Connecticut Birth to Three System Evaluation Study
Executive Summary

An evaluation of the treatment and effectiveness of the Connecticut early intervention system was conducted by the Division of Child and Family Studies, Department of Pediatrics, University of Connecticut School of Medicine, at the request and direction of the Connecticut (CT) State legislature. The evaluation of the system as administered by the Department of Mental Retardation focused on the relationship between cost and child/family outcomes, service intensity, and identification of the most effective services for children receiving early intervention under Part C of the Individuals with Disabilities Education Act (IDEA). The overall evaluation plan was established in response to general and specific questions concerning the implementation of early intervention services raised by members of the CT legislature.

The ability of early intervention services to help children with disabilities and their families has been established by many research and evaluation studies of national scope (e.g., Shonkoff & Hauser-Cram, 1987). This evaluation attempted to follow a framework proposed by a leader in early intervention (Guralnick, 1993; Guralnick, 1997b). This framework, termed "second generation research," is aimed at exploring questions of what, how, and who are best served, rather than continuing to replicate the basic positive finding of early intervention effectiveness. This approach was particularly appropriate for the current situation where an attempt to replicate basic findings would have been hampered by the small number of children and families available for the evaluation in Connecticut, and the limited monetary and temporal resources.

The evaluation that was conducted was focused on both confirming effectiveness, and identifying ineffectiveness (in order to abandon failed strategies and inform the design of alternative approaches), as recommended by the National Research Council's Committee on Integrating the Science of Early Childhood Development (2000, p. 41). Additionally, since outcome oriented evaluation designs have been suggested by the U.S. Department of Education as a way to document accountability to Congress, the Government Performance and Results Act (GPRA) indicators were used as a framework as were indicators of effectiveness used by international efforts in early intervention such as the Consultative Group on Early Childhood Care and Development (Myers, 2001) and UNESCO (Hanssen & Zimanyi, 2001).

To respond to the legislature's desire for systematic service, cost, and outcome information within this conceptual framework, four specific research questions were established for year 1 (1998-1999) of the evaluation:

- What is the relationship between costs and child/family services?
- Is service intensity related to child development and family profile?
- Are families benefiting from Birth to Three services?
- What are effective services as identified through the early intervention literature and documented by families and providers?

Results and conclusions of this evaluation are in Table A. The findings from year 1 were applied to year 2 (1999-2000) of the evaluation, which was then terminated by DMR because of budget constraints. The original year 2 plans were addressed in this past year (7/1/00 – 6/30/01) and form the basis of this document. In particular, the following questions were addressed and summarized in Table B. Data from the evaluation was shared and discussed with the CT Birth to Three managers in March 2001 and the Interagency Coordinating Council in April 2001.

Question 1. What is the relationship between costs and child/family services?

A time study was completed during two weeks in November 2000 to examine the variety of tasks that Birth to Three providers and directors engage in and the amount of time (e.g., resources) dedicated to these tasks. Full agency representation was ensured by selecting a sample of providers (full time and part time) from each of the 38 Birth to Three provider agencies in Connecticut. A total of 116 providers, representing 36 agencies participated in the time study. Participants recorded their activities in 15-minute intervals for a period of ten consecutive workdays. A comprehensive list of various tasks under the categories of service coordination, direct service, administrative, and supervision was used. The time study logs were field-tested by several providers, managers, and directors representing all regions and all agencies. Additional comments received from providers were expanded upon, incorporated into previous categories, or placed into new categories to reflect their description of tasks.

Findings

- Half of the program directors sampled had responsibilities outside of the birth to three population.
- Supervision accounted for 16% of director's total time.
- Providers spend as much time traveling as they do providing direct service.
- Providers spend 11% of time in service coordination.

Recommendations

- DMR should develop a Birth to Three program director's job description delineating expected duties and sample time allocations to those duties (e.g., supervision of staff, record keeping, etc.)
- DMR should examine the geographic location of providers and families and work with contracting agencies to develop service models that result in a decrease in the large amount of time that providers spend traveling.
- DMR should examine service coordination roles, responsibilities, and outcomes for families in the system.

Question 2. What are family perceptions of the service delivery model and provider practice?

2a. Family Survey

The family survey consisted of a four-page booklet that asked parents to complete 16 sections describing their child and family's background, frequency and location of early intervention services, parent/family involvement, parent choice, parent/family well-being, and program and provider practices and values. Parents responded to each section by using a Likert scale (i.e., 1to 5) to reflect the strength of their choice.

The first round of the family surveys were sent to parents the first two weeks of November 2000. Parents who were currently receiving services (N=3400) within the Birth to Three System as of October 2000 were included in the mailing. Approximately 937 family surveys were returned prior to the second round of mailings during the first week of January 2001. A total of 39% of the families sent family surveys had returned the family survey by April 2001. An additional 4 percent (N= 125) of the surveys were returned undeliverable, because the families had moved and left no forwarding address information.

2b. Telephone Interviews

Families who received the family survey were asked if they would like to participate in a phone interview about their experience in the Birth to Three System. Parents who enclosed the phone interview invitation along with their family survey formed the population pool for the phone interview. Approximately 30 percent (N=411) of the families returning the family survey volunteered to participate in the phone interviews. The family phone interview was a 20 to 30 minute phone conversation about the family's experience with the Birth to Three System from the time they were referred until they transitioned out of the system. The interview followed a structured protocol of both short and open-ended questions describing their child and family's background, evaluation, IFSP process, service provision, service coordination, service delivery, mediation, transition, and the overall Birth to Three System. The phone interviews began the second week in January 2001 with four interviewers attempting to call all of the families that had voiced an interest in participating in the phone interview. A total of 268 phone interviews were completed.

