in either the recommendation section or goal section of the IFSP document.

Six of the 35 recommendation sections of IFSP documents examined referred to all five developmental areas listed in the law. The goal statements for one child referred to all five developmental areas. The recommendation section for 14 IFSP documents referred to one of the five developmental areas. The goal section for 20 of the IFSP documents referred to one of the five developmental areas. The recommendation section of one child's IFSP document referred only to activities categorized as none and three children's goal sections referred only to activities categorized as none. The recommendation and goal statements for the remaining IFSP files were fairly evenly distributed among four areas, three areas and two areas as illustrated in Table 6 and Figure 3.

Table 6. Number of developmental areas referred to in recommendation and goal statements by IFSP document (n=35) (developmental areas: physical, cognitive, communication, social/emotional and adaptive).

Number of Areas	Recommendations	Goals
5	6	1
4	3	4
3	5	4
2	6	3
1	14	20
no areas	1	3

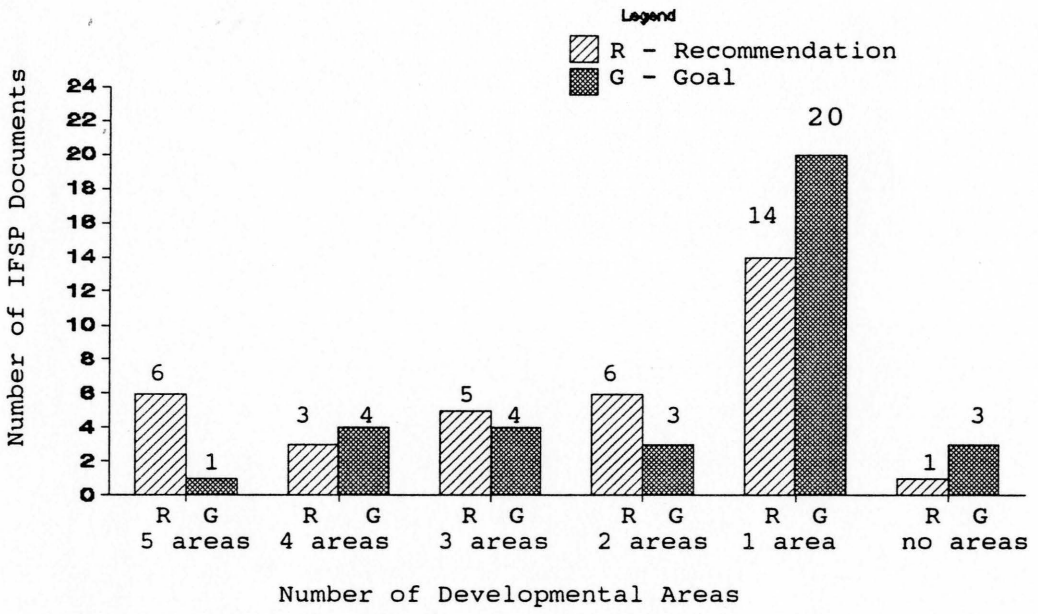

Figure 3. Number of developmental areas referred to in recommendation and goal statements by IFSP document (developmental areas: physical, cognitive, communication, social/emotional and adaptive).

The 35 IFSP documents evaluated contained 245 recommendation statements and 99 goal statements. Each recommendation statement and goal statement was evaluated to determine all developmental areas referred to by the statement. Statements could refer to development in more than one area or a sixth category, none. Statements coded as none included primarily recommendation and goal statements that referred to activities for adults to carry out such as making medical appointments, obtaining training for parents or modifying the home environment.

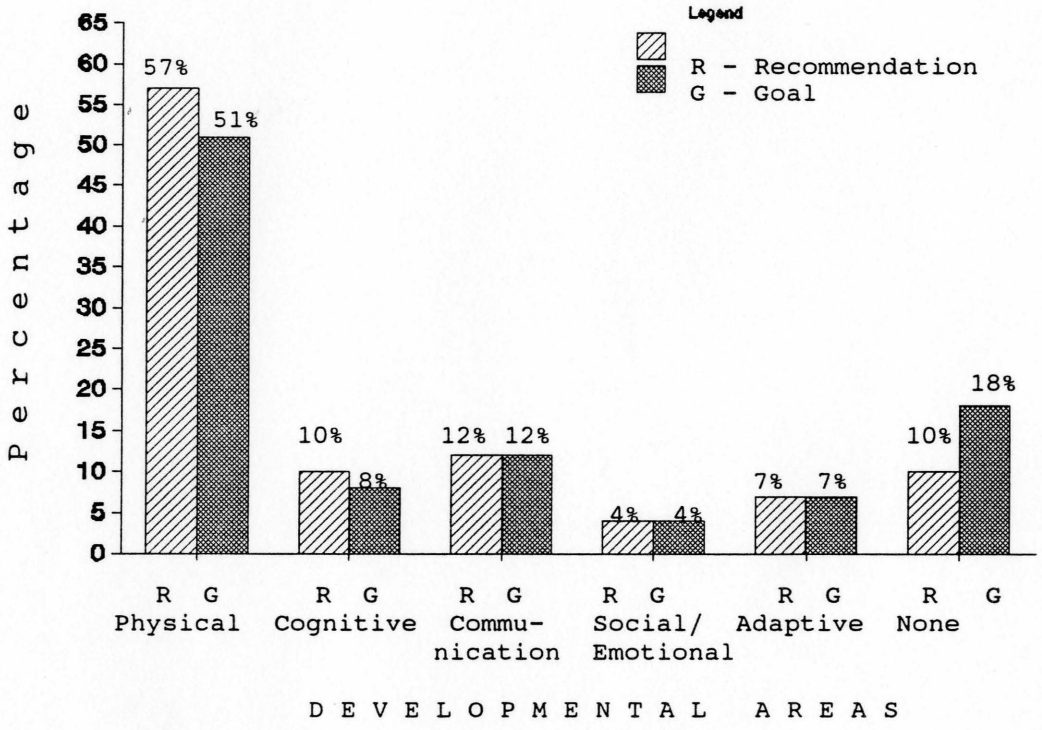

Figure 4. Percent of recommendations (R) and goals (G) referring to each developmental area.

