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MEASURING SATISFACTION WITH FAMILY-PROFESSIONAL PARTNERSHIP IN EARLY INTERVENTION AND EARLY CHILDHOOD SPECIAL EDUCATION PROGRAMS IN QATAR

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DEDICATION

With a warm heart, I dedicate this dissertation to my parents: The most loving mother in the world and in memory of the most supportive father ever; may God bless his soul.

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ABSTRACT

Family-professional partnership has been considered a recommended practice in Early Intervention/Early Childhood Special Education (EI/ECSE) programs for young children with disabilities and their families for the past two decades. The importance of establishing successful partnerships between families and professionals in educational planning has been made clear in research literature and federal legislation. Despite research support for the importance of family-professional partnership in the provision of services for children with disabilities and their families, there is a growing concern among families of young children with disabilities and service providers that the goal of effective partnership is not being met in Qatar. Thus, this study explored two critical aspects of EI/ECSE programs in Qatar: Family outcomes and family-professional partnerships. The study utilized a mixed-methods approach of "exploratory concurrent triangulation design". The Beach Center Family-Professional Partnership Scale, Family Outcomes Survey, Demographic Survey, and Semi-Structured Interviews were the primary data sources for this study. Participants for the study were families of young children with disabilities, service providers working in EI/ECSE programs, and program directors (n = 127). The study revealed statistically significant differences among families according to the child's type and severity disability with families of children with Cerebral Palsy were significantly less satisfied with their level of partnerships. There were significant differences in satisfaction with partnership amongst service providers from different disciplines. The study also demonstrated eight themes of interpersonal and structural factors that influenced successful partnerships. Recommendations for how to best use study findings in improving EI/ECSE programs in Qatar were discussed.

CHAPTER 1: Introduction

A fundamental principle in early intervention (EI) is embedded in the rationale for working with families of children with disabilities. Historically, the special education field in the United States has undergone a major paradigm shift in the emphasis of EI programs from focusing on the child to a family-centered approach (Bailey et al., 1998; Simeonsson & Bailey, 2000). This shift to family-centered practices was supported by Individuals with Disabilities Education Act (IDEA) Part C early intervention programs for infants and toddlers with disabilities which affirmed that a major goal of early intervention programs is to build the capacity of families to meet their child's needs (IDEA, 2004).

In the United States, a clear and strong commitment to the welfare and education of young children with disabilities and their families has been evident. This commitment translated into legislation that supports Early Intervention and Early Childhood Special Education (EI/ECSE) programs. The United States Congress provided a number of legislation initiatives for children with disabilities and their families such as the IDEA and the No Child Left Behind Act (NCLB) of 2001. The shift in EI programs from focusing on the child alone to family-centered practices were supported by Part C of the IDEA concerning early intervention programs for infants and toddlers with disabilities. Part C required implementation of statewide EI services that were family-centered, coordinated interagency services, and multidisciplinary for young children with disabilities, ages birth to three years, and their families. Part C contains four types of related services specifically designed for families, which include: 1) Family training, counseling, and home visit services [34 CFR § 303.12(d) (3)]; 2) Service coordination services [34 CFR § 303.12(d) (11)]; 3) Social work services [34 CFR § 303.12(d) (3)]; and 4) Special instruction [34 CFR § 303.12(d) (13)].

In addition to the related services, Part C provided guidance to professionals working in EI programs through the requirement of an Individualized Family Service Plan (IFSP). The IFSP must include a "family-directed" assessment of the concerns, priorities, and resources of the family; and identify supports and services required to enhance the family's capacity to meet the child's needs [34 CFR § 303.322(d)]. Part C also required that the IFSP include a statement of expected outcomes for the child and family as well as the criteria and procedures used to determine progress toward achievement of the outcomes [34 CFR § 303.344(c)].

In addition to Part C, family participation in early childhood special education programs for toddlers' ages three to five years is supported under Part B of the IDEA. However, Part B differs from Part C in that it does not require explicit goals for family outcomes. Part B requires provision of the following services for families: 1) Parent counseling and training [34 CFR § 300.34(c) (8)]; 2) Psychological counseling services for the child and parents [34 CFR § 300.34(c) (10)]; and 3) Social work services that includes group and individual counseling with the child and family [34 CFR § 300.34(c) (14)].

One of the key elements of the NCLB Act of 2001 is that it provides choices for parents. It requires educators to inform parents about choices regarding services for the child and the family, thereby strengthening the principle of parental choices. This principle of parental choice allows parents to know what services their children are receiving without undue efforts. The NCLB affords “parents substantial and meaningful opportunities in the education of their children” (Title I § 1001 (2)). It authorizes funding for Parental Assistance Information Centers, which provide support, information, and training for parents, professionals, and organizations that work with parents.

EI/ECSE programs play a critical role in the field of special education for young children with disabilities and their families. The importance of EI/ECSE programs for young children with disabilities and their families has been well documented in the research literature (Corsello, 2005; Greenwald, Siegel, & Greenwald, 2006; Guralnick, 1998; Hume, Bellini, & Pratt, 2006; Iovannone, Dunlap, Huber, & Kincaid, 2005; Levy, Kim, & Olive, 2006; National Research Council, 2001; Noyes-Grosser, Holland, Romanczyk, & Gillis, 2005; Odom & Wolery, 2003; Rapport, McWilliam, & Smith, 2003). Although research is consistent on the importance of early intervention for young children with disabilities and their families, debate exists on elements contributing to the effectiveness of EI/ECSE programs. The question about efficacy of early intervention continues to be raised despite the multitude of research studies on the outcomes of EI/ECSE programs (Meisels, 2006). One of the reasons is the current emphasis on accountability systems which focuses on outcome-based evaluations of EI/ECSE programs.

Indicators of program quality are often used to evaluate the efficacy of EI/ECSE programs (Meisels, 2006). These indicators reflect the diversity and complexity of early intervention programs including: Types of services provided (medical, educational, therapeutic); who is receiving these services (child with disability, family); when services are provided (age of child at onset of services, duration and intensity of services); settings where the services are provided (home-based, center-based, hospital-based, and community-based); and primary mission of the program (preventive, remedial) (McCollum, 2002). A close examination of the empirical research literature on the evaluation of the effectiveness of EI/ECSE programs reflects a broader look at the elements of program efficacy, including those relating to child outcomes, service delivery characteristics, and family outcomes (Anderson, Shinn, Fullilove, Scrinshaw, Fielding, Normand, & Carande-Kulis, 2003; Bailey, Bruder, & Hebbeler, 2006; Bruder, 2010; Corsello, 2005; Dawson & Osterling, 1997; Gorey, 2001; Greenwald, Siegel, & Greenwald, 2006; Guralnick, 1998; Guralnick, 1998; Harris & Handleman, 2000; Hughes, 2010; Iovannone, Dunlap, Huber, & Kincaid, 2005; Levy, Kim, & Olive, 2006; McCollum, 2002; Noyes-Grosser, Holland, Romanczyk, & Gillis, 2005; Odom & Wolery, 2003; Park et al., 2003; Rapport, McWilliam, & Smith, 2003; Wolery & Garfinkle, 2002). Moreover, research studies that examined EI for children with disabilities demonstrated that specific aspects of intervention were associated with positive outcomes in developmental gains (Campbell & Sawyer, 2007; Corsello, 2005; Dawson & Osterling, 1997; Greenwald, Siegel, & Greenwald, 2006; Guralnick, 1998; Harris & Handleman, 2000; Iovannone, Dunlap, Huber, & Kincaid, 2005; Levy, Kim, & Olive, 2006; Noyes-Grosser, Holland, Romanczyk, & Gillis, 2005; Odom & Wolery, 2003; Rapport, McWilliam, & Smith, 2003; Sheinkopf & Siegel, 1998). Three aspects that are critical to the efficacy of EI programs include the child’s age at early intervention onset as well as the degrees of individualization and family involvement in services (Corsello, 2005; Greenwald, Siegel, & Greenwald, 2006; Hurth et al., 1999).

The rationale for EI is rooted in the assumption that the early years are of a critical importance in child development (McCollum, 2002). The first three years of life are a period of considerable growth and development for infants and toddlers that represent critical windows of learning (Bagdi & Vacca, 2005; Bergen, & Coscia, 2001; National Research Council, 2000; Wasserman, 2007). This critical developmental period has been demonstrated through results of research on the neurological and brain development during the early years of a child life (Bergen, & Coscia, 2001; Lindsey, 1998; Wasserman, 2007). Research has shown that during the first three years of a child's life, there is rapid and extensive brain development, almost half of the child's critical brain development is completed by five years of age (Shore, 1997). Provision of early intervention, early experiences, and stimulation in this time period has a direct impact on the neural wiring of the brain that is essential for child development. Thus, the timing of intervention and the age of the child at the onset of intervention are of particular importance to achieving positive outcomes. Further, research studies have demonstrated that the earlier the intervention, the more effective it is. Intervention at birth or almost immediately after the diagnosis of a disability will result in greater developmental gains. Research has demonstrated larger developmental gains in children with Autism Spectrum Disorders (ASD) who began EI services prior to their fourth birthday (Harris & Handleman, 2000; Sheinkopf & Siegel, 1998). When compared to children whose age of onset was between four and five years of age, those younger (4 or below) made greater developmental gains in language, adaptive behavior skills, and IQ tests (Harris & Handleman, 2000; Sheinkopf & Siegel, 1998).

Much has been written in the literature about families as the primary nurturing context for children with disabilities (Bailey et al., 1998; Barnett et al., 2003; Hauser-Cram, Warfield, Shonkoff, & Krauss, 2001; Odom & Wolery, 2003). Young children spend the majority of their time in everyday activities with their families. An underlying supposition of EI programs is that children with disabilities who live with their families and participate in their natural environment are expected to grow up similar to their siblings without disabilities (Odom & Wolery, 2003). Consequently, the primary rationale for working with families of young children with disabilities is to enhance the child's development by promoting parents' ability to adapt and respond effectively to the child's special needs (Bailey et al., 1998; Barnett et al., 2003). The needs of young children with disabilities can challenge the sense of parental competency. Families of children with disabilities face challenges relating to their children's development, particularly issues relating to the uncertainties of atypical development, management of behavioral problems, responses to the child's communication needs, and meeting the health and medical needs of their child (Barnett et al., 2003; Hastings, 2002; Hauser-Cram, Warfield, Shonkoff, & Krauss, 2001). Correlational research established the relationships between these challenges and increased levels of anxiety, stress, and depression among parents of children with disabilities (Barnett et al., 2003; Nachshen, Woodford, & Minnes, 2003).

A crucial goal for working with families is to build the capacity of families to meet the needs of their children with disabilities (Simeonsson & Bailey, 2000). Recent literature provided three premises for building family capacity through individualization of services, parent enablement and empowerment, and active participation by building partnerships between families and the professionals who serve them (Bailey et al., 1998; Dunst, Johanson, Trivette, & Hamby, 1991; Gallagher & Desimone, 1995; McWilliam et al., 1998; Parker & Zuckerman, 2000; Simeonsson & Bailey, 2000). The first premise has established that each family is unique when it comes to its priorities, concerns, and culture. For that reason, an individualization of services is needed to identify the family needs, strengths, and priorities (Bailey et al., 1998; Gallagher & Desimone, 1995; McWilliam et al., 1998). Family services must take into consideration the family's beliefs as well as cultural and economic background (Gallagher & Desimone, 1995).

The second premise was centered on supporting families to utilize resources to meet their needs. Family empowerment reflects the view that families are the ultimate caregivers and decision makers for their children with disabilities (Bailey et al., 1998; Gallagher & Desimone, 1995). EI programs must support families, enable them to advocate for their children with disabilities, and promote the family decision-making power. The family support literature documented that both formal and informal support ultimately empowers families to better care for their children and adopt the role of advocate for services to meet the needs of their young child with disability (Knox, 2000; Resendez, Quist, & Matshazi, 2000). The last premise requires professionals work in partnership with the families (Bailey et al., 1998; Gallagher & Desimone, 1995; Park, Turnbull, & Park, 2001). Families must be partners and play an active participatory role in the identification of their concerns and priorities, the determination of goals, the planning process, and the provision of services (Park, Turnbull, & Park, 2001). This family-professional partnership and collaboration is necessary to provide family-centered services to meet the needs of families of children with disabilities. Professionals can rely on family collaboration and family knowledge of their child’s needs, making a partnership even more important.

Theoretical Framework

The theoretical foundation for family involvement and partnership has its roots in the Bronfenbrenner’s bioecological systems theory of human development and the family systems theory. The bioecological theory views children development within the context of the system of relationships that form their environment (Bronfenbrenner, 1992; Bronfenbrenner, 2005). Each of environmental system has an effect on the child’s learning and development. The interaction between these systems of the child’s biology, his immediate family, community environment, and the societal landscape fuels the child’s development. This theory places the family within its own microsystem, interacting continuously with many other systems. In order to work effectively with the child, it is important to understand not only the child and his immediate environment, but also understand the influences of other systems on that child and family. The implication of this theory is that involving and collaborating with families of young children with disabilities is a more powerful intervention than a child-focused approach (Hamilton, Roach, & Riley, 2003).

Family systems theory considers the family as key stakeholders who significantly influence the child’s development, which in turn, affects each family’s unique functioning (Turnbull & Turnbull, 2001). While this theory is commonly used in family counseling and therapy, it has a significant influence on special education service models and EI/ECSE settings (Christian, 2006). Adopting a family systems approach extends the range of early intervention services beyond the child to include family members and involve them in determining the goals for the child’s program and services. These services are founded on values that: Acknowledge the importance of the family system in the child’s development; respect families as decision makers for their child; view families as partners with professionals; and support families in their role of caring for and educating their child (Turnbull & Turnbull, 2001).

Research Problem

Family-professional partnership has been considered a recommended practice in EI/ECSE programs for young children with disabilities and their families for the past two decades (Blue-Banning et al., 2004; Bruder, 2000). Effective partnerships between families and professionals have been essential to achieving positive outcomes in early intervention (Park & Turnbull, 2003). Moreover, embracing a family-centered practices necessitate moving from collaboration to partnership with families. The importance of establishing successful partnerships between families and professionals in educational planning has been made clear in research literature and federal legislation (Epstein, 2001; Osher & Osher, 2002; Summers, Gavin, Hall, & Nelson, 2003). In special education, the importance of positive partnerships is further reinforced in the Individuals with Disabilities Act (IDEA), which mandates parent involvement in the educational decision making process (Turnbull & Turnbull 2001). Research studies have demonstrated EI/ECSE programs that are evaluated as being “family-centered” tend to share a common characteristic that demonstrates meaningful and effective partnership between families and professionals (Summers et al., 2001). A key element to practicing from a family-centered perspective lies in the professionals having the skills to build positive partnerships with parents and families making family-professional partnership the essence and foundation of family-centered practices (Dunst, 2002; Trute & Hiebert-Murphy, 2007).

In the United States, despite legislative support for establishing positive partnerships, collaborative partnerships have not been met (Blue-Banning et al., 2004). Research has indicated a gap exist between actual and recommended practices for collaborative partnerships (Blue-Banning, Turnbull, Pereira, 2000; Bruder, 2000; Turnbull & Turnbull, 2001). The most common reason for failure to develop positive partnerships is parents were not seen as equal partners by professionals who have maintained control of services (Blue-Banning, Turnbull, Pereira, 2000). Studies have demonstrated that parents who are dissatisfied with their relationships with professionals can experience stress and feel unwelcome in the educational decision making process for their young children with disabilities (Soodak & Erwin, 2000). In a study of African American parents, dissatisfaction in their relationships with service providers often lead to withdrawal from EI programs (Rao, 2000).

Despite research support for the importance of family-professional partnership in the provision of services for children with disabilities and their families, there is a growing concern among families of young children with disabilities and service providers that the goal of effective partnership is not being met in Qatar. In an explorative study of inclusion practices in general education schools in Qatar, the role of families was barely visible in decision-making process regarding their children’s educational planning (Al Attiyah, Al Abed, Al Balsheh, Al Hadad, & Lazarus, 2004). The study also reflected a lack of family involvement and lack of the needed family support services.

Significance of the Study

During the past decade, the state of Qatar has undergone a major transformation. One of the outcomes of this transformation is seen in the current reform in education, health, and social services. The enactment of the Persons with Disabilities Law in March 2004 guaranteed the rights of persons with disabilities and ensured their entitlement to government services which include among others: Education, healthcare and employment (U.S. Department of State, 2005). A translation of this law is evident in the government’s commitment to providing appropriate education to children with disabilities. The special education field in Qatar can be described as transitioning into a new era. In addition, the establishment of Shafallah Center for Children with Special Needs in 1998 represents a cornerstone in the provision of special education services for children with disabilities and their families (Al Attiyah & Lazarus, 2007).