2c. Focus Groups

Families taking part in Connecticut's Birth to Three System as of October 15, 2000 were sent parent invitations to participate in the focus groups along with a copy of the parent survey during the first two weeks of November 2000. All families were sent the survey again during the first week of January 2001. The families who returned the survey and stated that they would be willing to take part in the family focus groups were identified as the population pool in which families would be drawn to participate in the family focus groups across the five regions of Connecticut.

Families willing to participate in the family focus groups were grouped according to location of mailing address, and by region of the state, to accommodate travel time and convenience factors for families willing to travel to focus group locations. Due to the low turnout for the focus groups, focus groups were adapted to focus group conference calls to accommodate the needs of parents willing to participate. Of the 107 families indicating a willingness to participate, 85 were reached, 38 committed to participate in the focus group conference calls, and 20 families completed a conference call. Several attempts were made to contact and schedule/reschedule families for focus group conference calls at various times of the day and evening in the effort to reach and schedule every parent that had voiced a willingness to participate.

Findings

- Overall, parents were satisfied with their Birth to Three services.
- Fifty-nine percent of parents reported receiving services from more than one provider. In the telephone survey, 48% of parents reported there were no team meetings among their providers, while 43% reported that team meetings did occur. Only 34% of the families who had a team that met outside of the IFSP meeting were included in those meetings.
- The use of family centered principles and practices as reported by families was the strongest predictor of child and family outcomes.
- Over 60% of parents felt that providers implemented services in a manner that respected their input, schedules, and wishes, and half of the parents stated that providers were a lot to a great deal of help in providing parenting information and materials, and providing information about other programs. Approximately 25% to 35% of families reported that providers were a lot to a great deal of help in finding: opportunities to talk to other parents, child health care, play opportunities for children, family social activities, and financial assistance, yet greater than 40% of parents indicated that providers were little or no help in finding: resources and

supports related to child care; opportunities to talk with other parents; opportunities for participating in community activities; family social/recreational activities; and/or financial assistance.

- Over 97% of the parents indicated that Birth to Three providers rarely or never provided early intervention within community and family settings such as: 1) duck/fish pond or lake, 2) picnic or family gathering, 3) library/bookstore story hours, 4) car/bus ride, 5) food shopping; and 6) child's bathtime. Almost 10% of families indicated providers sometimes or often provided intervention during mealtime or parent-baby group.
- Fifty-six percent of families reported they had a service coordinator, and forty-four percent of families interviewed either reported that they didn't receive service coordination or that they didn't know if they received this service.
- Seventeen percent of families reported receiving assistance from their provider on how to independently implement interventions. The provider who was reported as most frequently doing this was the person providing special education.
- Forty percent of surveyed families reported no active involvement with intervention when it was being provided.

Recommendations

- DMR should establish and monitor performance standards for its Birth to Three programs and providers in service coordination, service delivery (including team models), and family centered practices.
- DMR should emphasize the delivery of early intervention in natural learning activities in the community.
- DMR should require that families who receive services from more than one provider are involved in a monthly team meeting.
- DMR should provide training and support to programs and providers in family centered practices.
- DMR should provide training and support to programs and providers in service provision using natural learning opportunities in the home and community.
- DMR should provide training and support to programs and providers to assist them to broaden their service coordination skills and help families achieve such goals as finding child care, participating in community activities, participating in social and recreational activities, and helping with financial assistance.

Question 3. Is service intensity related to the family profile?

A total of 268 families participating within the phone interview were asked if they would provide a copy of their child's most recent IFSP for use in the Connecticut Birth to Three System Evaluation Study. Parents were informed that this information would be used for descriptive purposes only, and that all information would be kept confidential and would be coded to conceal their family's identity. Parents either sent a copy of their family's most recent IFSP directly to the Division of Child and Family Studies, or they were sent an IFSP Release Form to sign and return via a postage paid enclosed envelope. Families that completed the phone interviews formed the participant pool for the service intensity portion of the study. The Division of Child and Family Studies received 82 Individualized Family Service Plans from families and their provider agencies to make up the participant pool for the current study.

Findings

- The majority of IFSPs contained one family outcome.
- The summary of Family's Concerns, Priorities, and Resources section on IFSPs was often ambiguous as to what information/resources were offered, who was providing the assistance, and how the need was being meet.
- Family needs and outcomes were not found to the IFSP service profile.

Recommendations

- DMR should provide support and training to programs in family centered IFSP development and documentations.
- DMR should establish performance standards to guide the development of individualized service delivery models that reflect a match between child/family needs and frequency, intensity, and duration of services.

Limitations

The key questions asked by the CT state legislature about the Birth to Three early intervention system (the relationship between cost and child/family outcomes, service intensity;,and the identification of most effective services) were not able to be addressed in depth. This was because of a number of limitations. First, the study's length prohibited longitudinal investigation. The first year of the study resulted in five months of data collection

because of a delay in processing the funding between the DMR and UConn. The second year's activities were terminated after two months and the third year's funding had to encompass the second year's costs. Second, there were limited data available for analysis. During the three years of the study, early intervention programs were not required to collect standardized developmental information on enrolled children, which restricted the evaluators' abilities to examine the developmental and behavioral outcomes of intervention. Third, information on early intervention participants were not shared with the evaluators by the lead agency. Therefore, the evaluation was limited to the collection of family/child data that could be requested from parents. These included families who volunteered to answer the written survey, be called on the phone and sign releases for allowing study staff to see their child's IFSP. This severely limited access to families/children from underrepresented samples, such as those who have low education levels and social-economic status.