The data were then summed by references to developmental areas to obtain a frequency of occurrence. As presented in Figure 4, this evaluation compares the references to a developmental area against the total number of references. For the 35 files examined, statements were coded as referring to a developmental area 311 times for recommendations and 122 times for goals. (Note: The number of references exceed the number of statements because statements could be coded as referring to more than one area.) Both recommendations and goals are shown in the same figure to illustrate the similarity in distribution by developmental areas. The majority of both the recommendation and goal statements referred to the physical development of the child, 179 (57%) of 311 for recommendations and 62 (51%) of 122 for goals. Communication development was next with 37 (12%) in recommendations and 15 (12%) in goals. The least referred to area for both recommendations and goals was social and emotional development with only 12 (4%) for recommendations and 5 (4%) for goals. The other two developmental areas, cognitive and adaptive were referred to in 32 (10%) and 21 (7%) of the recommendations. Cognitive and adaptive development were referred to in 10 (8%) and 8 (7%) of the goals. Thirty (10%) of the recommendations referred to activities that were classified as <u>none</u> or not relating directly to the developmental areas of the child. For the

goals, 22 (18%) of the statements were classified as referring to none of the developmental areas.

Representation of the developmental areas was reviewed in all the recommendation and goal statements for each child's IFSP by asking and answering the following question: "For this subject, was any recommendation made that referred to the area of physical development?" The same question was repeated for cognitive, communication, social/emotional and adaptive and **none**. Then the same questions were asked for each subject's goal statements. This yes or no categorization of the data yielded a count of the number of IFSP's in which reference to a developmental area was made. This analysis controls for the variable number of recommendation and goal statements made from file to file. It is a by-IFSP file analysis, by developmental area. Table 7 summarizes the data by developmental area. For example, the recommendations in 32 of the 35 IFSP's made reference to the physical area of development. Physical development was referred to in the goal sections of 31 of the 35 IFSP's evaluated.

Table 7. Developmental Areas Referred to/by IFSP (n=35).

Developmental Areas	Recommendations	Goals
Physical	32	31
Cognitive	15	8
Communication	17	11
Social/Emotional	8	4
Adaptive	11	5
None	19	12

A chi-square test was conducted to determine if the observed frequencies fit the theoretically expected frequencies. The difference in frequency to which developmental areas were referred was significant (X^2=102.29, df=15, p .001).

Research Question 3

Does congruence exist between recommendation and goal statements made by professional providers that were recorded on the IFSP?

A low rate of congruence between goal and recommendation statements was found. Ninety-nine goal statements were recorded on the IFSP documents for the 35 subjects whose files were evaluated. Of the 99 goal or outcome statements evaluated, 25 (25%) were coded as congruent to a recommendation. Seventy-four (75%) of the goal statements

evaluated were coded as not congruent or not the same or similar to any recommendation made for that child.

Table 8. Summary of Congruence Between Recommendation and Goal Statements

Recommendations	245
Goals	99
# Goals congruent	25 (25%)
# Goals incongruent	74 (75%)

An Apriori chi-square test conducted to determine if the difference in congruence and non-congruence of goal statements was beyond what might be expected for an independent sample revealed significance at p .01 (X^2=24.25, df=1).

Research Question 4

Do differences in gender and ethnicity affect congruence between recommendation and goal statements recorded on the IFSP?

The data did not indicate differences in recommendation and goal statements based on ethnicity or gender. Four ethnic groups were represented in the sample of 35 subjects whose IFSP documents were evaluated. Nineteen children (54%) were reported to be Hispanic, 14 (40%) Caucasian, one

(3%) Native American and one (3%) Black. Table 8 shows the number of recommendation and goal statements and congruence by ethnic group.

Table 9. Congruence of Recommendation and Goal Statements by Ethnic Group

	Recommendation	Goal	# Congruent
Hispanic (n=19)	118	52	9 (17%)
Caucasian (n=14)	104	40	13 (33%)
Native American (n=1)	16	6	3 (50%)
Black (n=1)	7	1	0 (0%)
Totals	245	99	25 (25%)

Two chi-square, contingency table analyses (Shavelson, 1988) were conducted on ethnicity to determine if differences in congruence were significant. An all ethnic group analysis was not significant (X^2=5.11, df=3, p .05). Native American and Black ethnic groups were each represented by a single IFSP file so they were omitted from a second analysis of the data. A chi-square test of the congruence for Hispanic and Caucasian children's IFSP files was not significant (X^2=2.66, df=1, p .05). Variation in congruence could not be accounted for by ethnic difference.

The data were analyzed by gender and appear in Table 9.

Table 10. Congruence of Recommendation and Goal Statements by Gender

Gender	Recommendation	Goal	# Congruent
Males	110	50	16 (32%)
Females	135	49	9 (18%)

A chi-square test, contingency table analysis, (Shavelson, 1988) conducted using the Yates correction for continuity for a 2 by 2 design revealed no differences of significance (X^2=1.34, df=1, p .05). The variables of congruence and gender are independent in the sample.

Research Question 5

Does the congruence between recommendation and goal statements recorded on the IFSP vary by case manager?