This study represents various perspectives of stakeholders about family-professional partnerships within the early intervention and early childhood (EIEC) delivery system. In understanding family-professional partnerships, it is more beneficial to include professionals’ perspectives along with views of parents in order to have a well-rounded understanding. Service providers' personal perspectives provide an insight into their beliefs and values that affects the ways in which family-centered practices and family partnerships are interpreted and implemented (Soodak & Erwin, 2000).

Being the first study to investigate family-professional partnerships in EI/ECSE programs in Qatar, the results of this study have implications for improved practice, policy, and future research. By understanding the gaps that exist in family-professional partnerships, administrators can utilize the study results to allocate staff, training, and support resources to shift the focus from a mere family involvement to family partnership. Administrators can identify possible barriers and facilitators to positive family-professional partnerships in their programs.

In regards to closing the gaps between actual and ideal practices, the results of this study can inform service providers across disciplines. Professionals in the field have long been concerned about observed gaps between recommended practices and the actual implementation of those practices (Gresham et al., 2000). The study sheds light on the practices that are not being ideally implemented when working with families of young children with disabilities. Programs can use these findings to provide more training to professionals on developing positive family-professional partnerships. Further, the study findings have important implications for policy makers. The main policy implication for this study is that it reveals a need for change. Policies could be designed to support effective family involvement as full partners at all levels of EIEC delivery systems.

Research Purpose and Research Questions

This study explored two critical aspects of EI/ECSE programs in Qatar: Family outcomes and family-professional partnerships. The purpose of this study was three folds. First, investigation of the level of satisfaction with partnerships between families of young children with disabilities and professionals who serve those children in EI/ECSE programs in Qatar. Second, identification of the factors that promote or hinder successful family-professional partnership in EI/ECSE programs from the perspectives of families, service providers, and program directors. Lastly, this research examined parents' perceived family outcomes in EI programs in Qatar.

The majority of the research in the area of family-professional partnership is limited to families of young children with disabilities in the United States, United Kingdom, Australia, and Japan (Blue-Banning et al., 2004; Dunst & Dempsey, 2007; Hodge & Runswick-Cole, 2008; Kasahara & Turnbull, 2005; O'Connor, 2008; Pinkus, 2003; Rodger, Keen, Braithwaite, & Cook, 2007; Summers et al., 2005a; Summers et al., 2005b; Summers et al., 2007). Family involvement and services for young children with disabilities are global issues as documented in the emergent literature. Considering the range of existing cultural differences, it is important that research in this area be expanded to include worldwide perspectives by examining family-professional partnership in the state of Qatar. Thus, the study sought to answer the following questions:

1) How satisfied are families of children with disabilities and service providers working in early intervention and early childhood special education (EI/ECSE) programs in Qatar with their level of partnership?
2) Is the level of satisfaction with partnership similar or different for families of young children with disabilities and service providers working with them in EI/ECSE programs in Qatar?
3) Is the level of satisfaction with partnership similar or different for families of young children with disabilities according to the child's type and severity of disability?

4) Is the level of satisfaction with partnership similar or different for service providers from different disciplines in EI/ECSE programs in Qatar?

5) Is the level of satisfaction with partnership similar or different for families and service providers between a hospital-based setting and a school/community-based setting?

6) What are the factors that promote or hinder successful family-professional partnership from the perspectives of families of children with disabilities, service providers, and program directors in EI/ECSE programs in the State of Qatar?

7) Are EI/ECSE programs effective in terms of achieving family outcomes for families of young children with disabilities receiving services in Qatar?

CHAPTER 2: Literature Review

This study explored various aspects related to family outcomes and successful family-professional partnership from the perspectives of families of young children with disabilities and professionals who serve those children in EI/ECSE programs. The aim of this review was to examine the existing empirical literature on the conceptualization of family outcomes, conceptualization of family-professional partnerships, issues related to partnership in EI/ECSE programs, and measures of partnerships. This review answered the following questions:

- How is “family outcomes” conceptualized in the research literature?
- How is the construct of “family-professional partnership” conceptualized in the research literature?
- Is there a link between family-professional partnership and positive outcomes in EI/ECSE programs?
- What are the factors that influence successful family-professional partnership?
- Are there psychometrically valid measures that assess family outcomes and family-professional partnership?
- What type of research design is utilized in the empirical research literature to investigate satisfaction with partnership from the perspectives of families of young children with disabilities and service providers working with them in EI/ECSE programs?

The primary source for this review was electronic databases including of the University of Oklahoma Library System including interlibrary loan and LORA. Secondary resources used included the World Wide Web search engines such as goggle. Search terms used included the following terms: family outcomes, family-professional partnership, family-professional relationship, parent-professional partnerships, family involvement, parent-involvement, parent participation, family-centered, family and professional collaboration, service coordination, and partnership with parents. The existing research on family outcomes and family-professional partnerships has focused predominantly on conceptualization of these concepts, development of measurement tools of family outcomes and the quality of partnerships, satisfaction with partnerships between families of children with disabilities and service providers, the association between satisfaction with partnership and intervention outcomes, and factors contributing to successful partnership.

Defining Family-Outcomes

According to Bailey and colleagues (2006), family outcome is defined as "a benefit experienced by families as a result of services received" (p. 228). Families are defined as "people who think of themselves as part of the family, whether related by blood or marriage or not, and who support and care for each other on a regular basis" (Poston, Turnbull, Park, Mannan, Marquis, & Wang, 2003, p. 319). Thus, this benefit is achievable for all members of the nuclear or extended families of children with disabilities including siblings, aunts, uncles, and grandparents (Bailey & Bruder, 2005).

Family outcome differs from delivery of services in that it is the result that occurs because of the provision of services (Bailey & Bruder, 2005). For instance, providing family members with information about their child's disability and educational needs is considered a service. A benefit is experienced by the family and a family outcome has been achieved when the family understands the information, finds it useful in advocating for needed services for their child, and promotes effective response to the child's needs.

Rationale for Establishing Family Outcomes

Although the rationale for working with families of young children with disabilities is well documented in research, limited research has investigated family outcomes in EI/ECSE programs. Much of the research has focused on assessing and documenting child outcomes (Anderson et al., 2003; Gorey, 2001; Guralnick, 1998; Ramey & Ramey, 1998; Wolery & Garfinkle, 2002). This decreased focus on family outcomes in the research can be explained by the general misconception that the main goal of EI/ECSE programs is to provide services to young children with disabilities; the lack of consensus on the type of recommended family outcomes in early intervention programs; and the challenges related to the measurement tools for family outcomes (Bailey & Bruder, 2005; Bailey et al., 2006).

However, in recent years there has been a greater emphasis on measurable outcomes for families of young children with disabilities in EI/ECSE programs (Bailey et al., 1998; Bailey et al., 2005; Bailey et al., 2006; Park et al., 2003; Roberts, Innocenti, & Goetze, 1999). There are four key points that provide the rationale for assessing family outcomes:

1. The complexity of EI/ECSE programs provides obligations for family outcomes. EI/ECSE programs are obligated to provide services for both young children with

disabilities and their families. This obligation is translated into a wide array of child-and family-focused services (Bailey et al., 2006). EI/ECSE programs encompass a wide array of services and programs for young children with disabilities and their families such as identification and evaluation, special education services, related services, transitions to preschool programs, and service coordination. It also involves many individuals at the service providers (qualified trained personnel), and services recipients' levels (young children with disabilities and their families) (Bailey & Bruder, 2005). This complex interaction between the child- and family-focused services, service providers, and service recipients create a great challenge within the EI/ECSE programs. Adding to the complexity of these interactions, the challenges associated with the type and severity of the child's disability (Hauser-Cram et al., 2001).

2. Parent involvement has also been considered an important factor that contributes to the efficacy of early intervention programs (Corsello, 2005; Dawson & Osterling, 1997; Harris & Handleman, 2000; Levy, Kim, & Olive, 2006; Sheinkopf & Siegel, 1998; Levy, Kim, & Olive, 2006). A growing number of research studies have demonstrated that intervention programs that have a parent component resulted in positive outcomes for young children with disabilities (Anderson et al., 2003; Gorey, 2001; Hurth, Shaw, Izeman, Whaley, & Rogers, 1999; Woods, Kashinath, & Goldstein, 2004). Numerous studies have demonstrated the effectiveness of parent-implemented intervention strategies in positive outcomes for young children with disabilities (Kaiser, & Hancock, 2003; Kaiser, Hancock, & Nietfeld, 2000; Mobayed, Collins, Strangis, Schuster, &

Hemmeter, 2000; Smith, Buch, & Gamby, 2000). For example, children with ASD whose parents implemented intervention strategies demonstrated positive outcomes in communication skills (Kashinath, Woods, & Goldstein, 2006).

3. Family outcomes are a valuable measure of EI/ECSE programs efficacy. The importance of EI programs increased the demand for evaluation to establish program effectiveness. Family outcomes are a valuable measure of the effectiveness of EI/ECSE programs (Bailey et al., 1998; Bailey et al., 2006; Bailey & Bruder, 2005; Park et al., 2003). Research studies acknowledged that family involvement and parent participation in EI programs is a strong predictor of children outcomes (Bailey et al., 2005; Dunst, 1999). In a national study that examined the perceived family outcomes at the end of EI, 2586 parents in 20 states completed a telephone interview near the child's third birthday (Bailey et al., 2005). The study showed that parents who experienced a greater level of family impact reported greater impact on children.
4. Demand for assessing family outcomes to meet legislative requirements and state accountability systems. The legislative entitlements of Part B and part C of IDEA formed the rationale for addressing family outcomes in EI/ECSE programs (Bailey et al, 1998; Bailey & Bruder, 2005). In particular, the legislative components that relate to family supports, evidence-based practice, and accountability. (Bailey et al, 1998; Bailey & Bruder, 2005). Further, in the past year there has been a great emphasis on the accountability of EI/ECSE programs (Roberts, Innocenti, & Goetze, 1999). Establishing measurable family outcomes is important to satisfy the current federal reporting requirements and as part of the

state accountability systems with regard to documenting service provision. In addition, the Government Performance and Results Act of 1993 (GPRA) required all federal agencies to develop measurable outcomes and submit annual reports on the effectiveness of programs in achieving their identified goals (GPRA, 1993). The Office of Special Education Programs (OSEP) has established a set of measurable outcomes and indicators for all of IDEA programs, including Part C and B that are reported to Congress annually. In Part C Annual Performance Report (APR), states are required to provide documentation to the following question: "Do family supports, services, and resources increase the family's capacity to enhance outcomes for infants and toddlers and their families?" (Bailey & Bruder, 2005, p. 1). At present, states are permitted substantial latitude to how they are defining "family capacity" and means of documenting it.

Literature Review of Recommended Family Outcomes

Although research demonstrated a widespread agreement on the importance of developing and documenting family outcomes in EI/ECSE programs, consensus about what are the recommended outcomes has recently emerged in the literature. The purpose of this section of the literature review was to identify the full continuum of family outcomes, proposed framework for developing family outcomes, and major areas of overlapping agreement in family outcomes. Analysis of conceptualization of family outcomes in the literature revealed three distinct categories of family outcomes that are: (1) based on synthesis of best practices; (2) based on results of discussions or focus groups with stakeholders; and (3) based on studies that involve quantitative and qualitative methodologies.

Category 1: Family Outcomes Based on Synthesis of Best Practices

This category of family outcomes was based on synthesis of best practices done by the authors for the purpose of development of measurement tool, recommendations for evaluation, or literature review. Four major frameworks of family outcomes were identified including: (1) Family outcomes in the National Early Intervention Longitudinal Study (NEILS) (Bailey et al., 1998); (2) Head Start Program Performance Measures and longitudinal study (Administration for Children, Youth, and Families, 1998); and (3) Personal Outcome Measures for Families with Young Children (Council on Quality and Leadership, 2004).

The conceptual framework for family outcomes in EI of Bailey et al. (1998) was created to direct the development of family outcome questions used in the National Early Intervention Longitudinal Study (NEILS). In this framework, Bailey and colleagues identified two broad types of family outcomes and eight questions that are consistent with the underlying philosophy, theories and models of family-centered practices in EI. The first outcome related to the family perceptions of the EI experience and included questions: “does the family see EI as appropriate in making a difference in their child’s life?; does the family see EI as appropriate in making a difference in the family’s life?; and does the family have a positive view of professionals and the special services system?” (p. 318). The second outcome focused on the impact that EI had on different areas of family life. It included questions such as: “did EI enable the family to help their child grow, learn, and develop?; did EI enhance the family’s perceived ability to work with professionals and advocate for services?; did EI assist the family in building a strong support system?; did EI help enhance an optimistic view of the future?; and did EI enhance the family’s perceived quality of life?” (p. 320). Further, the NEILS interview had 27 items designed to address these questions.

In 1995, Head Start developed the Head Start Program Performance Measures that was built on the opinion of key stakeholders including Head Start staff and parents, representatives of early childhood organizations, researchers, and experts in the fields of child development, education, and early intervention (Administration for Children, Youth, and Families, 1998). In 1996, Head Start began a longitudinal study, the Family and Child Experiences Survey (FACES), to determine experiences and outcomes of children and families. The study selected a national random sample of 3,200 children and their families in Head Start programs. Although, the focus of the study was on child outcomes, data on family outcomes were collected as part of the interview process. Of the five broad objectives in the Program Performance Measures, two objectives related to family outcomes. One objective directly addressed the family outcome relating to strengthening the family’s role as the primary nurturer of their child. The other objective indirectly related to the family outcome concerning linking children and families to community services. Both objectives had indicators, which included parents demonstrating improved parenting skills and emotional well-being; parents’ link with social service agencies, educational service agencies, and health care services to obtain needed services; and parents securing child care in order to go to work or school.

The primary focus of the Personal Outcome Measures for Families with Young Children was on family outcomes and the organizational supports that facilitated these outcomes (Council on Quality and Leadership, 2004). It identified specific organizational supports that enabled staff, working with families of young children with disabilities, to individualize services for families. In defining quality as “responsiveness to families” rather than compliance with organizational procedures, the Council shifted the focus to families instead of how well organizations perform. Thus, utilizing family outcomes as a measure of quality in program evaluation and assessing organizational performance. Moreover, the outcomes represented broad categories in which families can identify their own implication within each outcome; in other words, how the family defined the outcome from their perspective. The outcomes served three functions: (a) learning function where team members utilize the outcomes to identify and learn about the families’ needs and priorities; (b) facilitating function where the organization aligns services and resources to facilitate family outcomes; and (c) measuring function where the organization determines whether the family achieved the outcomes as they described it. Of the twenty suggested outcomes, fourteen directly related to families including: families are informed; families choose child development goals, their goals, and services and supports; families satisfied with their services and their life situations; families have economic resources, remain together, and are part of their communities; families exercise rights and are respected; and families experience security.

Category 2: Family Outcomes Based on Results of Discussions/Focus Groups with Stakeholders

This category of articles on family outcomes was based on findings of discussions or focus groups among stakeholders. Three major frameworks of family outcomes were identified including: (1) Family outcomes and indicators recommended by the OSEP focus group (Parrish & Philips, 2003); (2) Family Strand Participants National Goals

(National Goals Conference, 2003); and (3) Family outcomes of the State Part H Evaluators' Consortium (Roberts, Innocenti, & Goetze, 1999).

As part of the Early Childhood Outcomes (ECO) Center work, OSEP convened the Early Childhood Outcomes and Indicators Focus Group in January 2003 (Parrish & Philips, 2003). The purpose of the two-day meeting was to identify child and family outcomes and performance indicators for Part B and Part C programs. The focus group consisted of 22 stakeholders and was divided into two subgroups: child outcomes and family outcomes. A set of seven family outcomes and accompanying indicators were developed: (1) "enhance family capacity to facilitate child development"; (2) "enhance family capacity to provide learning opportunities for their child"; (3) "families have a positive vision of child's future"; (4) "families are confident in their ability to carry out parenting responsibilities and skills"; (5) "families view themselves as competent in parenting their child"; (6) "families exercise options within a framework of evidence-based practice"; and (7) "parents are effective advocates for their child" (p. 26).

The National Goals Conference was held in Washington, DC in January 2003 to identify national goals for people with intellectual and developmental disabilities and address knowledge base and research activities that contribute to achievement of these goals (Turnbull et al., 2006). Twelve topic areas of relevance and importance to these goals identified, subgroups convened, and reports produced. One relevant group related to support for families and family life across the lifespan. The family subgroup identified one overarching goal with five related goals. The overarching goal was supporting the caregiving efforts and enhancing the quality of life of families. The associated goals related to ensuring family-professional partnership, family full participation in their communities, services and supports for all families are available and accessible, families and professionals have full access to state-of-the-art knowledge and best practices, and sufficient funding to implement these goals. Although not all of these goals fit the criteria for a family outcome, they were useful in the development of family outcomes.

The family outcomes of the State Part H Evaluators' Consortium were a result of a series of discussions among members of a consortium of professionals responsible for Part H (now Part C) evaluations (Roberts, Innocenti, & Goetze, 1999). These series of discussions were a part of the Federal Interagency Coordinating Council's Subcommittee on Service Integration and Continuity of Services. Three categories of family outcomes were identified: (1) service related outcomes; (2) satisfaction outcomes; and (3) quality of life outcomes. The service related outcomes covered outcomes related to the type of services received, family's perception of hassles in obtaining services, and the level of parents' control in interactions with service providers. Satisfaction outcomes included general satisfaction with services provided, family's competence as a result of services received, and the family's perception of the interaction with the service providers and agency. Quality of life outcomes included outcomes related to the families' participation in everyday activities within their communities, receipt of childcare for the child, and the parent's ability to return to work.

Category 3: Family Outcomes Based on Studies that Involve Quantitative and Qualitative Methodologies

This category of articles on family outcomes was based on findings of studies that involved quantitative and qualitative methodologies. Two studies of family outcomes were identified including: (1) Family outcomes in Service Coordination (Bruder, 2005); and (2) Family outcomes in Growth and Development Model (Early Childhood Research Institute, 1998).

The Research and Training Center (RTC) in Service Coordination was a project funded by the OSEP to carry out a research program to recommend future policies and practices for service coordination. RTC conducted a series of four national studies with various stakeholder groups to identify recommended outcomes of effective service coordination (Bruder, 2005). The first and second studies involved focus groups methodology with two national samples and a Delphi method using a survey with a large number of experts to refine the outcomes generated in first study. The third study utilized a survey methodology with a national survey to collect information from a large number of stakeholders to quantify the desired outcomes for service coordination. The last study utilized a case study methodology using interviews with a sample consisting of 100 families and their service coordinator to identify family experiences and outcomes as a result of service coordination. The final refinement of all the outcomes collected and analyzed through the four studies resulted in five family outcomes across three categories of immediate, intermediate, and long-term outcomes. The immediate family outcomes included: Families are knowledgeable about their child’s needs; families make informed decisions about the services and resources for their child; and families have the support and tools to address their individual needs. The intermediate outcome included: children and families receive coordinated and individualized for their needs. The long-term outcomes included: families attain a quality of life; and families are able to meet the special needs of their child.

The family outcomes in Growth and Development Model were generated by a group of researchers funded by OSEP (Early Childhood Research Institute, 1998). The main purpose of the study was to identify family outcomes that relate to family involvement in the child's growth and development. The study involved two steps where in the first step a series of interviews were conducted with parents of young children with disabilities to determine the outcomes that the families perceive as important. In the second step, the research team selected four out of the eleven outcomes identified by the families that specifically relate to the family's involvement in their child's growth and development. These outcomes included: Families understand child development and are able to identify their child's needs; families are able to evaluate their child's progress in outcomes identified on the Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP); families make decisions about interventions for their child and are able to implement those interventions effectively; and families feel that their beliefs and values are respected by professionals as well as being an equal members of the team.

Category 4: Recommended Family Outcomes Developed by the Early Childhood Outcomes (ECO) Center.

The ECO Center is a 5-year project funded by the OSEP to advance the development of child and family outcome measures for young children with disabilities (Bailey et al., 2006). The ECO were a result of multiple meetings with key stakeholders and a literature review of major frameworks of family outcomes. The meetings were conducted over a year and consisted of meetings with the ECO National Advisory Board (consisting of key stakeholders including researchers, parents of young children with disabilities, and program administrators), a two-day meeting with the Family Technical Work Group (eight well-known family researchers), and a two-day meeting with the Family Work Group (nine stakeholders including parents, directors of major parent organizations, and agency administrators). Conference calls were held for revising and editing the final family outcomes. The conference calls also resulted in the exemption of quality of life as a specific family outcome as it was viewed to be outside the scope of early intervention and early childhood programs. The five recommended family outcomes include:

1. "Families understand their child's strengths, abilities and special needs;
2. Families know their rights and advocate effectively for their children;
3. Families help their children develop and learn;
4. Families have support systems; and
5. Families access desired services, programs, and activities in their community" (p. 227).

Measures of Family Outcomes

Research studies acknowledged that family involvement and parent participation in EI programs is a strong predictor of children outcomes (Bailey, Hebbeler, Spiker, Scarborough, Mallik, & Nelson, 2005; Dunst, 1999). In a national study that examined the perceived family outcomes at the end of EI, 2586 parents in 20 states completed a telephone survey near the child's third birthday (Bailey et al., 2005). Parents reported enhanced competency in caring for their children, increase in their ability to advocate for service for their children, and access to needed supports. The study also reflected the importance of EI programs in improving the well-being of families of young children with disabilities.

A theme that has dominated family involvement research in past years was the notion of satisfaction with services. Many research studies focused on assessing parents' perception and level of satisfaction with EI/ECSE services (Dillenburger, Keenan, Gallagher, & McElhinney, 2004; Hume, Bellini, & Pratt, 2005; McNaughton, 1994; Spann, Kohler, & Soenksen, 2003). Numerous authors raised a number of concerns with the use of parent satisfaction in evaluating family outcomes (Bailey et al., 2006; Bailey & Bruder, 2005). These concerns were related to the many factors that affect parents' perceptions and view of their children needs, which in turn affect their satisfaction with the services provided. Such factors included the age of the child, the type and severity of the child's disability, and the family's socioeconomic status (Bailey, Blasco, & Simeonsson, 1992).

In his literature review of 14 studies on parental satisfaction, McNaughton (1994) concluded that all studies demonstrated high levels of parent satisfaction. These findings were hindered by the individually developed instruments which compromised the validity and reliability of these measurement tools. The measurement of parent satisfaction provides very little use if their findings are always positive and do not identify aspects of programs in need of further development and improvement. Although these concerns are justified, parent satisfaction is regarded as an important component of EI/ECSE program evaluation and efficacy and new instruments are needed to provide reliable and valid data on parent satisfaction with EI services (Roberts, Innocenti, & Goetze, 1999). Regardless of its importance, parent satisfaction is not considered as a family outcome of services

(Bailey et al., 2006; Bailey & Bruder, 2005). Satisfaction with a service is merely a reflection of whether parents like the services received, but does not essentially mean that a benefit has occurred.

The Family Outcomes Survey (FOS), developed by ECO center, is a 15-items instrument that provided information of the efficacy of EI/ECSE programs as it relate to positive outcomes for families of young children with disabilities (Early Childhood Outcomes Center, 2006b). The survey consisted of five sections that mirror the five sets of family outcomes developed by the ECO center (families understand their child's strengths, abilities and special needs; families know their rights and advocate effectively for their children; families help their children develop and learn; families have support systems; and families access desired services, programs, and activities in their community). Each outcome domain had three key constructs. For example, the first outcome relating to families' understanding of their child's strengths, abilities, and special needs asked parents to rate their knowledge and understanding of the (a) child's development, (b) child's special needs (health needs, disability), and (c) child's progress (Early Childhood Outcomes Center, 2006c). The FOS had two versions: Part C (Birth to three), and Part B (Preschool). Both versions are available in English and Spanish. In addition, the state of Minnesota translated the FOS into ten different languages including Arabic, Cambodian, Croatian, Hmong, Laotian, Chinese, Oromo, Russian, Somali, and Vietnamese (Early Childhood Outcomes Center, 2005).

Though studies that examined family outcomes in EI programs were limited in the research literature, there was a recent study that examined the utilization the FOS in EI programs (Raspa et al., 2010). In their study Raspa and colleagues (2010) examined parents’ perception of achievement of family outcomes as well as factors influencing family outcomes in EI programs. A total of 2,849 families of children with disabilities receiving EI services in Illinois and Texas completed two measures: The FOS and the Family-Centered Services part of the National Center for Special Education Accountability Monitoring Part C Family Survey, which provided information on parents’ perception of how EI services were delivered. The study findings revealed that families rated themselves highest on the following outcomes: Access to high-quality medical care, ability to help their child practice new skills, feeling comfortable in participating in meetings with professionals, and understanding of their child's special needs. On the other hand, families rated themselves lowest on the following outcomes: Knowing what services are available for their child, having their child participate in activities, and having someone to call for help when they needed it. The study also showed that length of time spent in EI programs was associated with parents’ perception of achievement of outcomes as families who just enrolled in EI programs reported lower family outcomes than families of children who received EI services for a longer period of time.

Defining Family-Professional Partnership

In the literature a broad range of terms has been used to describe the relationships between families of young children with disabilities and professionals. These terms included collaboration, parent involvement, and parent participation (McWilliam, et al., 2000; Park & Turnbull, 2003). The research literature provided various definitions for family-professional partnership that reflected the gradual evolution of family-professional relationships and the change in emphasis over time. Dunst and Paget defined partnership as an “association between a family and one or more professionals who function collaboratively using agreed-upon roles in pursuit of a joint interest or common goal” (Dunst & Paget, 1991 as cited in Park, Turnbull, & Turnbull, 2001, p. 158). A more recent and inclusive definition reflect the specific characteristics of partnerships “mutually supportive interactions between families and professionals, focused on meeting the needs of children and families with competence, commitment, equality, positive communication, respect, and trust” (Summers et al., 2005, p. 65).

The concept of family-professional partnership encompasses a broad range of overlapping characteristics. The literature has identified several important themes related to successful partnerships between service providers and families of children with disabilities (Blue-Banning et al., 2004; Park & Turnbull, 2003; Soodak & Erwin, 2000; Summers et al., 2001). In their qualitative study of parents’ perception of factors that influenced their participation in their child’s education, Soodak and Erwin (2000) identified three defining characteristics of parent-professional partnership: trust, shared vision, and open communication. Trust referred to the parents having confidence in professionals to keep to their words, respect their children and help them to learn, share information, and support their decisions and opinions. Shared vision reflects having a mutual understanding and a similar vision for the child’s education and future. The third defining characteristic of positive partnership was frequent and open communication between parents and professionals.

In a qualitative study that utilized focus groups to synthesize perceptions of parents, service providers, and administrators, Blue-Banning and colleagues (2004) identified six broad domains of interpersonal partnerships: communication, commitment, equality, skills, trust, and respect. Both quantity and quality of communication between families and professionals are important to positive partnerships. Communication should be two-way, open, honest, free of jargons, and frequent. Communication also included access to and sharing information, explanation of reports, and description of the family’s rights. Effective partnership is dependent on professionals’ demonstration of commitment and dedications to their work (Blue-Banning et al., 2004). Commitment was translated into loyalty and devotion to the child and family. A professional who demonstrated commitment was someone who is flexible, consistent, and accessible to the child and family.

Another domain of positive partnership involved competency and skills of service providers. Skills were reflected into demonstration of recommended practices approaches to working with children and their families. Positive partnership necessitates equality between service providers and families. An equal partnership requires professionals making an active effort to empower parents and acknowledging parents’ opinions. Central to positive partnership is trust between service providers and families. Trust entails both reliability, in the sense of fulfilling promises, and dependability. A final and crucial element of positive partnership was respect between service providers and families. Respect denotes valuing the child as a person not a diagnosis, showing common courtesy, and acknowledging parents’ contributions with respect to their child. Further, It is f importance to note that the result of Blue-Banning and colleagues’ study (2004) led to the development of the Beach Center Family-Professional Partnership Scale, a measurement tool designed to measure the quality of partnerships that exist between families of children with disabilities and service providers (Summers et al., 2005b).

Measures of Family-Professional Partnership

Even though there was an agreement on the importance and benefits of collaborative partnership between parents of young children with disabilities and the professionals who work with them, there was a scarcity of instruments that measures the quality of family-professional partnership in EI/ECSE programs. Research literature provided a wide range of measures of family/parent satisfaction with services and measures of family-centered practices (Bailey, Scarborough, & Hebbeler, 2003; Johnson & Duffett, 2002; Lanners & Mombaerts, 2000; Laws & Millward, 2001; Murphy, Lee, Turnbull, & Turbiville, 1995; Woodside, Rosenbaum, King & King, 2001). Parent satisfaction measures assess parents' perception and satisfaction with the amount of services they and their children receive, the quality of services, and the quality of their relationships with the service providers (Bailey, Scarborough, & Hebbeler, 2003; Johnson & Duffett, 2002; Laws & Millward, 2001). The majority of these measures was designed specifically for the intended studies and targeted the services being evaluated by the study. In the National Early Intervention Longitudinal Study (NEILS), Bailey and colleagues (2003) utilized a structured telephone interview and a survey to assess families' satisfaction with EI programs and interactions with professionals that was specifically designed and tailored for the purpose of the study. Lanners and Mombaerts (2000) developed a measure of parent satisfaction with EI services in eight European countries. In their study, 584 families from different European countries completed the European Parent Satisfaction Scale about Early Intervention (EPASSEI). The scale consisted of 57 items that measured parental satisfaction in eight dimensions of intervention in early childhood education services: child-centered practices, parent-centered practices, sibling-centered practices, partnership between professionals and parents, organization of the service, parent’s access to social networks, child’s access to social networks, and access to community resources.

Measures of family-centered practices tended to measure parents’ perception of the extent to which the services delivered to them and their children were family-centered. These measures assessed both the relational and participatory components of family-centered practices (Dunst, 2002). Relational practices referred to the relations between the family and the professional and were associated with good interpersonal skills, professional’s beliefs and attitudes toward family’s capabilities, and competence. Participatory practices included practices that are individualized and responsive to families’ priorities and concerns, families’ involvement in decision making, and collaboration with families.

The Measure of Process of Care (MPOC) is a measure of family-centered services that is used in pediatric clinical settings (Woodside, Rosenbaum, King, & King, 2001). MPOC is a self-report measure that assesses all aspects of family-centered care that it is mainly used in Canada and the United Kingdom. The revised version (MPOC-56) is a 56-item questionnaire that consists of five subscales that represent fundamental aspects of family-centered care: 1) Enabling and Partnership, 2) Providing General Information, 3) Providing Specific Information about the Child, 4) Coordinated and Comprehensive Care for the Child and Family, and 5) Respectful and Supportive Care (King, Rosenbaum, & King, 1995). For each item, parents are asked to rate their service providers on a 7-point rating scale (7 = "to a great extent”; 4 = "sometimes"; and 1 = "never"). A "not applicable" category is also provided for the respondents. Further, The Measure of

Processes of Care for Service Providers (MPOC-SP) is the professional version of the MPOC (Woodside, Rosenbaum, King, & King, 2001). The MPOC-SP was designed as a self-assessment tool for pediatric service providers to measure their perceptions of the extent to which the services they provided were family-centered. Unlike the family version, the professional version consisted of 27 items and four subscales: 1) Showing Interpersonal Sensitivity, 2) Providing General Information, 3) Communicating Specific Information about the Child, and 4) Treating People Respectfully.

Measures of parent satisfaction and family-centered practices encompassed a broader concept of partnership between families and professionals that reflected specific components of partnership. However, the majority of these measures were either developed for intended studies (Bailey, Scarborough, & Hebbeler, 2003; Johnson & Duffett, 2002; Laws & Millward, 2001) or was limited in use to specific services such as clinical pediatric rehabilitation programs (Woodside, Rosenbaum, King, & King, 2001). In terms of psychometric properties, some of these studies did not report any psychometric information (Bailey, Scarborough, & Hebbeler, 2003; Lanners and Mombaerts, 2000) while others were well established measures and had good evidence of psychometric properties (Measure of Processes of Care and the European Parent Satisfaction Scale about Early Intervention).