Differences were found in congruence between recommendation and goal statements when analyzed by case manager, but acceptable degree of statistical significance was not found. There were 15 case managers coordinating the services for the 35 subjects and their families whose IFSP documents were included in the congruence analysis. Table 11 lists the number of IFSP's, goals, and number congruent by case manager.

Table 11. Congruence of Recommendation and Goal Statements by Case Manager

Case Manager N = 15	# Cases N = 35	# Goals N = 99	# Congruent N = 25
A	4	11	2 (18%)
B	2	7	1 (14%)
C	2	10	6 (60%)
D	1	2	0 (0%)
E	1	3	2 (67%)
F	1	4	1 (25%)
G	1	3	2 (67%)
H	1	2	0 (0%)
I	6	20	7 (35%)
J	8	19	2 (11%)
K	4	8	1 (13%)
L	1	3	0 (0%)
M	1	3	0 (0%)
N	1	2	1 (50%)
O	1	2	1 (0%)

The number of goals written on the IFSP document varied but had a mean of 2.83, median of 3 goals and a mode of 2 goals. The congruence between goals and recommendations also varied by case manager from a congruence of 67% for the files of one case manager to no congruence for five case

managers. The number of files by case manager varied and tended to be small. A chi-square test, contingency table analysis, (Shavelson, 1988) conducted to determine if the variation in congruence could be accounted for by difference in case manager was not significant (X^2=21.11, df=14. p=.05).

Because nine case managers contributed only one IFSP file for examination, a second chi-square test was conducted to determine if variation in congruence could be accounted for by difference in case manager using only the IFSP files of the 6 case managers who contributed two or more IFSP files. No difference of significance was found at p .05 (X^2=10.99, df=5), but became significant at p=.10.

Summary

The findings of this study show a low rate of compliance with the seven requirements for content of the IFSP plan. Further, all developmental areas are not referred to with equal frequency. Finally, a statistically significant difference exists for congruence between goal and recommendation statements recorded on the IFSP document that cannot be accounted for by gender or ethnicity. To some extent, the variance in congruence may be affected by differences in case managers.

CHAPTER FIVE

CONCLUSIONS

This research provided data regarding specific aspects of the IFSP process of planning services for young children with disabilities and their families. The system of service delivery is being revised, adjusted and is evolving continuously. For example, during the six months of data collection (November, 1992 to May 1, 1993), the English version of the printed forms used to create the IFSP document was changed three times by the Division of Developmental Disabilities. Although the basic content of the forms did not change, case managers and IFSP teams had to adjust to altered forms and the way items were to be listed three times in six months.

In addition to a changing service delivery system, some authors have stated that this revised system for children with disability and their families has incorporated several assumptions (Bailey et al. 1992; Bailey and Simeonsson, 1986; Gallagher, 1992; and Yoder, 1990). In this study, the research questions were designed to determine if several assumptions concerning implementation of the IFSP were accurate. The research questions are reviewed to show that some assumptions incorporated into the requirements of the law are not verified by the data. Implications of the data are discussed by research question.

1. Do the files evaluated contain the seven requirements for an IFSP as stated in P.L. 99-457?

The assumption investigated in this question is that IFSP files will contain the seven requirements listed in Public Law 99-457. In this study, they did not.

The criteria used for evaluation of compliance with the requirements of the law were very liberal. Any statement recorded anywhere on the IFSP document that referred to a requirement was counted as compliance, yet no requirement for content of the plan achieved 100% compliance.

Only 57% (n=28) of the IFSP documents examined included statements regarding family strengths and needs. This may indicate a discomfort level with this requirement for either case managers (family service coordinators) or families. Amendments in P.L. 102-119 have altered the wording of this requirement as follows:

> A statement of the families resources, priorities and concerns relating to enhancing the development of the family's handicapped infant or toddler. (p. 597).

The regulations to P.L. 102-119 also added that such statement be made only with concurrence of the family. Changes in this requirement indicate attempts to improve functioning of the IFSP process through adjustment to the law. Further investigation is necessary to determine whether the amended wording resulted in greater compliance.

The least complied with requirement for content of the IFSP plan was to record information concerning the steps to be taken to support the transition of the child to preschool or other services. As reported in the methods section, the mean age of the children from whose IFSP documents data were taken was 365 days (one year). The majority of these children would not transition to preschool or other services for two years. The absence of transition plans in most of the IFSP documents may indicate that transition was not of primary importance to families or case managers (family service coordinators) at the time the IFSP was written.

The law requires that the IFSP be in writing and contain information that will clarify services for the family and child who are to receive such services. The law requires that the child's present levels of development, the strengths and needs of the family, the major outcomes expected, the specific services to be provided, the dates for initiation and duration of services, the name of the case manager and the plan for transition to preschool or other services be specified. Only eight of the 49 files evaluated for procedural compliance met all seven requirements for content of the plan. When analyzed by requirement, no requirement was met in all files. Because of this, services for children and their families were not so clearly specified in the IFSP as the law requires. One assumption inherent in the requirement to include the seven

components for content of the IFSP plan is that, when they are included, families will understand the services better. In order to assure that parents receive information intended to focus and clarify services, IFSP teams who work to develop the IFSP plan should include all information required for content of the plan.

2. Are the five developmental areas specified in the IFSP under present level of development referred to with equal frequency in recommendation and goal statements recorded on the IFSP?

The law specifies that a statement of the child's present level of development in all areas will be included in the IFSP. The assumption being examined is that all areas of development will be considered in recommendation and goal statements. Based on the recorded recommendations and goals in the IFSP's included in this study, they were not.