Of the measures that assessed the quality of partnerships that was psychometrically valid, applicable to a wide range of ages of children with disabilities, and assessed both families and professionals perceptions is the Beach Center Family-Professional Partnership Scale (Blue-Banning et al., 2004; Summers et al., 2005a; Summers et al., 2005b). The partnership scale consisted of 18-item that assessed the extent to which families were satisfied with the relationships they had with professionals serving their children with disabilities (Summers et al., 2005a). It had both a family and a professional version. The family version of the scale consisted of two subscales: Child-Focused Relationships and Family-Focused Relationships. The Child-Focused Relationships subscale reflected the parent's perceptions about how the professional worked with and treated the child. The Family-Focused Relationships subscale contained items related to the parent's perceptions about how the professional worked with them.

Even though the Beach Center Family-Professional Partnership Scale was psychometrically valid and reliable, it was not culturally sensitive to provide objective assessment of partnership in a different cultural context. Validation study of the scale involved culturally diverse American families (American Indian, Asian American, Hispanic, and African American) who were either English or Spanish speakers (Summers et al., 2005b). There were no studies reported that had tested the applicability of the existing partnership measurement tools with families from Arabic culture. Thus, existing tools may not be culturally sensitive or appropriate for Arab families.

Satisfaction with Family-Professional Partnership

There were a limited number of empirical studies that specifically examined satisfaction with partnership between families and service providers in EI/ECSE programs (Hodge & Runswick-Cole, 2008; Kasahara & Turbull, 2005; O'Connor, 2008; Pinkus, 2003; Rodger, Keen, Braithwaite, & Cook, 2007; Summers et al., 2005a; Summers et al., 2005b; Summers et al., 2007). In a study that examined parents' satisfaction with partnerships with the service providers working with their children, 147 parents of children with disabilities of different ages completed the Beach Center Family-

Professional Partnership Scale (Summers et al., 2005a). The study demonstrated that parents of younger children (birth to 3 years) reported higher level of satisfaction with their partnerships than parents of older children (3-5 years and 6 to 12 years). This difference in satisfaction levels across the three age groups (birth to 3 years, 3 to 5 years, and 6 to 12 years) could be explained by the nature of service system and service delivery model across the age groups. Children ages birth to 3 years were generally served in EI programs that were characterized by family-centered service delivery model. On the contrary, children ages 3 to 5 years were served in ECSE programs that are center-based service delivery model where there was less emphasis on family support services. At age 6 children usually transition to special education programs and start receiving categorical services and deal with issues related to inclusion in general education. Further, the study findings showed an inverse relationship between parents' age and level of education and levels of satisfaction, where, younger and less educated parents were more satisfied than older and more educated parents. This association was better explained by the fact that parents became more aware of their rights and expectations as their child grow up.

Even though in the United States, indicators of successful partnerships between professionals and families have been well defined in the literature, there was very little in the research literature concerning family-professional partnerships in diverse cultural contexts. Kasahara and Turnbull (2005) have explored the meaning of family-professional partnership from the perspectives of Japanese families of children with disabilities. The study utilized a purposive sample of thirteen mothers of children with disabilities ages birth to 12 years of age, from three different geographical areas in Japan. The primary method of data collection was focus groups in addition to interviews that were used with only two participants who could not attend the focus groups. The study findings suggested four themes that reflected expectations for positive partnerships: (a) the quality of child-professional relationship, (b) quality and individualization of services based on the child's strengths and needs, (c) equality of relationships between families and professional reflected in empathy, commitment, and trustworthiness, and (d) empowerment of families through guidance and access to resources and information. In a qualitative study, O'Connor (2008) utilized a phenomenological approach to explore parents' perceptions of partnerships in Northern Ireland. More specifically, the study utilized interviews to examine 20 parents' perception of their role as partners and factors that influenced their partnerships with various professionals. The study findings showed that parents did not perceive their role as partners when it came to partnership with professionals as they were treated unequal and that professionals maintained their role as the "expert" in this relationship. In addition, the study revealed that parents experienced a sense of tension due to lack of appropriate communication and professionals' deficiency in understanding and meeting the special needs of their children.

Positive Outcomes Associated with Family-Professional Partnership

Successful family-professional partnership has been linked to positive outcomes in EI/ECSE programs (Dunlap et al., 2001; Dunst & Dempsey, 2007; Lucyshyn et al., 2002; North & Carruthers, 2005). Research studies have demonstrated that effective partnerships empowered parents and enhanced parenting capabilities and parents' beliefs in their own abilities to advocate for their children (Dunst & Dempsey, 2007; Dunst, Hamby, Trivette, Raab, & Bruder, 2000). Parent empowerment is critical for parents of children with disabilities and had been linked to the achievement of desirable outcomes in a variety of educational settings (North & Carruthers, 2005). Parents reported better experiences when they felt they were treated as a valued and equal member in the decision making process (Soodak & Erwin, 2000). Further, in a study of 150 parents of young children with disabilities and developmental delays in Western North Carolina, Dunst and Dempsey (2007) examined the association between family-professional partnership and parents' empowerment. Families completed four measures including: The Enabling Practices Scale, the Everyday Parenting Scale, and two measures that were designed specifically for the study to assess parent control appraisals. Using hierarchical multiple regression analysis, the study findings demonstrated a correlation between family-professional partnership and parent empowerment but not correlated to the parenting competence and capabilities. This may be related to the measure used to assess family-professional partnership as the authors utilized seven items of the Enabling Practices Scale. Further, the study utilized a different definition for family-professional partnership that was part of the enabling practices in that "Parents and other family members working together with professionals in pursuit of a common goal where the relationship between the family and the professional is based on shared decision-making and responsibility and mutual trust and respect" (p.308).

A unique context in which family-professional partnership explored was in the area of addressing challenging behaviors of children with disabilities. Problem behaviors exert a significant impact on all aspects of children and family life (Fox, Vaughn, Wyatte, & Dunlap, 2002). The research literature provided a number of studies that documented the importance of partnerships between families and professionals in designing and implementing positive behavior support intervention (Dunlap et al., 2001; Lucyshyn et al., 2002).

In a recent study, Summers and her colleagues (2007) explored family-professional partnerships in relation to parental perceptions of service adequacy and the impact on family quality of life. The study involved 180 families of young children with disabilities ages birth to five years. Families completed three measures including: 1) The Services Inventory which was used to assess families' perception of the adequacy of services they were receiving; 2) The Family-Professional Partnership Scale used to assess families' perception of their satisfaction with level of partnership with professionals working with them; and 3) The Family Quality of Life Scale which was used to assess families' perception of their satisfaction with the different domains of family quality of life. The study showed that parents were mainly satisfied with the service provider's friendliness and less satisfied with the provider's ability in helping them to gain skills or information to enable them to meet their child needs. The study also demonstrated that parents' perception of adequacy of service provision was a significant predictor of partnership and that partnership operated as a partial mediator of the effects of service adequacy on family quality of life.

Factors Influencing Successful Family-Professional Partnership

There were a limited number of studies that investigated the development of positive partnerships and factors influencing successful family-professional partnership in EI/ECSE programs (Park and Turnbull, 2003; Soodak & Erwin, 2000). In a qualitative study of ten parents of young children with significant disabilities who were educated in inclusive settings, development of positive partnerships between parents and school educators was a critical factor that influenced parents’ participation in their children inclusive education (Soodak & Erwin, 2000). Even though the study utilized a small sample size, it demonstrated specific factors that are inherited in the school climate or the organization environment and the individuals working in them that set the context for the development of positive partnership. At the organizational level these factors included effective leadership and professional collaboration. At the interpersonal level, factors that promote positive partnership between parents and school personnel included trust, open communication, shared values and vision for their children’s future.

In a review of literature on service integration, Park and Turnbull (2003) provided a framework of interpersonal and structural elements of effective partnerships. Interpersonal factors referred to the characteristics of the relationships at the individuals’ level that promote or hinder successful partnership. They identified a set of interpersonal attitudes, skills, and values that contributed to effective partnerships between families and professionals, which included: Sharing information and keeping parents informed, open communication, professional expertise and knowledge, mutual understanding and shared vision, and displaying equal respect. Structural factors referred to the elements of the relationships at the agencies’ or systems’ level that facilitated effective partnerships such as: Funding, flexibility of the program (home-based or center-based), caseload, effective communication system, and administrative support for partnership activities.

CHAPTER 3: Methodology

Research Design

The study utilized a mixed-methods approach to examine family outcomes, satisfaction with family-professional partnership, and factors that promoted and/or impeded successful partnership from the perspectives of families of young children with disabilities, service providers, and program directors in EI/ECSE programs in Qatar. Mixed methods research involves the use of combination of quantitative and qualitative approaches in a single study (Johnson, Onwuegbuzie, & Turner, 2007; Tashakkori & Teddlie, 2003). The rationale for utilization of a mixed methods approach in this study was rooted in a number of reasons. First mixed methods design was utilized to provide a better understanding to the complex construct of “partnership”, as neither a quantitative nor a qualitative approach is sufficient to capture the construct in details (Johnson, Onwuegbuzie, & Turner, 2007). Second, utilization of a combination of qualitative and quantitative methods in a single study allowed for the two methods to complement each other by offsetting the biases or weaknesses inherited in each method and capitalizing on the strengths of each method (Tashakkori & Teddlie, 2003). Third, utilization of a mixed methods design provided breadth and depth to data collection as the study involved perspectives of multiple key stakeholders including families of children with disabilities, service providers, and program directors (Johnson, Onwuegbuzie, & Turner, 2007). Finally, the research questions required understanding of the partnership construct in terms of broad trends at the national level and detailed perspectives at the individual level (Creswell, 2003).

Empirical research that examined family-professional partnership utilized either qualitative or quantitative inquiry (Blue-Banning, Summers, Frankland, Nelson, & Beegle, 2004; Dunst & Dempsey, 2007; O'Conner, 2008; Park & Turnbull, 2001; Rodger, Keen, Braithwaite, & Cook, 2008; Summers, Hoffman, Marquis, Turnbull, & Poston, 2005a; Summers, Hoffman, Marquis, Turnbull, Poston, & Nelson, 2005b; Summers, Marquis, Mannan, Turnbull, Fleming, & Poston, 2007). Qualitative research was used to provide an understanding of the meaning of partnership and indicators of collaborative partnership (Blue-Banning et al., 2004). Qualitative inquiry was also used as a primary tool to explore parents' experiences of partnership with service providers, more specifically parents of diverse cultural backgrounds (O'Conner, 2008; Park & Turnbull, 2001; Rodger, Keen, Braithwaite, & Cook, 2008). Quantitative research, on the other hand, had been used to examine the relationship between family-professional partnership and positive outcomes for families of children with disabilities including parenting competence, satisfaction with services, and family's quality of life (Summers et al., 2005a; Summers et al., 2005b; Summers et al., 2007). Thus, utilization of a mixed-methods design for this study provided for a broad and in depth understanding of parent-professional partnership in EI/ECSE programs in Qatar.

The research design adopted in this study was "exploratory concurrent triangulation design" in which the quantitative and qualitative data collected and implemented concurrently at the same time of the research study (Creswell et al., 2003). In this design, qualitative and quantitative approaches were used to "confirm, cross-validate, or corroborate findings within a single study" (Creswell et al., 2003). Thus, the rationale for using this strategy was to allow for convergent triangulation of both quantitative and qualitative data as well as to provide validity evidence for the Partnership Scale (Tashakkori & Teddlie, 2003). Further, this design was used to address the concern related to the cultural specificity of the partnership scale by allowing for cross validation and triangulation of findings where qualitative methods was used to gain detailed information of the target culture. Therefore, the concurrent triangulation design allowed for the use of existing measurement of partnership with a culturally diverse population through triangulation of quantitative and qualitative findings.

The study utilized a descriptive design for the quantitative strand to explore broad trend using two measures. The first measure was the Beach Center Family-Professional Partnership Scale used to assess the extent to which families and service providers were satisfied with partnership and factors contributed to successful partnership in EI/ECSE programs. The second measure was the FOS used to examine parents' perceived outcomes in EI/ECSE programs. Nevertheless, the qualitative strand utilized a phenomenological approach to understand families' and service providers' "lived experiences" about factors contributed to successful partnerships (Patton, 2002). An important aspect of this study was the experiences of key stakeholders including families, service providers, and program directors. Hence, semi-structured interviews were a particularly useful avenue of gaining a more in-depth description of key stakeholders' experiences. The study utilized a balanced design where both quantitative and qualitative strands had an equal priority and importance (Tashakkori & Teddlie, 2003). Integration occurred at the interpretation stage for similarities and discrepancies in the findings of the study.

Participants and Sampling

To assess perceived family outcomes, the extent of satisfaction with partnership, and factors affecting successful partnership between families and service providers in EI/ECSE programs, this study utilized concurrent mixed methods sampling (Teddlie and Yu, 2007). To provide a comprehensive picture of family-professional partnerships, participants in this study included key stakeholders in EI/ECSE programs: Families of young children with disabilities receiving EI/ECSE services, service providers serving young children with disabilities in EI/ECSE programs, and EI/ECSE program directors. Using the sampling scheme identified by Teddlie and Yu (2007), a stratified random sampling scheme was utilized for the quantitative strand of the study. At the same time, a snowball purposeful sampling scheme was utilized to explore factors that influenced successful partnerships in more depth through a qualitative phenomenological approach.

Participants for the study were 127 families of young children with disabilities, service providers working in EI/ECSE programs, and program directors. Participants were recruited from Hamad Medical Corporation and Shafallah Center for Children with Disabilities, which are the two major centers for provision of EIEC services to young children with disabilities from birth to six years old and their families. This sample size was appropriate as the research literature that examined satisfaction with partnership utilized a sample size in the range of 145- 180 participants (Dunst & Dempsey, 2007; Summers et al., 2005a; Summers et al., 2005b; Summers et al., 2007). Of the total 127 participants, 57 (45%) were families of young children with disabilities, 66 (52.0%) were service providers, and 4 (3%) were program directors. There were 31 (24%) male and 96 (76%) female participants. Overall, sixty-five percent (n = 83; 65%) of the participants were from HMC while the remaining thirty-five percent (n = 44; 35%) were from Shafallah Center. Table 1 provides a description of the study sample for the quantitative strand according to gender and setting.

Table 1

Study Sample according to Gender and Setting (N = 132)

Variable	**n**	**Percent**	**Cumulative %**
Participants			
Families	57	45%	45%
Service Providers	66	52%	97%
Program Directors	4	3%	100%
Gender			
Male	31	24%	24%
Female	96	76%	100.0%
Setting			
HMC	83	65%	65%
Shafallah	44	35%	100.0%

For the quantitative component, a stratified random sample of 57 families of young children with disabilities was recruited from HMC and Shafallah Center to complete both the Beach Center Family-Professional Partnership Scale and the FOS. Family participants met the following inclusion criteria: (a) have a young child (birth to six years old) with identified disability, and (b) receiving one or more EI/ECSE services. Stratification for families was based on child’s type of disability. Six strata were identified as follows: (1) Autism Spectrum Disorders (ASD); (2) Down Syndrome (DS); (3) Cerebral Palsy (CP); (4) Other Neurological Disorders (OND) (affecting the motor system which includes muscular dystrophy, spina bifida, and developmental delay); (5) Hearing Impairment/visual impairment (HI/VI); and (6) Developmental Language Disorders (DLD). The categories for the child's type of disability reflected the primary diagnoses utilized by pediatricians at both HMC and Shafallah Center. Out of the 57 randomly selected families, 19% (n = 11) families had a child with ASD, 17% (n = 10) families had a child with Down Syndrome, 15% (n = 8) families had a child with Cerebral Palsy, 17% (n = 10) families had a child with Other Neurological Disorders, 15% (n = 8) families had a child with hearing/visual impairment, and 17% (n = 10) families had a child with Developmental Language Disorders. See Table 2 for percentage of families according to their child's type of disability.

Table 2

Frequencies (Percentages) of Families according to Type of Child's Disability (N = 57)

Variable	**n**	**Percent**	**Cumulative %**
Child's Type of Disability			
Autism Spectrum Disorders	11	19%	19%
Down Syndrome	10	17%	36%
Cerebral Palsy	8	15%	51%
Other Neurological Disorders	10	17%	68%
Hearing/Visual Impairment	8	15%	83%
Developmental Language Disorders	10	17%	100.0%
Total	**57**	**100.0%**	

Due to the limited number of services providers working with young children with disabilities in Qatar, the professionals sample included all of the services providers at both HMC and Shafallah Center. Sixty-six (n = 66) service providers comprised the professionals sample for the quantitative strand of the study. The majority of the service providers sample was from HMC (59%, n = 39), while the remaining twenty-seven participating professionals were from Shafallah Center (41%, n = 27). The majority of the service providers were females comprising 70% (n = 46), with the remaining professionals were males (30%, n = 20).