The analysis of the 35 IFSP documents that included both recommendation and goal statements found that most of the recommendations were for activities or skill development that were coded as referring to the area of physical development. The law requires that the IFSP include a statement of the child's development in five areas: physical, cognitive, communication, social and emotional and adaptive. The law does not specify that recommendation and

goal statements must refer to all areas of development, but the assumption is that all aspects of the child's growth and development will be addressed. The data showed, that for most children, recommendations and goals did not include skill development in all areas of development. The majority of recommendation statements in the IFSP files evaluated referred to two or fewer developmental areas. The majority of goal statements referred to one developmental area. A central concern for infants and toddlers is physical development and the data show recommendations and goals emphasize this developmental area. Although greater representation of cognitive, communication, social and emotional and adaptive areas might be expected, such practice was not demonstrated in the findings of this study.

A unique aspect of the law is the inclusion of family-centered goals on the IFSP. The results of this analysis indicate inclusion of such goals on the IFSP documents examined. Ten percent of the recommendations and 18% of the goals referred to activities identified as belonging to needs and goals that were not centered around skill development for the child.

Persons preparing IFSP documents should indicate if all developmental areas are considered. Further research is needed to determine if the children being served predominantly have physical disabilities as was indicated by the statistically significant difference in number of

recommendations for physical development. Interviews with families should be conducted to evaluate why families selected goals that emphasized physical development. In addition, future research should investigate goals that did not refer to any developmental areas of the child to determine the reasons for inclusion of such goals on the IFSP and the ways in which such goals either enhance development of the child or the capacity of the family to meet the special needs of their child with disability.

3. Does congruence exist between the recommendation and goal statements made by professional providers that were recorded on the IFSP?

An assumption in the law is that family members present at the IFSP meeting will participate, be respected members of the team, understand the recommendations made by the professionals providing services and make use of the information discussed when selecting goals for their child and family. The analysis of congruence between recommendations and goals recorded on the IFSP document did not verify this assumption.

After professional providers discuss the findings of their evaluation of the child and make recommendations for skill development, congruence would be one measure of the communication and understanding between professionals providing services and family members who attend the IFSP

meeting to select goals for their child and family. Only one goal was congruent with a recommendation for every four goal statements recorded on the IFSP. This low rate of congruence between the recommendations recorded on the IFSP and goal statements was statistically significant, indicating that family members may not have been incorporating the recommendations made by professionals regarding services into the goals selected or that professionals making recommendations were not communicating effectively with family members.

The data did not support the assumption inherent in the law that professionals will make recommendations that will be used by parents and IFSP teams in goal planning. However, such a conclusion may be misleading because the data coder did not make judgments concerning related or prerequisite skill development. Thus, while some of the recommendation statements addressed specific skills that, when mastered, would contribute or lead to acquisition of the goal skill selected by the parents and IFSP team, the coder would record no congruence in these instances. For example, a professional may have recommended that the child work on skills such as rolling from back to tummy, increasing head control and working on supported sitting; while the parent selected as a goal that the child be able to get in and out of a sitting position. Although not congruent, these recommendations refer to prerequisite

skills for getting in and out of sitting. A review of the data indicated that six goal statements might be coded as congruent if the definition for congruence was expanded to include related pre-requisite skills. However, the results of such adjustment would not significantly alter the analysis or implications of the data and may negatively affect intercoder reliability judgements.

In other cases, the professional recommendations were for therapy to do activities such as "stretch out hand through wrist" and "provide sensory input to the left arm" while the parents goals were to have their child crawl, walk and hold a cup. Both recommendation and goal statements addressed skill acquisition for the child, but no sense of joint focus and communication led to a plan of activities that would accomplish the goals selected by the parents.

Finally, examples of cases where recommendations and goals were unrelated are presented below:

1. Recommendations were made to attend to socialization for the child and to continue with speech therapy, while the parents said they wanted their child not to fall so much when she ran and to help her not be afraid of loud noises.

2. The parent asked that a goal be to get her child on a regular feeding schedule, but no recommendations recorded on the IFSP addressed feeding or schedules.

3. In some cases, the professional recommendations addressed several areas of the child's development, but the parents selected general topics as goals such as having their child "be well", having their child get along with his siblings or that their child continue to make progress. One parent's primary goal for her child was to have the child baptized.

4. Some goals were family-focused. A goal written in a file was for the child's mother to continue her education. Other goals were that a parent find employment, that a family find a larger home, that the family get screens for the windows to keep flies out and that a family win the lottery.

The low rate of congruence found in this study may have been affected by the limitations of the definition for congruence which did not include evaluation of prerequisite skills made as recommendation statements. Other possible reasons for a low rate of congruence include increased emphasis on family goals, willingness of the IFSP team to follow family desires over professional recommendations in goal development, professional providers use of technical language that was not understood by family members attending the meeting or a lack of readiness on the part of the family members to address developmental issues for their infant or toddler. An additional possibility was that for some IFSP teams, the contribution of goals by the parents was viewed

as the parents opportunity to bring up objectives that have not been mentioned by anyone else at the meeting. For teams operating within this view, very low congruence would have occurred between professional provider recommendations and parent guided goal statements.

Further research is necessary to establish more clearly the reasons for the low rate of congruence found between professional recommendations and goals. This research should include analysis of the language used in recommendations and the relationship between the goals selected and the number and type of recommendations made. Professional providers and family members should be interviewed to evaluate ways in which communication and mutual goal planning can be improved.

Further, research on implementation of services needed by the children should be conducted. Service agencies need to determine if activities recommended by professional providers are implemented into services even though they were not represented on the IFSP as goals.

4. Do differences in gender and ethnicity affect the congruence between recommendation and goal statements recorded on the IFSP?

The law assumes that all children will be evaluated and served without bias regardless of gender or ethnicity. The results of this study found this assumption to be true

regarding congruence between recommendation and goal statements recorded on the IFSP. While there were numerical differences in congruence by ethnicity and gender, none was statistically significant.

The researcher noted the following serendipitous finding; each case manager spoke of all families with respect and appeared dedicated to providing the best services for all families. A positive outcome of this research was that no difference in congruence could be accounted for by difference in gender or ethnicity. However, future research should continue to evaluate data in this way to assure such equity in services continues.

5. Does congruence between goal and recommendation statements recorded on the IFSP vary by case manager?

This question evaluated the assumption that all families will have a service plan developed to meet their individual needs regardless of the case manager who assists them in planning and implementation of services. Fifteen different case managers were responsible for the 35 IFSP documents evaluated for congruence. The low number of files for each case manager limited conclusions that can be drawn from the data. The analysis showed that there were differences in congruence by case manager that were significant at the p=.10 level. This did not establish a strong relationship between rate of congruence and case

managers. The results indicated only that differences by case manager occurred in this study.

Further investigation of case manager behavior prior to and at the IFSP meeting, case manager education and the ways in which families are matched to case managers is necessary to increase understanding of how case managers influence family participation and decision-making at the IFSP meeting.

Recommendations

Future Research

Suggestions for further research have been made throughout Chapter 5. The following list provides a summary of additional research that would enhance understanding of the IFSP process.

1. IFSP files should be evaluated for compliance with the requirements as listed in P.L. 102-119.
2. Interviews should be conducted with involved family members, professional providers and case managers to gain information concerning their perspective of the IFSP process and to gather suggestions for improvements to this system of services.
3. Recommendation statements made by professional providers should be examined to determine if the language used is appropriate for communication with family members.

4. Non-congruent goal statements should be examined to determine the content of such goals and the extent to which such goals address family issues.

5. Research should study attendance at IFSP meetings to gain greater understanding of the applied IFSP process and evaluation of the communication among IFSP team members, especially with family members.

6. Research should evaluate implementation of services following IFSP development to determine if services that were recommended (but not listed as goals) are implemented.

7. Evaluation of communication among members of the IFSP team should be correlated with consumer satisfaction and with levels of case manager training.

8. The existing laws must be examined to determine if they require record keeping that does not lead to improved services for the intended population. Legal requirements for record keeping should be eliminated if they do not lead to improved services. For example, the data showed low compliance with the requirement to include a transition plan in the IFSP. Is it necessary that a transition plan be discussed at every IFSP meeting? Perhaps this requirement only becomes relevant when the child has reached 18 or 24 months of age and does not need to be included in the IFSP file of younger children. The requirement to specify duration of services was usually included on IFSPs, but the duration was most often listed as "3 years" or "as

necessary." While it is important that families understand how long services will last, the information gathered from the files in this study do not indicate information that would be helpful to families. These requirements must be examined to determine the extent to which they contribute to improved services.

Implementation of Services

The members of the IFSP team have been given a difficult assignment. To the maximum extent possible, they strive to have the IFSP process be family guided. They report that they have been advised "not to put words into the families mouths". Yet there are requirements for the IFSP that demand attention to detail and completion of legal requirements such as recording information required for content of the IFSP plan and determining development in all five areas. Case managers at DDD demonstrated genuine caring for the families they serve, but indicated intolerance for the required paperwork. Professionals providing social services must meet the requirements of many laws and funding sources to provide services to families. As a group, they lacked appreciation for the ways in which compliance with the requirements of the law enhances the services delivered to the child and family. Studies also need to determine if positive attitudes and leadership from administrators contribute to an improved outlook from the

implementers of service concerning the requirements of the law.

The researcher believes that based on the information in the IFSP files, the communication process at the IFSP meeting could be improved. The ideal of the law is that parents select those goals that are important to the child and family, but with the focus on improving the child's developmental status. Further evaluation of this IFSP planning process including interviews with professional providers, case managers and family members is essential to gaining understanding of the communication process. Professional providers and parents may need to spend more time in discussion with a genuine give and take of questions and answers to improve exchange of information that should improve congruence between recommendations and goals. Finally, what constitutes a family focused goal that will enhance the child's development must be clarified. Ultimately, case managers require more training on how to support and guide family decision-making under this new philosophy.

Summary

Rutter (1976) wrote of danger in treating as truths beliefs that have not been established by facts. Inherent in the laws that established services for infants and toddlers with disability is the belief that such services will improve outcomes for those children. Emphasis in P.L.

99-457 on inclusion of the family assumes that outcomes will be improved when implemented as planned. An additional assumption in the law is that compliance with the requirements for planning services will clarify and enhance services. However, compliance was not found. Therefore, if services recommended were provided, they occurred in spite of the IFSP.

Mark Wolery (1993), editor for the Journal Topics in Early Childhood Education, made several observations about provision of services in early childhood including the following:

1. There is a short history.
2. Providing early childhood services is complex.
3. Professionals in early childhood special education use varied service delivery models and a wide range of practices.
4. The professionals in the field have shown a consistent commitment to improving and maximizing the quality of intervention services (p. ix).

Wolery added that professionals working in this system have learned a great deal about a complex process in a short time. Professionals providing services for infants and toddlers with disability often provide help and services immediately and sometimes their practices develop ahead of evaluation and utilization of research results.

This study evaluated components of the IFSP, which is one of the new services in the system Wolery described. Professionals providing services to children and families in

the Division of Developmental Disabilities in District 2, Arizona have had to deliver services immediately and make adjustments to changing laws. They work in a rapidly evolving system. The results of data analysis show lack of compliance with the legal requirements for content of the IFSP plan, unequal emphasis on the five areas of development and lack of congruence between recommendation and goal statements. However, conversations with the case management staff at DDD indicated a high level of professionalism in staff concern and attitudes toward the families they serve. Without exception, the case management staff verbalized a commitment to provision of quality services for children and their families.