In an effort to be inclusive, the professionals sample included service providers from multiple disciplines in EI/ECSE programs. The represented disciplines included 15 special education teachers (23%), 31 related services therapists (47%), 11 paraprofessionals (17%), and 9 health and social services providers (13%). Tables 3 and 4 shows frequencies and percentages of professionals sample according to their discipline.

Table 3

Frequencies (Percentages) of Professionals According to Discipline (N = 66)

Variable	**n**	**Percent**	**Cumulative %**
Discipline			
Special Education Teachers	15	23%	23%
Related Services Therapists	31	47%	70%
Paraprofessionals	11	17%	87%
Health & Social Services	9	13%	100.0%
Total	**66**	**100.0%**	

Table 4

Frequencies (Percentages) of Professionals According to Specific Discipline (N = 66)

Variable	**n**	**Percent**
Discipline		
Special Education Teachers	15	23%
Paraprofessionals (Teacher Aid)	11	17%
Physical Therapists	11	17%
Occupational Therapists	10	15%
Speech & Language Pathologists	10	15%
Psychologists	5	7%
Pediatricians	3	4%
Social Worker	1	2%
Total	**66**	**100.0%**

The majority of the professionals comprised of the related services therapists including ten (n = 10) occupational therapists, eleven (n = 11) physical therapists, and ten (n = 10) speech and language pathologists. The smallest represented discipline group was the health and social services providers (13%, n = 9) including three (n = 3) pediatricians, five (n = 5) psychologists, and one (n = 1) social worker. Tables 4 shows frequencies and percentages of professionals sample according to their specific discipline.

For the qualitative phase, a snowball purposive sampling strategy was used to select participants for the semi-structured interviews in order to obtain maximum variance within the sample (Creswell, 2007). Participants for the qualitative sample included three subgroups: families of young children with disabilities, service providers working with them, and EI/ECSE program directors. The criteria for selecting service providers included: (a) being a service provider working in EI/ECSE programs serving children birth to six years of age and (b) interacting with families of young children with disabilities frequently. The criteria for selecting families included parents who: (a) have at least one child with a disability ages birth to six years and (b) receiving EI/ECSE services. All program directors were included to ensure that inclusion of the different views and perceptions of both centers. Interviews were conducted with the different managerial levels, including top management, middle management, and first line management to ensure a broad spectrum of perspectives. Further, the number of interviews conducted was flexible to achieve saturation of data.

Personal interactions with families and service providers, as well as previous work experience at both HMC and Shafallah Center informed the initial selection for participants from each subgroup. Initially selected participants gave recommendations of persons they believe could best serve the purpose of the one-on-one interviews. Concerning the subgroups categories, many of the participants had dual roles that are interrelated including a professional role as a service provider along with a supervisory/administrative role. For example, the Supervisor for Pediatric Occupational Therapy at HMC also served as an occupational therapist working with young children with disabilities and their families; the General Manager of Shafallah Center also served as a social worker. Thus, they were categorized into the subgroups they identified themselves.

A total of eight interviews were conducted with families, service providers, and program directors at both centers. Out of the eight interviews, two participants were families of young children with disabilities, two participants were service providers, and four were program directors. All participants were assigned pseudo names to ensure confidentiality. The one-on-one interviews included a total of two service providers from Hamad Medical Corporation (Pediatric Occupational Therapist and Supervisor Pediatric Occupational Therapist). Four of the eight interviewees were program directors at both HMC and Shafallah Center. Although the aim of the researcher was to include all program directors to ensure the inclusion of the different views and perceptions at both centers, interviews were conducted with only four program directors who gave consent to the one-on-one interviews. Of the four program directors, two administrators were from HMC and two were from Shafallah Center. At HMC interviews were conducted with the following program directors: Assistant Director for Rehabilitation Services and Rehabilitation Coordinator. At Shafallah Center interviews were conducted with the Managing Director of Shafallah Center and Head of Psychological Services. Table 5 provides an overview of the number of participants and their roles and discipline. Following is a brief description of the participants:

1. *Ali*, Pediatric occupational therapist, who has been working for the past fifteen years at HMC as a pediatric occupational therapist in a wide range of programs including inpatient and outpatient pediatric programs. He had a Bachelor degree in occupational therapy.

2. *Carol*, Assistant Director for Rehabilitation Services at HMC, with thirteen years of experience all of which in Qatar at HMC. She had a Bachelor degree in Occupational Therapy. Carol has been working in this capacity for four years.
3. *Leela*, Rehabilitation Coordinator at HMC, who also served as a pediatric occupational therapist at HMC. She has been serving in this capacity for less than a year, more specifically seven months. Leela had a Bachelor in Occupational Therapy and had a total of twenty-four years of experience as an occupational therapist of which fifteen years were as a pediatric therapist. Leela has been working at HMC for the past eight years mainly in outpatient children rehabilitation programs.
4. *Farah,* Supervisor Pediatric Occupational Therapy at HMC, she also served as an occupational therapist in outpatient programs. Farah had fifteen years of experience with only ten years of experience as a pediatric occupational therapist at HMC and had Bachelor degree in Occupational Therapy.
5. *Sarah*, the Managing Director of Shafallah Center, had fifteen years of experience as a social worker in Qatar. She had a Bachelor degree in Social Work and a Master degree in Educational Leadership. She has been in this capacity for less than one year but served as an Acting Managing Director for the Center for eight years.
6. *Hani*, Head of Psychological Services at Shafallah Center, who had twenty-one years of experience of which only six years of experience in Qatar at Shafallah Center. He had a Master degree in Psychology and Behavior Analysis and currently working toward a doctoral degree in Psychology.

The last two interviews were conducted with families of young children with disabilities at HMC. Families at the Shafallah Center were unreachable at the time of data collection of the study as it was the Summer Vacation for the children at the Shafallah Center. Thus, only two families consented to be interviewed at HMC as follows:

1. *Talal*, father of a young child (five years old) with Hearing Impairment and Hyperactivity who was receiving EI services at HMC at the time of the study.
2. *Asma*, mother of a young child (three and a half years old) with ASD who was receiving ECSE services at HMC at the time of the study.

Table 5

Qualitative Strand Sample: Participants According to their Roles & Discipline (N = 8)

Participants
Program Directors
Carol - Assistant Director for Rehabilitation Services (HMC)
Leela – Coordinator Professional Development (HMC)
Sarah - Managing Director (Shafallah Center)
Hani - Head of Psychological Services (Shafallah Center)
Service Providers
Ali - Occupational Therapist (HMC)
Farah - Supervisor Pediatric Occupational Therapy (HMC)
Families
Talal - Parent (HMC)
Asma - Parent (HMC)

In conclusion, the quantitative component of the study involved a sample with a large number of participants than the qualitative component. This ensured a random sample that was a representative of the population thereby controlling for the internal validity of the study, while the smaller sample size in the qualitative component ensured the representativeness/saturation trade-off (Teddlie & Yu, 2007). This sampling strategy allowed for the transferability of study findings thereby increasing external validity of the quantitative results (Teddlie & Yu, 2007).

Setting

The State of Qatar

The study was conducted in the State of Qatar, a small peninsula in the middle of the Persian Gulf. The state of Qatar occupies a total area of 11,437 square kilometers, which is nearly the combined size of both Connecticut and Rhode Island (US Department of State, 2010). According to the Qatar Statistics Authority, Qatar has an estimated total Population of 1.6 million (1,678,568 persons) of whom approximately 76% are males and 24% are females (Qatar Statistics Authority, 2010). Qatari citizens comprise a minority with approximately a quarter (25%) of the total population, while the majority of the population (75%) is made up of expatriates employed in different parts of the Qatari economy. Expatriates have been attracted by the rapidly growing Qatari economy, more specifically in the petrochemical industry. As the majority of the expatriates are male, it further explains the significantly skewed sex ratio in the composition of the population in Qatar (3 males per female).

Qatar’s expatriate residents come predominantly from South Asia (India, Sri Lanka, Bangladesh, Nepal and Pakistan), south-east Asia (Philippine), non-oil-rich Arab countries, and Europe (Qatar Statistics Authority, 2010). Because expatriates form the majority of the population in Qatar, it has given rise to a distinct social diversity in Qatar (Nagy, 2006). Added to the already existing social diversity of Qatari citizens who come from Arab, Persian or African descent as well as those of Bedouin traditions, a mosaic of cultural traditions, religion, and customs is evident in the Qatari society. Yet, Qatar can best be described as a conservative society, rooted in tribal values and customs, with very traditional Islamic views that is trying to adapt to the rapidly sweeping modernization and liberalization movement across the country.

Over the past decade Qatar has experienced rapid economic growth from the vast revenues brought by the oil and natural gas resources. Qatar has the third largest natural gas reserve in the world, which made Qatar the second highest per capita income country (CIA World Fact book, 2009). The revenues from natural gas have been used to build an outstanding social, educational, and health infrastructure coupled with the vision of the Emir of the state of Qatar, HH Sheikh Hamad bin Khalifa Al-Thani. The Emir aimed for Qatar to become a role model for economic and social transformation not just among the Gulf Cooperation Council (GCC) countries, specifically Saudi Arabia, Kuwait, Bahrain and the United Arab Emirates, but also in the Middle East region. To achieve this vision, a series of initiatives and reforms have been implemented in both the educational and health care systems.

The educational system has undergone a major reform over the past decade in Qatar. A major initiative that started the education reform was the establishment of Qatar

Foundation for Education, Science and Community Development in 1995 by HH Sheikh Hamad Al-Thani (Rostron, 2009). Qatar Foundation (QF) is private, non-profit organization that aim to raise the competency of individuals and the quality of life in Qatar by investing in human capital, state-of-the-art facilities, and partnerships with elite international organizations in the fields of education, health, and community development (Brewer et al., 2007). Chaired by H. H. Sheikha Mozah Al Missned, Sheikh Hamad's consort, Qatar Foundation played a central part in the reform of kindergarten through grade 12 (K–12) education system that was launched in 2002 alongside the partnership of RAND (Research And Development) Corporation (Brewer et al. 2007). Further, H. H. Sheikha Mozah Al Missned has been the driving force behind the establishment of Education City, a multi-billion dollar project, which houses six branch campuses of the top American universities including: Carnegie Mellon University, Georgetown University School of Foreign Service, Texas A&M University, Virginia Commonwealth University School of the Arts, Cornell University's Weill Cornell Medical College, and Northwestern University (Rostron, 2009).

The State of Qatar commitment to education reform has been extended to the field of special education to meet the needs of children with disabilities. An inclusive education framework has been adopted by the Supreme Council of Education to meet the needs of students who require additional educational support (Supreme Education Council, 2009). A set of policies has been established by the Education Institute of the Supreme Education Council to assist schools in meeting the educational needs of all students including students with Physical Disabilities, Intellectual Disabilities, Hearing Impairment, Vision Impairment, Autistic Spectrum Disorder, Speech Language

Disorders, Multiple Impairments, and Deaf Blind Disabilities. Although not legally binding, these policies merely represent a strong moral commitment of the Supreme Education Council toward meeting the educational needs of children with disabilities. Nevertheless, the major initiative that support provision of special education and related services was the establishment of the Shafallah Center for Children with Special Needs in 1999 (Shafallah Center, 2005).

By resourcefully using the revenues from natural gas, Qatar has built an innovative health care infrastructure. Health care reform in Qatar utilized a western model where quality is assured through Joint Commission International (JCI) accreditations, which is an international body that assesses health care organizations and medical centers across the world. Over the past decade, Qatar has also collaborated with many internationally renowned organizations including the Pasteur Institute, the University of Pittsburgh, Weill Cornell Medical College, and Mayo Clinic (Bener & Al Mazroei, 2010). This collaboration has resulted in major improvements in all aspects of the health care system: clinical, diagnostic, health care management, and research.

In 2005 a new National Health Authority (NHA) was established by the Qatari government to replace the former Ministry of Public Health upon the recommendation of RAND-Qatar Policy Institute (RQPI) and as part of the National Heath Care Strategy for Qatar (RAND, 2006). In 2009, the Supreme Council of Health (SCH) was established by his Highness the Emir of Qatar to guide the health care reform in Qatar with the ultimate goal of establishing one of the world’s renowned health care system. The primary role of the SCH is to “create a clear vision for the nation’s health direction, set goals and objectives for the country, design policies to achieve the vision, regulate the medical landscape, protect the public’s health, set the health research agenda, and monitor and evaluate progress towards achieving those objectives” (Supreme Council of Health, 2010). The SCH also has a central function in overseeing and monitoring the quality and efficacy of service delivered by supervising public hospitals including Hamad Medical Corporation, private medical facilities, laboratories, pharmacies, and primary health care centers.

Besides health care policies, Qatar is investing in outstanding development in medical facilities such as Sidra Medical and Research Center and Hamad Medical City. Sidra Medical and Research Center, which is expected to open in 2012, will be a center of excellence for the provision of world class healthcare services for women and children in Qatar and the Middle East region (Robertson-Malt, Herrin-Griffith, & Davies, 2010). Hamad Medical City is the largest comprehensive medical facility in the Middle East region, which houses the offices of the Supreme Council of Health as well as Hamad Medical Corporation (MHC). In addition, Hamad Medical City will include three new state-of-the-art specialized hospitals, due to open in the coming years, including a 217-bed children's hospital, a 200-bed Trauma and Orthopedic Center and a 230-bed center for physical medicine and medical rehabilitation (Hamad Medical Corporation, 2010).

Hamad Medical Corporation

Hamad Medical Corporation (HMC) is the leading non-profit public health care provider in Qatar. Over the past three decades since its establishment in 1979, HMC has made impressive accomplishments toward becoming a highly specialized medical facility that is recognized on an international level. HMC has been relentlessly guided by His

Highness the Emir Sheikh Hamad Bin Khalifa Al Thani and Her Highness Sheikha Mozah Bint Nasser Al-Missned and their vision of having a center of excellence and a state-of-the-art integrated healthcare system in Qatar. In 2006, HMC has achieved the accreditation of the Joint Commission International (JCI), which certified that the health care services provided by HMC are equivalent to those provided by world-class and prominent hospitals. HMC was further reaccredited by JCI in November 2009, which reflects the remarkable effort of the corporation management toward improving the clinical care at HMC (Hamad Medical Corporation, 2009). In effect, HMC is one of few hospitals in the Middle East region to receive JCI accreditation. Further, HMC utilized international quality standards that are aligned to the Joint Commission on Accreditation of Healthcare Organization (JACHO).

Hamad Medical Corporation manages five affiliate specialized hospitals with over 1,300 total beds as follows: Hamad General Hospitals (611 beds), Rumailah Hospital (480 beds), Women’s Hospital (343 beds), Al Khor Hospital (117 beds), and Al Amal Oncology Hospital (51 beds) (Hamad Medical Corporation, 2010). Future projects within the coming few years will include upgrading of existing facilities and opening of five new specialized hospitals: Cardiology Hospital (2010), Al-Wakra (Southern Area) Hospital (2011), Children’s Hospital (2012), Trauma/Orthopedic Hospital (2012), the new Women’s Hospital (2012), and Medical Rehabilitation Hospital (2012). In addition to specialized units including: Dialysis Unit, Minor Surgery Unit (40 beds), Interim Skilled Nursing Facility (90 beds), and Skilled Nursing Facility (261 beds). All of these hospitals will be housed within the Hamad Medical City Complex (HMCC) which will make it the largest medical facility in the Middle East region.