IFSP files were the source for the data evaluated in this study. While the information recorded on the IFSPs should reflect planning and services, it does not provide information concerning actual implementation of planned services. More research is necessary to gain greater understanding of implementation of planned services and the relationship among parents and professional providers. The law is created to set policy and guide services toward practice that encompasses the best knowledge available at the time. Input from professional providers, families and results of research have contributed to the knowledge and beliefs that are incorporated into law, including requirements for the IFSP. Studies of policy implementation

suggest that the local professionals who implement "their version of the law" have tremendous impact on the design and delivery of such services (Krauss, 1990). Federal policy and law is limited to the extent that it can make the implementers of service do what they have not committed themselves to do (Hebbeler et al., 1991).

APPENDIX A

INFORMED CONSENT FORM

Dear Parents,

Your child receives services through the Division of Developmental Disabilities. It is important to us that family members are included as full participants in the design and implementation of planned services. The Individualized Family Service Plan (IFSP) is the written plan for services that will be implemented for your infant or toddler according to your wishes.

A researcher from the University of Arizona has received a grant from the Federal Government to study the IFSP process. She would like permission from you to look at your child's file and take information from the recommendations made by the professionals who assessed your child and from the goal statements on the IFSP. The information will be used for this research only and will be kept confidential. At no time, in any way, will you, your child, or your family be identified.

It is important that we gather information about the services we bring to you, your child, and your family. The use of IFSP's is new and we want to be sure that we are following procedures that create the best outcome for you, your child, and your family. Doing research on the IFSP process is one way we can gather information on the effectiveness of this process. If you are willing to allow this researcher to read information in your child's file, please sign the statement below.

Thank you.

Sincerely,

I grant permission to allow a researcher from the University of Arizona to read information in my child's file and to use that information in a study of the IFSP process. I understand that my child, my family, and I will not be identified in any way.

_____

NAME OF CHILD

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

APPENDIX B

CODING FORM

DATE: CODER INITIAL: CLIENT#:

RECOMMENDATIONS	DEVELOPMENTAL AREAS					NO DEVELOPMENTAL AREA IDC NOTES		
	PHYSICAL	COGNITIVE	COMMUNICATION	SOCIAL-EMOTIONAL	ADAPTIVE			
						CONGRUENCE		MATCHES WITH #
GOALS						Y	N	

APPENDIX C

BLANK IFSP FORM

DD-225 (5-93)
P/P Ch.800

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
INDIVIDUAL SERVICE AND PROGRAM PLAN (ISPP)

FAMILY'S NAME	DATE

ISPP FORMS CHECKLIST

Use this check-list as you collect the forms you need.

STANDARD ISPP FORMS

- ☐ DD-214 Cover Sheet
- ☐ DD-215 Review and Update of Last ISPP
- ☐ DD-217 Team Assessment Summary (2 pages)
- ☐ DD-218 Preferences and Vision of the Future
- ☐ DD-219 Long Term Goal & Implementation(2 pages)
- ☐ DD-225 ISPP Forms Checklist

SUPPLEMENTARY ISPP FORMS

- ☐ DD-216 Summary of Professional Evaluations (3 pages)
- ☐ DD-220 Support Information (2 pages)
- ☐ DD-221 Individual Spending Plan
- ☐ DD-222 Individual Family Service Plan (2 pages)
- ☐ DD-223 Transfer Checklist
- ☐ DD-224 Changes in ISPP Outside Team Meeting

1. PLACEMENT EVALUATION. This initial ISPP is required within 30 days of eligibility.
   - ☐ The standard ISPP forms, except DD-215.

2. ANNUAL. An ISPP should be completed within 30 calendar days of assignment to programs and services operated or financially supported by the Division, and at least annually thereafter. The forms required for annual ISPPs will vary depending upon the age and/or placement status of the individual.

   2.1 Residential Settings
   - ☐ The standard ISPP forms
   - ☐ DD-216 (page 1,2 & 3), DD-220 (page 1 & 2), DD-221

   2.2 Children In Foster Care
   - ☐ The standard ISPP forms
   - ☐ DD-216 (page 1,2 & 3), DD-220 (page 1 & 2), DD-221
   - ☐ PS-035, Part A, Staffing Minutes/Team Recommendations
   - ☐ PS-035, Part B, Case Plan/Written Agreement
   - ☐ PS-035, Part D, Case Plan/Signature Sheet

   2.3 Day Programs
   - ☐ The standard ISPP forms
   - ☐ DD-216 (page 1,2 & 3), DD-220 (page 1)

   2.4 Children Birth to Age 3 Participating in Part H Programs-- Individual Family Service Plan (IFSP)
   - ☐ DD-214, DD-217, DD-219
   - ☐ DD-222 (page 1) Plan of Action (one for each outcome chosen by the family)
   - ☐ DD-222 (page 2) Transition Plan (if applicable)

   If the child is ALTCS-eligible, use the forms below as needed.
   - ☐ DD-217 (page 2) ☐ DD-216 ☐ DD-220 (page 1)

   2.5 All Other Persons
   - ☐ The standard ISPP forms
   - ☐ DD-216 (if needed) ☐ DD-220 (page 1 if needed)

   2.6 If Division is Representative Payee for SSI/SSA
   - ☐ DD-221

3. OTHER MEETINGS & ISPP CHANGES. The team may meet periodically during the year to revise or update the ISPP. Use the pages that are needed. Include narrative if necessary.