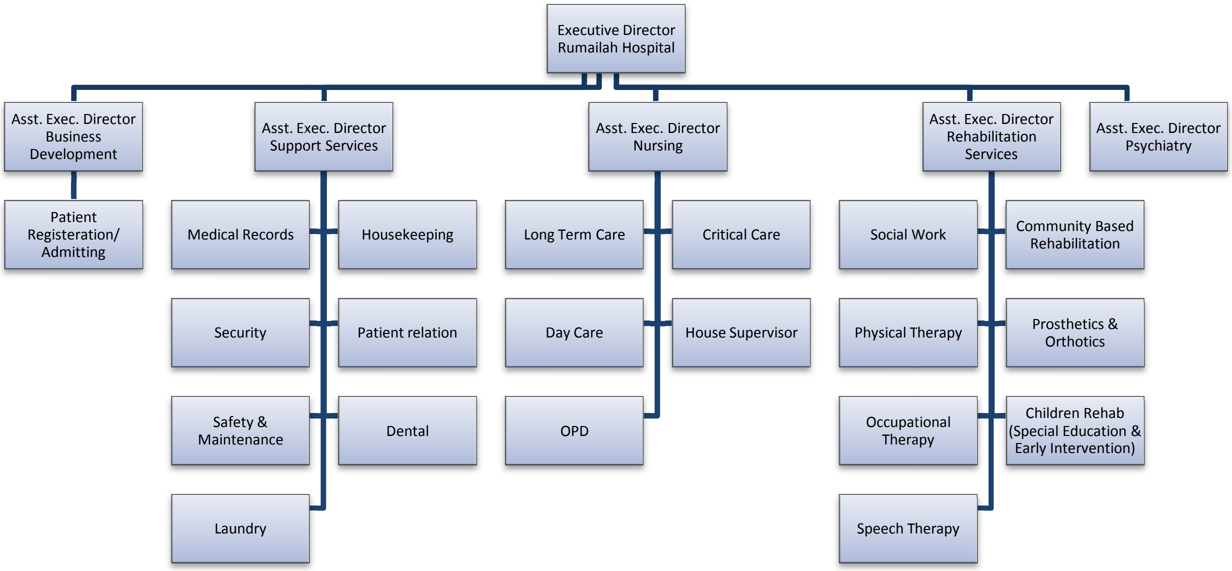
HMC adopted a new decentralized model of management and organizational structure in 2005 to meet the vast development in services and increase in number of hospitals and facilities (Hamad Medical Corporation, 2008-2009). In decentralized model of management, higher-level management at the corporate delegate decision-making authority to lower-level management, more specifically at the hospital levels. Thus, decision making power is distributed and the various hospitals under the umbrella of HMC have varying degrees of autonomy. The decentralized management system held each hospital accountable as well as derived efficiency and productivity. The shift toward a decentralized organizational structure was further facilitated with the consultation of Victorian Healthcare Association (VHA) Global, an Australian health consultancy consortium, and the appointment of the current Managing Director of HMC, Dr. Hanan Al-Kuwari, who is the first woman to hold this position in the history of the corporation (Anonymous, 2006).

Participants for this study were primarily recruited from Rumailah Hospital (RH), a 480-bed hospital that provides rehabilitation services for children and adults with disabilities (Hamad Medical Corporation, 2010). Rumailah Hospital is the oldest medical facility in Qatar opened in 1957 as a general hospital. In 1982 Rumailah Hospital became a rehabilitation center following the opening of Hamad General Hospital (HGH). Further, RH went under complete renovation in 1997 into a modern hospital with state-of-the-art technology for diagnostic services and clinical care. In addition to the rehabilitation services, RH includes the following specialized services: Plastic Surgery, ENT Surgery, Day Care Surgery, Ophthalmology Clinic, Dermatology Clinic, Dental Clinic, Stroke Unit, and Burns Unit.

According to the Hamad Medical Corporation Annual Report 2008-2009, Rumailah Hospital had a manpower of 1,716 employees, of which 162 were physicians, 814 nurses, 352 Allied Health Professionals, 33 technical, and 355 Administrative and Clerical Personnel (Hamad Medical Corporation, 2008-2009). At the time of the study, the Rumailah Hospital was managed by the Acting Executive Director, who has five Executive Assistants for the following service: Rehabilitation Services, Support Services, Nursing Services, Psychiatry, and Business Development (Patient Registration and Admission). Figure 1 provides an overview of the Rumailah Hospital Organizational Chart.

<u>Figure 1</u>

The Rumailah Hospital Organizational Chart

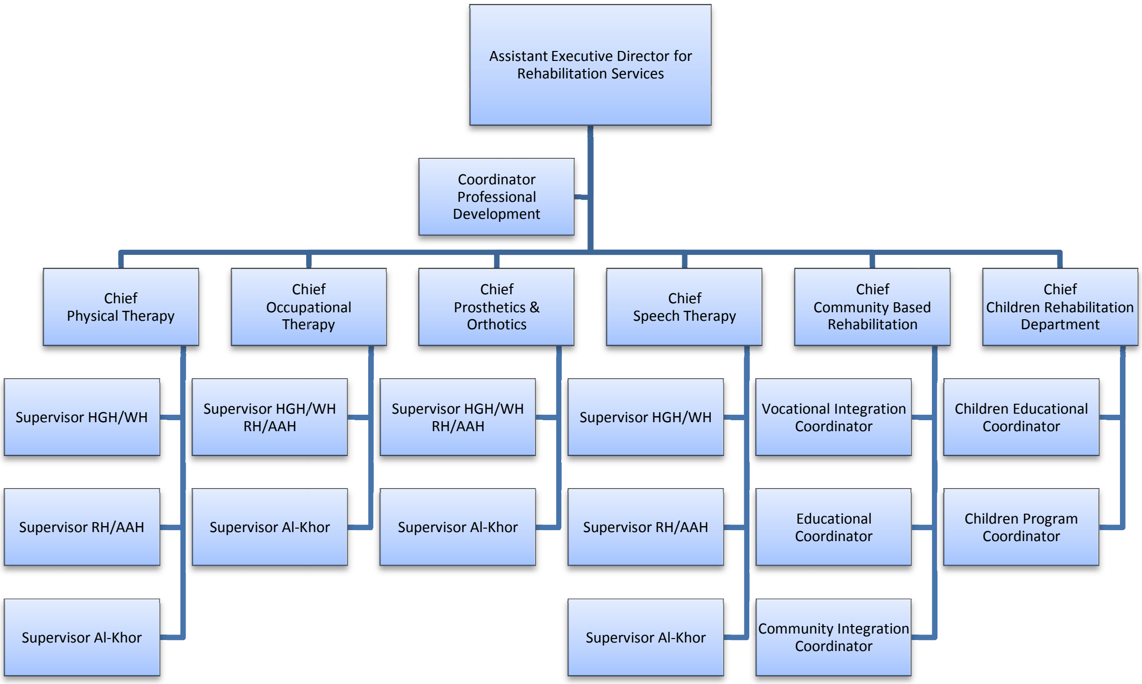


The Assistant Executive Director for Rehabilitation Services manages the following departments: Children Rehabilitation Department (ECSE), Community Based Rehabilitation, Occupational Therapy, Physical Therapy, Orthotics and Prosthetics, Speech Therapy, and Social Work. Each department is managed by Chief of Department and services within the departments are further organized into divisions with Supervisors. Divisions are categorized according to the location of services (i.e. hospital, inpatients, outpatients), type of population served (i.e. pediatrics, adult neurology, female rehabilitation, Stroke, Spinal Cord Injury, Orthopedics), or type of services/programs (i.e. hand therapy, adaptive equipment, psychiatry, vocational integration). Figure 2 provides an overview of the Rehabilitation Services Organizational Chart.

Pediatric therapy services at Rumailah Hospital designed for children from birth to 14 years with all type of disabilities. Therapeutic services offered through two settings: inpatients and outpatients clinics. Inpatients services offered mainly through the Children Rehabilitation Unit (CRU), while outpatient pediatric therapy services offered through outpatients clinics at each department, two Day Care Programs for children with Down Syndrome and Cerebral Palsy, Children Rehabilitation Department (CRD), and Bin Omran Outpatient Pediatric Physical Therapy.

Figure 2

Rehabilitation Services Organizational Chart – Rumailah Hospital



HGH = Hamad General Hospital

WH = Women’s Hospital

RH = Rumailah Hospital

AAH = Al Amal Hospital

Rumailah Hospital offered two Day Care Programs for children (3-6 years) with Down Syndrome and Cerebral Palsy. The programs designed as a multidisciplinary, intensive outpatient service, where the children received five hours of therapy services including special education and related services. The programs were similar to a preschool setting with the main focus is on provision of related services of occupational therapy, physical therapy, and speech therapy. Transportation services were available for children enrolled in these programs. Further, children were admitted to the program for a period of three months that could be extended for additional month depending on the child’s needs. Decisions and treatment plans were made through a team approach that included the following disciplines: Pediatrician, special education, occupational therapy, physical therapy, speech therapy, prosthetics and orthotics, nursing, and social work.

Outpatient physical therapy services offered through Bin Omran Center. Although the center is located outside the premise of Rumailah Hospital facility, it is under the administration of RH. The center provides physical therapy services to children from birth to fourteen years with all types of disabilities. Bin Omran Center is not contiguous with the Rumailah Hospital, which made a team-based multidisciplinary approach difficult to implement.

The Children Rehabilitation Department (CRD) is a newly established unit that replaced the Special Education Department previously. CRD was established as an integrated day care outpatient program for young children three to six (3-6) years with mild to moderate level of cognitive impairment. The program was established as a result of the shift in medical care at HMC to a more family-centered care. The overall objective of the program was to provide a multidisciplinary intervention in a structured environment and to prepare children with disabilities for integration into different educational settings. Another objective of the program was to enhance the capacity of families to meet the needs of their children with disabilities through parent education and training. The program provides intensive special education and related services intervention (5 days a week for a total of 20 hours per week). Criteria for admission to the CRD included the following: child must be between the ages of 3-6 years, the family is willing to participate and must sign an agreement to follow program regulations, child had a mild to moderate level of cognitive disability and had the potential to develop function for future community integration, and child required at least three of the rehabilitation services and medically stable and able to tolerate intensive therapy services. The period of admission to the program was dependent on the child’s level of cognitive disability being 2-4 months for mild cognitive disability or 3-6 months for moderate cognitive disability. Further, children were excluded from admission to the program if they have one of the following diagnoses: Severe visual impairment, severe hearing impairment, severe behavioral problems, or Pervasive Developmental Disorders (PDD).

Shafallah Center for Children with Special Needs

Shafallah Center for Children with Special Needs is a non-profit, private center that provides diagnostic, assessment, and special education and related services for children with all types of disabilities from the age of 3-21 years old. The center was established in 1998 at the behest of H.H. Sheikha Mozah Bint Nasser Al-Missned to meet the demanding needs of children with disabilities in Qatari society. Shafallah Center has been striving to be a center of excellence in the Middle East region for the provision of comprehensive educational and rehabilitation services for children with disabilities and their families (Shafallah Center, 2005).

Shafallah Center provided a wide range of diagnostic, educational, and rehabilitation services. Educational services provided through four programs: Early Intervention Program, School Program, Autism Program, and Vocational Training Program (Shafallah Center, 2005). The EI Program designed as a center-based preschool/kindergarten program for children 3-5 years old. The program provided special education and therapy services according to the child’s individual needs as well as social play and activities of daily living. Upon reaching the age of six years old, the students transitioned to the School Program. The school program utilized adapted regular school curricula along with a functional curriculum of social skills and activities of daily living skills. The center offered two school-age programs depending on the severity of the child's disability: School Unit One and School Unit Two. School Unit One designed for children between the ages of 6-14 years, with mild to moderate level of disability. The program focused on pre-academic, academic, and pre-vocational skills. School Unit Two designed for children with moderate to severe cognitive disability and/or multiple disabilities, whose ages between 6-21 years old. Unlike School Unit One, School Unit Two program focused on activities of daily living skills, self-care skills, social skills, basic communication skills, and assistive technology.

The Autism Program is exclusively designed for children diagnosed with ASD, whose ages range between 6-21 years. The program utilized a structured teaching model based on the Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH) curriculum. In addition, the program utilized other intervention models such as Discrete Trial Training (DTT), an Applied Behavior Analysis (ABA) intervention strategy, and visual communication systems depending on the child's needs. The last educational program offered through the center was the Vocational Training Program, which was designed for children between the ages of 14-21 years. The program provided young adults with opportunities and exposure to various job experiences. The aim was to match a suitable job to every student by evaluating the students' interests and abilities and providing opportunities to practice the skills needed for the job.

In addition to the educational services, Shafallah Center provided an array of clinical services including: Child and adolescents psychiatry services, therapy services, psychological services, and family support services (Shafallah Center, 2005). The psychiatrist at Shafallah Center served as the clinical director for all medical and paramedical services as well as provided direct services to children including psychopharmacological intervention. Based on the child's needs, the center offered therapy services including occupational therapy, physical therapy, and speech and language pathology. Therapy services were provided on an individual one-on-one basis as well as group therapy.

Shafallah center provided numerous psychological services including: Behavior Analysis, Counseling, and Cognitive Evaluation. Functional Behavior Assessment (FBA) is utilized for children with challenging behaviors. Individual counseling services are provided for children and their families. Further, psychologists at the Shafallah Center utilized both verbal and nonverbal assessment tools to evaluate cognitive functioning to identify strengths and weaknesses areas that impacts student's learning and development of social skills. Last, Shafallah Center provided family support services through a wide range of lectures and hands-on workshops, support groups, counseling, and training. The social workers provided the point of contact for families by coordinating communication between families and the center.

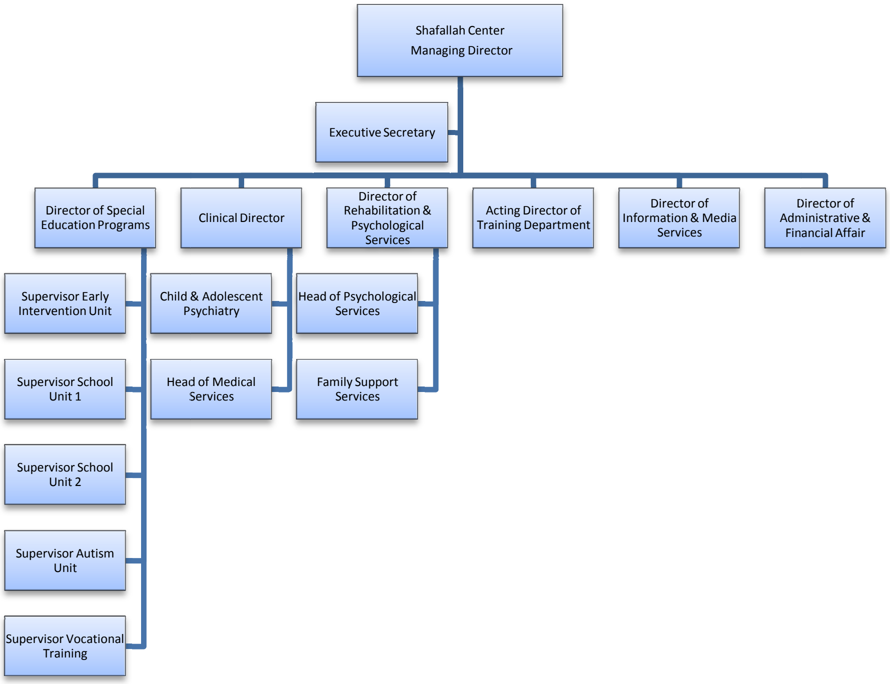
At the time of data collection, Shafallah Center had manpower of 547 employees, of which 20 were Medical and Nursing Professionals, 54 Allied Health Professionals (13 Occupational Therapists, 22 Physical Therapists, and 19 Speech and Language Pathologists), 179 Special Education Teachers, 85 Paraprofessionals, 12 Information and

Media Personnel, 37 Drivers, 89 Clerical Personnel, and 71Administrative Personnel. Of the total 547 employees, 186 (34%) were Qataris and 361 (66%) were Non-Qataris. Further, the number of personnel providing EI services was 41 professionals as follows: Ten Special Education Teachers, nine Paraprofessionals, twelve Allied Health Professionals, three Medical and Nursing Professionals, two Psychologists, one Social Worker, and four Administrative Professionals (Al-Qassimi, 2009).

Shafallah Center is managed by a Managing Director with a Board of Directors. The Board of Directors oversees the major projects of the center including: 1) Shafallah Center for Children with Special Needs, 2) Al-Noor Institute for Individuals with Visual Impairment, 3) Shafallah Medical Genetics Center, 4) The Sports Center for People with Disabilities, and 5) The Sports Stadium for Special Olympics (Al-Qassimi, 2009). The organizational structure for the Shafallah Center (Figure 3) followed a centralized structure, where the decision making power was concentrated in the top layer of the management, more specifically the Board of Directors and Managing Director. Management of the center exercised close control over the different units of the center. The top management was represented by the Board of Directors, Managing Director, and a consultant Advisor to the Board of Directors. The middle management was represented by the directors of the programs including: Director of special education programs, Director of clinical services, Director of rehabilitation and psychological services, and Director of training department (Shafallah Center, 2005).