☐ DISCHARGE PLAN. A Discharge Plan is required whenever a person moves from one licensed setting to another. The team must complete the Transfer Checklist. If the person is medically involved, notify the utilization review nurse to complete and attach the Discharge Plan. Check the box if applicable.

☐ COST-EFFECTIVENESS STUDY. A Cost-effectiveness Study is required for an ALTCS-eligible individual when discharge from an ICF/MR is planned, if the person is ventilator-dependent, or if the cost of services exceeds 80% of the cost of institutional care. Check the box if applicable.

☐ CONSENTS. Consent forms must be updated annually. If an update is needed, check the box.

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INDIVIDUAL SERVICE AND PROGRAM PLAN (ISPP)

COVER SHEET

Name:_____ Date of Plan:_____
Address:_____
Current Residential Setting_____
Birthdate:_____ SSN:_____ Phone:_____
ASSISTS I.D._____ AHCCCS I.D._____
ALTCS Eligible: Yes____ No____ Third Party Liability: Yes____No____
If TPL "Yes," Company Name:_____ Policy#:_____ Ins. Code:_____
Health Plan:_____ Primary Care Physician:_____
ASH: Yes____No____ Amer. Indian (placed by tribe or BIA): Yes_____No_____
Ventilator Dependent: Yes_____No_____ Foster Care: Yes_____No_____ ARS 15: Yes_____No_____
Responsible Person:_____ Phone:_____
Address:_____
Case Manager / Service Coordinator:_____ ID_____ Phone:_____
Reason for Team Meeting:
Placement Evaluation_____ Annual_____ Other (specify):_____

COMMITMENTS AND SIGNATURES

I understand that my signature indicates participation in the plan's development, and that I will carry out all duties and responsibilities assigned to me in this plan. I understand that service decisions may require further approval, subject to Title XIX requirements and/or state funding. This plan will be in effect from _____ to _____ unless it is jointly modified. The grievance and appeal procedures have been explained to me. Any disagreeing party wishing to institute an administrative review must request one within 35 days of the date of the plan. If a team member was absent, note the reason why the meeting was held in that member's absence.
Reason:_____.

Printed Name	Signature	Agree	Disagree	Relationship to Person	Date

Other Approvals If Needed

Printed Name	Signature	Position Title	Date

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NAME _____ Date _____

TEAM ASSESSMENT SUMMARY

List key points of the team's discussion under each domain. If this is an IFSP for a child under age 5, record Present Level of Development, assessments used, and the family's concerns & recommendations. Check if an (A) Objective & Outcome, (B) Service Plan Component, and/or (C) Team Agreement & Assignment may be needed. The actual A, B, C list will be made later in this meeting. If no action is needed at this time, check the N column. Use PAS and ICAP information, as appropriate, to fill out this page.

Strengths & Resources	Needs, Concerns, & Recommendations	A	B	C	N
Health and Physical Development (Include fine and gross motor skills):	Health and Physical Development (Include fine and gross motor skills):				
Cognitive Development:	Cognitive Development:				
Communication Skills (Language and Speech Development):	Communication Skills (Language and Speech Development):				
Psychosocial Skills:	Psychosocial Skills:				
Self-Help Skills:	Self-Help Skills:				

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NAME _____ Date _____

TEAM ASSESSMENT SUMMARY (continued)

Strengths & Resource	Needs, Concerns, & Recommendations	A	B	C	N
Family:	**Family:**				
Community Involvement and Supports:	**Community Involvement and Supports:**				
Educational / Vocational:	**Educational / Vocational:**				
Guardianship Status & Current Placement:	**Guardianship Status & Current Placement:**				

Inventory for Client and Agency Planning, ICAP

Date: _____ **Score:** _____ **If new evaluation is needed, check C →** ☐

Pre-Admission Screening, PAS

Date: _____ **Results:** _____

DIAGNOSIS

Enter the diagnoses that qualify the person to receive services from the Division. Include the name(s), title(s), and date(s) of the physician, psychologist, or other qualified specialist who gave the diagnosis.

Diagnosis	Code	By whom	Date

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NAME _____ Date _____

LONG TERM GOAL & IMPLEMENTATION

LONG TERM GOAL: _____

IMPLEMENTATION OF GOAL

Re-examine every A, B, and C that was checked on Assessment Summary pages in terms of its priority for achieving the long term goal. Now develop objectives, service plan components, and team agreements and assignments. The person responsible for each objective will submit the teaching plan/strategy to the Case Manager by the date given in C (below).

- If a Behavior Plan is needed, include as an Objective and list monitor's name in part C below.
- If an augmented communication device is ALTCS funded, address its use in an Objective.

A. OBJECTIVES & OUTCOMES	Persons Responsible	Time Frames: start & end date

B. SERVICE PLAN COMPONENTS

Type of Service	Svc Code	Units/Kind per mo.	Provider/Comments	

C. TEAM AGREEMENTS & ASSIGNMENTS	Persons Responsible	Due Date

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NAME _____ Date _____

LONG TERM GOAL & IMPLEMENTATION (continued)

IMPLEMENTATION OF GOAL

A. OBJECTIVES & OUTCOMES (continued)	Persons Responsible	Time Frames: start & end date

B. SERVICE PLAN COMPONENTS (continued)

Type of Service	Svc Code	Units/Kind per mo.	Provider/Comments	

C. TEAM AGREEMENTS & ASSIGNMENTS (continued)	Persons Responsible	Due Date

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INDIVIDUAL SERVICE AND PROGRAM PLAN (ISPP)

NAME _____ Date _____

INDIVIDUAL FAMILY SERVICE PLAN

PLAN OF ACTION

The Plan of Action describes the plan for addressing each outcome that the family chooses to work on, including: what actions are to be taken, by whom, and when. As progress is made describe what was done, the timeline, revisions, and additional services that will be needed.