Figure 3

Organizational Chart: Shafallah Center for Children with Special Needs



Data Collection

A concurrent mixed methods data collection was employed in this study to validate quantitative data with qualitative data (Creswell et al., 2003). The Beach Center Family-Professional Partnership Scale, FOS, Demographic Survey, and semi-structured interviews were the primary data sources for this study to obtain a comprehensive understanding of the different participants’ perspectives about family-professional partnership in EI/ECSE programs. The family and professional version of the Partnership Scale were used to assess the perception of families and service providers of the extent to which they were satisfied with their partnerships. At the same time the experiences of families, service providers, and program directors were explored simultaneously using qualitative semi-structured interviews.

Quantitative Data

The primary data source for the quantitative strand included: 1) The Beach Center Family-Professional Partnership Scale, 2) The FOS, and 3) Demographic Survey.

The Family-Professional Partnership Scale

The partnership scale was used to assess the quality of partnerships for both families of young children with disabilities and professionals who work with them in EI/ECSE programs. The scale is applicable to a wide range of ages of children with disabilities and has two versions to assess both families and service providers' perceptions (Blue-Banning et al., 2004; Summers et al., 2005a; Summers et al., 2005b). The scale is psychometrically valid where validity studies demonstrated a Chronbach's alpha for satisfaction ratings was 0.96 (for the Child-Focused items was 0.94 and for the Family-Focused items was 0.92). Chronbach's alpha for importance ratings was 0.93 (for the Child-Focused items was 0.90 and for the Family-Focused items was 0.88) (Summers et al., 2005).

The families of young children with disabilities completed the Beach Center Family-Professional Partnership Scale (Appendix A). The scale consisted of 18-item that assessed the extent to which families were satisfied with the relationships they had with professionals serving their children with disabilities (Summers et al., 2005a). The Scale contained two subscales: 1) Child-Focused Relationships, and 2) Family-Focused Relationships. The Child-Focused Relationships subscale reflected the parent's perceptions about how the professional worked with and treated their child. It included activities, attitudes, and services related to the professional caring for their child with disability. Items in this subscale included: professional being reliable and competent in meeting the special needs of the child, professional has the skills to make the child succeed, informing parents about the good things that their child do, treating the child with dignity, build on the child’s strengths, keeping the child safe, and keeping the child’s best interest in mind). The Family-Focused Relationships subscale contained items related to the parent’s perceptions about how the professional worked with them. It contained activities and attitudes related to respectful and supportive treatment of the family as a whole such as honesty, friendliness, polite communication, dependability and trust, confidentiality, respect for the family’s values and beliefs, professional being available when parents need them, and paying attention to what the parents say. The scale items are rated on a 5-point continuum scale from very satisfied to very dissatisfied. The scale also asked participants to rate their perception of the importance of each item on a 5-point continuum scale. A slightly modified version of the scale was used for this study as participants were only asked to rate their satisfaction levels.

The service providers completed the Family-Professional Partnership Self-Assessment, which is the professional version of the Beach Center Family-Professional Partnership Scale (Appendix B). The scale consisted of 18-item that assessed the attitudes and skills of a positive family-professional partnership and mirrored those in the family version of the scale. The scale utilized a 10-point continuum scale with 10 being the best to rate participants’ current skills and attitudes. A slightly modified version of the scale was used for this study in which participants were asked to evaluate and rate their current skills and attitudes on a 5-point continuum scale with 5 being the best instead of the 10-

point continuum scale in the original scale. The participants were also asked to identify what helped and what hindered the demonstration of the attitude or skill in each item.

The Family Outcomes Survey

In addition to the Partnership Scale, families of young children with disabilities completed the FOS (Appendix C). The FOS is a 15-items instrument that assessed parents' perceived family outcomes in addition to their perception of the efficacy of EI/ECSE programs in meeting their needs (Early Childhood Outcomes Center, 2006b). The survey assessed the extent of families' perception on a 7-point lickert scale (1 = just beginning/ seldom/poor; 3 = some/sometimes/fair; 5 = a good amount/many/good; and 7= a great deal/almost always/excellent).

The FOS consisted of five sections that mirrored the five sets of family outcomes developed by the ECO center. For each outcome domain there were three constructs. For the first outcome relating to families' understanding of their child's strengths, abilities and special needs, the survey asked parents to rate their knowledge and understanding of the child's development, child's special needs (health needs, disability), and child's progress (Early Childhood Outcomes Center, 2006c). For the second outcome relating to families knowing their rights and advocating for their children, parents rated their knowledge of available programs and services for their child and the family, how comfortable they were when participating in team meetings, and how well they know their rights. For the third outcome relating to families helping their children develop and learn, parents rated: their ability to help their child develop and learn, their ability to help their child learn to behave, and their ability to help their child practice new skills at home and in the community. For the fourth outcome relating to the families having support systems, parents are asked to rate whether they have someone they trust to listen to them and talk with them, someone they can call when they need help, and whether the family is able to do things they enjoy. For the final outcome relating to the families being able to access desired services, programs, and activities in their community, parents rated the medical care that their child receive currently, the child care they had for their child, and their child's participation in activities in the community. In addition, the FOS included three questions at the end of the survey that assessed families' perception of the helpfulness of the EI/ECSE programs and their role as a partner in the decision making process. The three questions asked the families to what extent has EI helped the family know and understand their rights, effectively communicate their child's needs, and their ability to help their child develop and learn.

Demographic Survey

In addition to the partnership scale and the FOS, participants completed a survey of demographic information. The family demographic survey consisted of three sections: 1) Family characteristics, 2) Child characteristics, and 3) Service inventory (Appendix D). The family characteristics section included demographic information such as parents' age, nationality, educational level, household income, number of children in family, and number of children with disabilities in the family. The child characteristics included information about the child with disability such as age, gender, type of disability, severity of disability, use of medical devices/adaptive equipment, age at which diagnosed, and age at which referred to early intervention services. Severity of disability was measured by the ABILITIES Index, which provided a profile of the child's functional abilities and limitations across nine major areas (Simeonsson & Bailey, 1991). These nine domains include the following: Vision, Structural Status, Integrity of Physical Health, Audition, Behavior and Social Skills, Intellectual Function, Limbs (both upper and lower limbs), Communication, and Tonicity. The instrument items were integrated within the family demographic survey. Lastly, the service inventory section provided information about the type of early intervention and therapy services that the child receive, frequency of services, settings where the child receive services, family involvement, and parents' satisfaction with quality of services.

Service providers completed the Service Providers' Demographic Survey, which consisted of three sections: 1) information about the service provider, 2) information about the clients served by the service provider, and 3) information about the early intervention services provided (Appendix E). The first section included demographic information about the service provider including age, gender, nationality, educational level, discipline, years of experience, and years of experience working in Qatar. The second section provided information about the clients that the service providers served such as caseload, children's age, and type of disability. The last section provided information on service-related variables such as type of setting, home-based services, type of intervention approach (one-on-one and/or group), family involvement (choice about type of services their child receive, assessment process, and intervention planning process), and team work and team meetings.

Qualitative Data

For the qualitative strand of the study, the process of collecting data relied primarily on semi-structured in-depth interviews with participants including: 1) families of young children with disabilities; 2) service providers working in EI/ECSE programs; and 3) EI/ECSE program directors. In addition to the interviews, qualitative data were collected from service providers on the professional version of the partnership scale. Service providers were asked to identify factors that facilitated or impeded successful partnership as it relate to each item in the scale. The demographic surveys also provided an opportunity to collect additional qualitative data from all participants through the additional comments or information that participants shared regarding family-professional partnership or EI services in general.

Semi-structured Interviews

Semi-structured in-depth interviews were conducted with participants including: 1) families of young children with disabilities; 2) service providers working in EI/ECSE programs; and 3) EI/ECSE program directors. Interviews were conducted at a location of the participant's choice to ensure the participant was comfortable with the interview; most often was at the participants' work place. With advance permission from participant, the interview sessions were recorded using an audio recorder (See Appendix I for consent form for families and service providers). Further, all participants were provided with copies of the interview protocol and consent form prior to the interview.

Interview Protocols

Three interview protocols were developed in advance, based on related literature on family-professional partnership, for all participants including families, service providers, and program directors to ensure consistency across interviews (Blue-Banning et al., 2004; Park & Turnbull, 2003). The protocols were designed to encourage participants to share their stories and perceptions through the use of open ended questions. To capture a broad perspective of the participants' perceptions, the interview protocols were designed in a similar set of domain theme questions with slight differences relating to the category of participants (i.e. families, service providers, and program directors). Four major domain themes were used for the interview protocols including: participant's background information, family involvement/partnership, indicators of positive partnerships, and barriers and facilitators of positive family-professional partnership.

Families Interview Protocol

The families' interview protocol comprised of four major domain themes (Appendix F). The first session of the families' interview protocol included questions about their child with disability (age, gender, type of disability, use of medical device/equipment), age of child when diagnosed and when he was first referred to EI services, EI services that the child was receiving at the time of the study, and length of time in EI. The second session about family involvement and partnership and included questions such as: (a) how do you feel about your involvement in the intervention/educational program for your child?, (b) how important is it for you to be involved in your child's intervention/educational program?, (c) how were you involved in developing the intervention/educational program for your child?, and (d) what has been your experience in working with service providers in early intervention programs?. The third sessions included questions about the barriers and facilitators of positive Family-Professional Partnership. This session included questions such as: (a) how satisfied are you with the relationship/partnership you have with the service providers working with your child?, (b) what type of information are usually communicated or shared with you as a parent of a child with a disability ?, (c) what things (skills/attitudes) that service providers do that enable you have a good relationship/partnership with them?, (d) describe one example of a successful partnership you had with a service provider?, and (e) describe one example of unsuccessful partnership you had with a service provider?. Finally, the families were asked based on their experience with early intervention programs in Qatar, what are the three things they would like to change to make these programs more responsive to the family's needs and priorities or to promote positive/successful partnerships.

Service Providers Interview Protocol

The service providers' interview protocol comprised the same four major domain themes questions but worded differently to align with the services providers' role (Appendix G). The participant background information included the following questions: (a) tell me about your current professional position, (b) how long have you worked (years of experience)? , (c) what is your level of education? , (d) how many years have you work in Qatar? , describe your current caseload? , and describe your classroom/program (e.g. age, ability level, type of disability). The next session explored the service provider’s commitment to family involvement and partnership. Examples of questions in this session include: (a) how do you feel about family involvement in the educational process/treatment program? , (b) how do you see the role of families in Early Intervention programs? , (c) what strategies do you use as a professional to involve families in the educational process/treatment program? , and (d) what has been your experience in working with families of children with disabilities?. The last two sessions were concerned with indicators of positive partnership and barriers and facilitators of positive family-professionals partnership. Following are examples of the open-ended questions that guided the last two sessions of semi-structured interview for service providers: (a) when do you hear the words “family-professional partnership”, (b) what first comes to your mind? , (c) what skills do you have/strategies you used that have helped you in the past in building positive partnerships with families? , (d) think of examples of effective/positive partnerships between you as a professional and parents you have worked with in the past. Describe what factors made these partnerships successful? , (e) what is challenging in establishing successful family-professional partnership? , and (f) how have your perceptions of family-professional partnership changed over time?

Program Directors Interview Protocol

The program director’s interview protocol comprised the same four major domain themes questions with the exception of an additional session on program information (Appendix H). Following are examples of the open-ended questions that guided the program information session: (a) describe your early intervention program. What kinds of early intervention services does your program staff provide directly to children with disabilities and their families? , (b) what kind of curricula (if any) do you utilize in your early intervention program? , and (c) what is the approach or philosophies of your early intervention program?. In the indicators of positive partnerships session, questions were directed toward organizational variables that support positive partnerships such as: (a) what is your program's philosophy in terms of facilitating communication with families of young children with disabilities? What strategies does your staff/program use to facilitate open communications with families about their child's care/education? Describe some of the strategies you use in your program to communicate with families, (b) does your program provide training for early intervention service providers in strategies to work/partner with families of young children with disabilities? What kind of training is provided? Describe examples of topics covered in these training the frequency of training?, and (c) how does your program address linguistic and cultural diversity of families of young children with disabilities? How does the program honor a family's diversity?

Procedures

This section provides an overview of the procedures employed to collect data for the research study. It is further divided into four parts: (1) Translation procedures, (2) General procedures, (3) Survey procedures, and (4) Interview procedures.

Translation Procedures

The first step employed in collecting data for the study involved translating both versions of the Partnership Scale to Arabic. Several procedures were utilized to assure quality and accuracy of translation. Translation procedures followed the "Forward-Back translation Approach" (Chen & Bates, 2005). Forward-Back translation is the most commonly used approach in instrument translation across different cultures. The process starts by translating each version from the original language (English) to the target language (Arabic) by two bilingual forward translators (fluent in both English and Arabic) who are also experts in the area of special education and disability. This process is referred to as forward translation. For this study, the researcher along with an expert working in Qatar, who had a doctoral degree in special education and had been working with children with disabilities for over 15 years, served as the expert translators for the forward translation. After reaching an agreement on the final Arabic version, the Arabic version was then translated back to English by another two bilingual experts in the Arabic language and special education field. The two backward translators were also experts working in Qatar for the past ten years. The final version was then reviewed by the two experts for language equivalency and meaning of each item in the scale (see Appendix J for both the families and professionals Arabic version of the Partnership Scale).

Following the guidelines outlined by Chen & Bates (2005) for selecting the proper strategy for translation approach, a “one shot/forward only” was used to translate both versions of the demographic survey (Family and Professional versions). The rationale for this choice lied in the following reasons: (a) the researcher was an expert in the subject matter, and (b) the researcher was bilingual and fluent in the target language (Arabic). In this approach one or more bilingual translators translate the instrument from its original language into a second language. Each translator makes his own translation independently and then translated versions compared and discussed to reach a final version. The researcher along with an expert working in Qatar, who had a doctoral degree in special education and have been working with children with disabilities for over 15 years, served as the two expert translators for the “one shot/forward only” translation (see Appendix K for both the families and professionals Arabic version of the Demographic Surveys). With regard to the FOS, the researcher used the Arabic version of the FOS that was available at the ECO Center website (http://www.fpg.unc.edu/~eco/index.cfm) (see Appendix C for Arabic version of the Family Outcomes Survey).

General procedures

Ethical approval was granted by the University of Oklahoma-Norman Campus Institutional Review Board (OU-NC IRB) on April 6, 2009. In addition, ethical approval to conduct the study was also granted by both sites: Hamad Medical Corporation and Shafallah Center for Children with Special Needs. Permission to use the Family-Professional Partnership Scale was obtained from the scale developers at the Beach Center on Disability. Even though the Family Outcomes Survey (FOS) was available for use at the ECO Center website, permission was obtained to use the survey in this study.

Survey procedures

Procedures for collecting survey data were similar for both sites. The researcher met with the Managing Director for the Shafallah Center and Executive Director of Marketing, Media, and Public Relations at Hamad Medical Corporation. The purpose of the meeting was to establish rapport and to agree on general terms of the study. As HMC a large establishment, a circular to facilitate the researcher work in conducting the study was posted on the internal network website for HMC. A second purpose of the meeting was to designate a contact person at each site to work directly with the researcher. At Shafallah Center, the contact person was the Director of Psychological and Rehabilitation

Services. At HMC, the contact person was Senior Special Educator of the Autism Services.

The next step involved meetings with the contact person at Shafallah Center and the department chairs at HMC (Occupational Therapy, Physical Therapy, Speech Therapy, and Children Rehabilitation Department). The purpose of the meetings was to establish rapport and to agree on the study timelines as it relate to participants' recruitment and selection, and data collection process. For the families' sample, the researcher requested a list of children with disabilities from birth to six years old currently receiving services from each department. To protect participants' confidentiality, the list did not include identifier information. Instead codes were used to identify participants. Further, the list included the following information: child's primary diagnosis and date referred to EI services.

Once the lists were collected from the department chairs at HMC and Shafallah Center, all lists were compiled into a single list and assigned an identification number. As some of the children receive EI services from more than one department at HMC, file numbers were compared to avoid duplication of participants. The compiled list had 598 children with disabilities who were receiving EIEC services at both sites at the time of the study. Of the 598 children, 557 (93%) children were from HMC and 41 (7%) children were from Shafallah Center. Further, the children from Shafallah Center were receiving services as follows: 31 children were receiving services at the EI Unit, 7 were receiving services as an outpatient in the morning and evening programs, and 4 were in the Portage program (home-based EI program for young children with disabilities). To prepare the list for a stratified random sampling, the list was further categorized into six groups according to type of disability as follows: (1) Autism Spectrum Disorders (94, 16%); (2) Down Syndrome (66, 11%); (3) Cerebral Palsy (154, 26%); (4) Other Neurological Disorders (204, 34%); (5) Hearing/visual impairment (28, 5%); and (6) Developmental Language Disorders (52, 8%). A random sample was then employed to select twelve (12) participants from each stratum for a total family sample of 72 participants using an online calculator (www.randomizer.org).