Desired Outcome. Include criteria and timeline:

_____

_____

_____

Action to be Taken. Include procedures and responsible parties:

_____

_____

_____

_____

_____

Monthly Progress Toward Accomplishing the Outcome:

_____

_____

_____

_____

_____

_____

_____

_____

Revisions:

_____

_____

_____

_____

Date Accomplished: _____

Additional Services Needed:

_____

_____

_____

_____

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INDIVIDUAL SERVICE AND PROGRAM PLAN (ISPP)

INDIVIDUAL FAMILY SERVICE PLAN (continued)

TRANSITION PLAN

FAMILY NAME: _____

CHILD'S NAME: _____

1. Identify possible transitions and discuss them. Date: _____

Comments:

2. Team recommendations for a smooth transition process:

3. Identify results or decision made. Date: _____

Comments:

4. Steps taken to implement transition:

Date child is expected to transition into pre-school (Part B): Date: _____

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Division of Developmental Disabilities
INDIVIDUAL SERVICE AND PROGRAM PLAN (ISPP)

NAME _____ Date _____

SUMMARY OF PROFESSIONAL EVALUATIONS

This form is required for individuals receiving services for residential and adult day programs operated or financially supported by the Division. It is optional for persons living with their families.

Team members will review current written and/or oral reports from professionals and enter key points, including prognosis, below. Check if an (A) Objective, (B) Service Plan Component, and/or (C) Agreement and Assignment may be needed. The actual A, B, C list will be made later in this meeting. If the item requires no action at this time, check the N column. If the team disagrees with a recommendation, record the reason for rejection in brackets following the summary.

Report and Dates	Results and Recommendations	A	B	C	N
Physical Exam evaluator: _____ date: _____					
Audiology evaluator: _____ date: _____					
Vision evaluator: _____ date: _____					
Dental evaluator: _____ date: _____					
Psychological evaluator: _____ date: _____					

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INDIVIDUAL SERVICE AND PROGRAM PLAN (ISPP)

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NAME _____ Date _____

SUMMARY OF PROFESSIONAL EVALUATIONS (continued)

Report and Dates	Results and Recommendations	A	B	C	N
Occupational Therapy evaluator: _____ date: _____					
Physical Therapy evaluator: _____ date: _____					
Speech Therapy evaluator: _____ date: _____					
Developmental or Educational or Vocational evaluator: _____ date: _____					
Residential evaluator: _____ date: _____					

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INDIVIDUAL SERVICE AND PROGRAM PLAN (ISPP)

NAME _____ Date _____

SUMMARY OF PROFESSIONAL EVALUATIONS (continued)

Use this page to summarize specialty evaluations that are required due to the unique medical needs of the person. Include: gynecology, cardiology, neurology, orthopedics, nutrition, psychiatry, nursing, etc. Additional categories may include: hospitalizations and emergency room visits that occurred since the last ISPP.

Report and Dates	Results and Recommendations	A	B	C	N

Arizona Department of Economic Security
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INDIVIDUAL SERVICE AND PROGRAM PLAN (ISPP)

NAME _____ Date _____

SUPPORT INFORMATION

MEDICATIONS

Name of Medication	Dosage/Route of Administration	Reason for Medication	Precautions

ADAPTIVE EQUIPMENT, MECHANICAL SUPPORTS, DURABLE MEDICAL EQUIPMENT

Type	Schedule for Periodic Evaluation	Reason for Use (when, where, how)

COMMENTS

Use this space to record additional information necessary for a complete plan.

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INDIVIDUAL SERVICE AND PROGRAM PLAN (ISPP)

NAME _____ Date _____

REVIEW AND UPDATE OF LAST ISPP

Date of Last Plan: _____

ACCOMPLISHMENTS

Accomplishments (highlight the person's major accomplishments since the last ISPP meeting):

STATUS OF PREVIOUS PLAN ELEMENTS

Report on the status of each element of the person's last ISPP. Has it been achieved, changed, or terminated?

A. Objectives & Outcomes

B. Service Plan Components

C. Team Agreements & Assignments

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Arizona Department of Economic Security
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INDIVIDUAL SERVICE AND PROGRAM PLAN (ISPP)

NAME _____ Date _____

CHANGES IN ISPP OUTSIDE TEAM MEETING

Use this form to describe and document changes in the ISPP that do not require a team meeting. In each case provide justification for the change.

☐ A. CHANGES IN OBJECTIVES & OUTCOMES	Persons Responsible	Time Frames: start & end date
Original goal #/ID: Change to: Justification:		
Original goal #/ID: Change to: Justification:		

B. CHANGES IN SERVICE PLAN COMPONENTS:

☐ Units/Kind ☐ Provider ☐ New Service ☐ Service Terminated

☐ Other (specify):_____

Change of Service to:	Svc Code	Units/Kind per mo.	Provider/Comments	Time Frames: start & end date

Justification of changes:

☐ C. CHANGES IN TEAM AGREEMENTS & ASSIGNMENTS	Persons Responsible	Due Date
Original #/ID: Change to: Justification:		

☐ **CHANGES IN SPENDING PLAN.** Describe and justify:

Submitted by: _____ Date _____

I have read and approve of the above changes. I have explained the change to the individual/responsible person. The change does not require a team meeting to implement.

Case Manager Name: _____ Signature: _____ Date: _____

The Case Manager has explained the change to me. I understand that service decisions may require further approval, subject to Title XIX requirements and/or state funding. I also understand that if I disagree with the change and wish to request an administrative review I must request one within 35 days of the date of the change. Agree:____Disagree:____Request Team Meeting Before Change:____

Responsible Person: _____ Signature: _____ Date: _____

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