Once potential participants were selected, survey packets were distributed at both HMC and Shafallah Center. The survey packet for families included: (1) Cover Letter informing participants of purpose of the study, participation is voluntary, and assure confidentiality and that no identifiable information would be reported; (2) Information Sheet that served as a consent for participation in the study (see Appendix L for both Arabic and English versions of the Information Sheet); (3) Family Demographic Survey; (4) FOS; (5) Family-Professional Partnership Scale (family version); and (6) Sealed envelope to return survey addressed to researcher. No personally identifying information was on the surveys or return envelope, only an identification code number was used for the demographic data. Further, there were two versions of the packets: one for Arabic-speaking families and one for English-speaking families. Both Arabic and English versions of the packets were distributed.

Survey distribution was considerably different for HMC and Shafallah Center due to the differences in policies at both sites. For HMC the researcher distributed the surveys personally. The researcher coordinated with the treating therapist to give the families the survey packets in person at time of their child’s scheduled treatment sessions. Surveys were also collected by the researcher directly from the families. The researcher was available on a daily basis at HMC (the researcher used the Public Relations office at Rumailah Hospital). On the other hand, the survey distribution was different for the Shafallah Center due to the center's policy that only social workers were allowed to directly contact the families. Thereby, survey packets were sent to families via the social worker for the EI Unit. Families' confidentiality was assured as no identifiable information was used on the surveys. The researcher collected the sealed surveys from the designated contact person at the center.

In addition to the differences in survey distribution at both sites, the allocated time for survey data collection was completed at different times. At the time of the study, HMC was in the process of preparing for the reaccreditation process by the JCI, which takes place every three years. Thus, survey packets were distributed at HMC between mid-June and early September. For Shafallah the data collection for surveys was delayed until mid-September and end October as the center was closed for the summer vacation at time of survey data collection. To increase response rates, the social worker at the Shafallah Center conducted follow-up phone calls to families to encourage them to return completed surveys. A total of 72 surveys were distributed to families of young children with disabilities at both sites. Of the 72 surveys, 57 surveys were returned for a response rate of 79%.

For the professionals' sample, the researcher requested a list with the number of therapists/doctors working with young children with disabilities (birth to six years old) with their current job from Shafallah Center and department chairs at HMC. No identifier information was used. The professionals sample included all service providers from multiple disciplines working in EI/ECSE programs at both HMC and Shafallah Center.

The total number of service providers at HMC was 55 professionals as follows: 5 (9%) special education teachers, 33 (60%)related services therapists (10 physical therapists; 13 occupational therapists; and 10 speech therapists), 5 (9%) paraprofessionals, and 12 (22%) health and social services providers. For Shafallah Center, the number of service providers was 38 as follows: 12 special education teachers (31%), 4 (11%) related services therapists (one physical therapists; one occupational therapists; and 2 speech therapists), 14 (37%) paraprofessionals, and 8 (21%) health and social services providers. Thus, the total professional working with young children with disabilities at the time of the study was 93 from both HMC and Shafallah Center.

Once the number of professionals was available for all departments at HMC and Shafallah Center, survey packets were prepared for professionals' sample. The service providers survey packet included: (1) Cover Letter informing participants of purpose of the study, participation is voluntary, and assure confidentiality and that no identifiable information would be reported; (2) Information sheet that served as a consent for participation in the study; (3) Service Providers Demographic Survey; (4) Family-Professional Partnership Self-Assessment (professional version); and (5) Sealed envelope to return survey addressed to researcher. The researcher distributed survey packets based on the professionals' language preference. Two weeks later, professionals were reminded to return completed surveys to researcher during staff weekly meetings. Although the total number of service providers working in EI/ECSE programs at both sites was 93, some of the services providers weren't available at the time of study due to their annual leaves. Thereby, a total of 81 surveys were distributed to service providers at both sites

(48 surveys at HMC; 33 surveys at Shafallah Center). Of the 81 surveys, 66 surveys were returned for a response rate of 81.5%.

Interview procedures

For the qualitative phase, a snowball purposive sampling strategy was used to select participants for the semi-structured interviews. Participants included three subgroups: families of young children with disabilities, service providers working in EI/ECSE, and program directors. The researcher's personal interactions with families and service providers as well as previous work experience at both HMC and Shafallah Center informed the initial selection for participants from the families and service providers' subgroup. Once interviews conducted with initially selected participants, they gave recommendations of persons they believe could best serve the purpose of the one-on-one interviews. For the program directors subgroups, all program directors were included to ensure that inclusion of the different views and perceptions of both HMC and Shafallah Center. However, only program directors that consented to the interviews were included in the study. Further, interviews were conducted with the different managerial levels, including: (a) top management (Assistant Director for Rehabilitation Services at HMC and Managing Director for Shafallah Center); (b) middle management (Rehabilitation Coordinator at HMC, and Head of Psychological Services at Shafallah Center); and (c) first line management (Supervisor Pediatric Occupational Therapy at HMC).

Interviews were conducted at a location of the participant's choice to ensure the participant is comfortable with the interview; most often was at the participants' work place. Interviews for the program directors were conducted at their offices. With regard to the supervisors and service providers, they were interviewed at the Public Relations Office. The researcher scheduled the interviews at a time where the office was unoccupied. The two families' interviews were conducted at the Children Rehabilitation Department.

With advance permission from participant, the interview sessions were recorded using an audio recorder. All participants were provided with copies of the interview protocol and consent form prior to the interview. Although most of the interviews were conducted in the participants' native language (Arabic), interviews with non-Arabic speaking participants were conducted in English. In addition, few of the service providers at HMC preferred conducting the interviews in English. Length of the interview was in the range of 60-90 minutes. Prior to asking questions, a brief statement was read to the participants about the purpose of the study. Participants were asked a uniform set of questions according to the interview protocol. Though, some minor adjustments in the questions were made by the researcher in response to individual participants. Probes were used throughout for clarification and additional thoughts. All participants were assigned pseudo names to ensure confidentiality.

Data Analysis

Qualitative Data Analysis

Data analysis was an ongoing process throughout the study. For the interviews, the first step in data analysis involved verbatim transcription. Next, a "one shot/forward only" translation approach was used to translate all interviews that were conducted in Arabic. Data analysis for the transcribed and translated interviews followed a phenomenological inductive approach to qualitative inquiry as described by Creswell (2007).

A thematic analysis was conducted to determine salient themes that stand for the essence of experience. First, the transcript was imported into Hyper RESEARCH, a qualitative analysis software program designed to code and retrieve data. The transcript was read carefully to develop a list of significant statements, a process referred to as horizontalization of data (Creswell, 2007). Next, the statements were coded using Hyper RESEARCH. Factors influencing successful family-professional partnership identified from the literature (such as sharing information and keeping parents informed, open communication, professional expertise and knowledge, mutual understanding and shared vision, and displaying equal respect) and the framework that examined these factors at two levels (interpersonal and structural) guided the initial coding process. Additional codes were added as new ideas emerged from the data. The codes were then categorized into clusters of themes or meaning units that were applicable to understanding how factors influencing successful partnerships were experienced. The next step involved developing the structural and textual descriptions. The structural description highlights the context and setting of the phenomenon while the textual description highlights how the phenomenon was experienced and the description of the meaning the participant attributed to the experience (Creswell, 2007). The last step involved integrating both descriptions into one that captured the essence and meaning of the experience of factors influencing successful family-professional partnership.

Quantitative Data Analysis

Quantitative data was analyzed using both descriptive and inferential statistics. Data analysis was conducted using Statistical Package for the Social Sciences (SPSS) 19.0 to assist in Partnership Scale and FOS items analysis. Descriptive statistics were utilized to measure the overall mean of satisfaction with partnership for both families of young children with disabilities and service providers as well as achievement of family outcomes. Descriptive statistics utilized included means, variance, percentages, and frequencies for Partnership Scale items and family outcomes.

With regard to inferential statistics, analyses were done along four categories: Setting (hospital-based vs. community/school based), child's type of disability, child's severity of disability, and professionals' discipline. First, the t-test for independent samples was used to compare the overall mean scores of satisfaction level with partnership for the families of children with disabilities and service providers (family versus service provider) on the Child-Focused Relationships subscale, Family-Focused Relationships subscale, and the overall Partnership Scale. T- tests were also used to compare the overall mean score differences between the two settings (HMC/hospital-based vs. Shafallah Center/school based). Second, repeated measures ANOVA were used to analyze differences between service providers according to the type of discipline (Special Education Teachers, Related Services Therapists, Paraprofessionals, and Health & Social Services Providers) as well as between families according to the type of child's disability (ASD, DS, CP, DLD, HI/VI, and OND) and severity of disability (mild, moderate or severe). Last, statistical significance was explored between families of young children with disabilities according to the type and severity of disability, and between service providers according to their discipline. The Bonferroni adjustment was applied to decrease the occurrence of a Type I error when interpreting the data.

Validity and Reliability

Trustworthiness and credibility were verified through peer reviews, member checks, and the inclusion of multiple sources of data. These strategies increased confidence in the research findings and added accuracy and richness to the final results of the study. Thus, to increase credibility in the study's findings member checking was utilized as a means of verifying the accuracy of the transcribed interviews data in an effort to control the researcher bias (Creswell, 2003; Punch, 2005). Member checking was achieved during the interview by restating and summarizing the information received from the participant to ensure what is heard is correct. Following data collection and transcription of the interviews, member checking was achieved by offering the participants the opportunity to review a brief summary that was prepared describing the major themes and key findings under each theme. Participants were asked to review the summary and to give feedback regarding the accuracy of the observations. Participants who replied reported positive feedback regarding a good fit between what they recalled saying during the interview and the summarized findings.

Another measure to achieve trustworthiness in the study was through peer review which involved discussion of the study's findings and conclusions with other people and experts in the field. Expert reviews were employed to further increase the credibility of findings (Creswell, 2003; Punch, 2005). A professional expert who had over 15 years of experience working with families of children with disabilities in Qatar was asked to conduct an informal peer review of the study results. He indicated that the findings were consistent with his perceptions and perspectives over the years of experience working in EI/ECSE programs in Qatar.

Validation strategies were employed to enhance credibility and dependability of the study findings. To gather multiple perspectives about the factors affecting family-professional partnerships, interviews were conducted with key informants including families of young children with disabilities, service providers from multiple disciplines, and program directors from different management levels. According to Patton (2002) utilization of multiple informants facilitates accuracy of findings and further validates research finding.

Strengths of the Study

A major strength of this study was embedded in the use of concurrent triangulation mixed methods design which allowed for methodological triangulation (Patton, 2002). The choice for a concurrent triangulation approach for this research proposal allowed for triangulation of data as quantitative and qualitative methods were used to confirm, cross-validate or corroborate findings (Creswell, 2003; Creswell et al., 2003; Tashakkori & Teddlie, 2003). According to Patton "Triangulation strengthens a study by combining methods." (2002, p. 247). Quantitative methods have the advantage of collecting data which was easily compared and statistically aggregated from a set of specific questions, while qualitative methods had the advantage of providing in-depth inquiry. By combining the two methods, the study used both advantages to fully investigate the research questions.

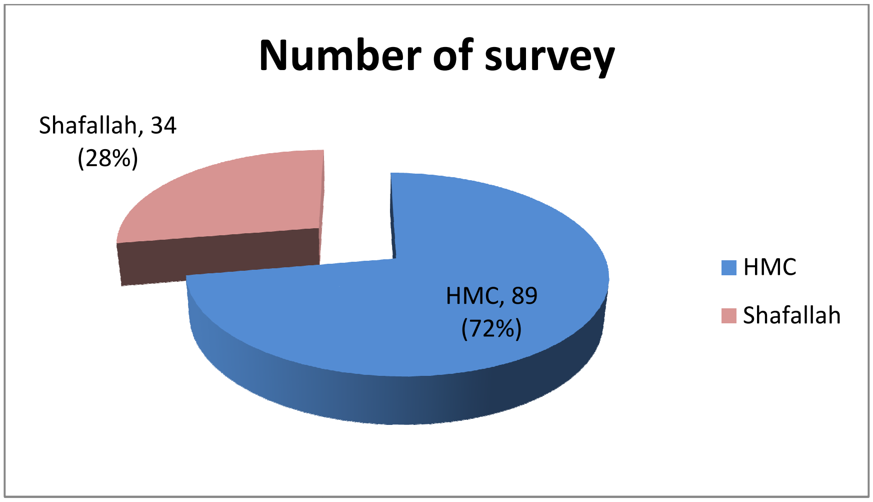
CHAPTER 4: Results

Introduction

A total of 153 survey packets were distributed to families of young children with disabilities and professionals working in EI/ECSE program at both HMC and Shafallah Center. Of the 153 surveys distributed, a total of 129 questionnaires were returned. About six (6) surveys were returned incomplete and thus could not be used in the study analysis. Consequently, the final usable sample was 123 participants from both sites. The overall response rate was 80% (123/153), which was considered good for subsequent analysis. The majority of the returned surveys were from HMC for a total of 89 (72%) participants, while the remaining 34 (28%) of the total returned surveys were from Shafallah Center. Figure 4 provides a pie chart representation of the overall number of surveys according to setting.

Figure 4

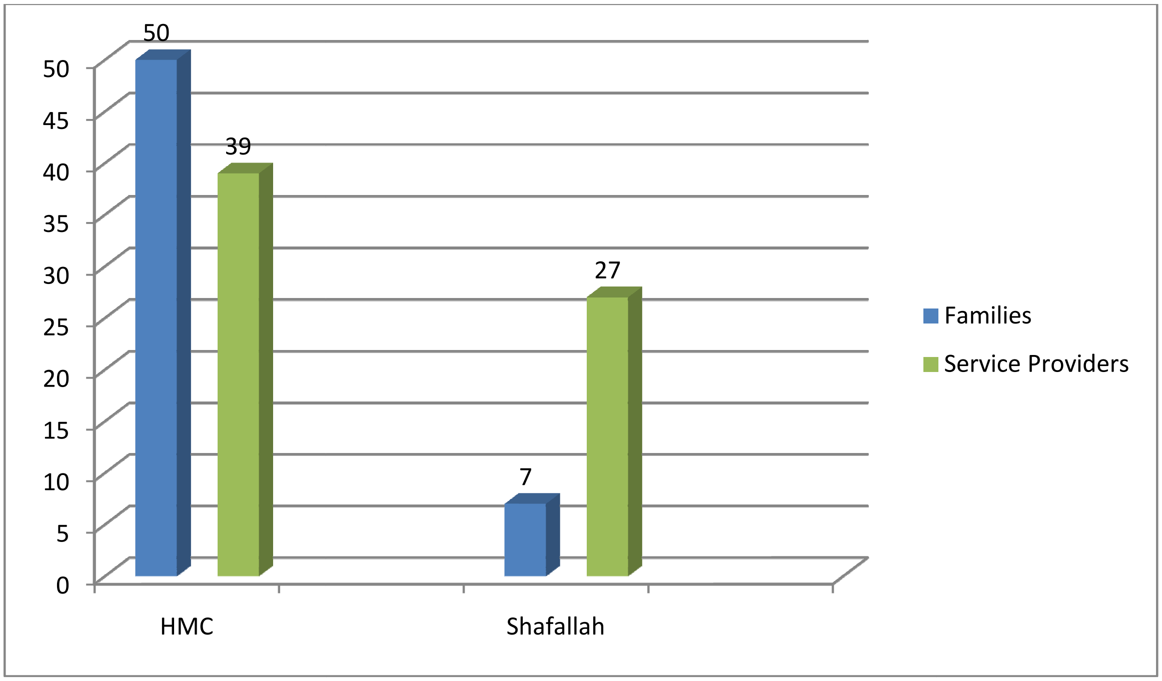
Number of returned surveys according to setting



A total of 123 participants completed the survey packets from HMC and Shafallah Center. Respondents from HMC were as follows: Fifty (50) families of young children with disabilities and thirty nine (39) service providers from different disciplines. Respondents of the Shafallah Center comprised of seven (7) families of young children with disabilities and twenty seven (27) service providers. Figure 5 provides a graph chart representation of the participants according to setting.

<u>Figure 5</u>

Number of participants according to setting



For the families' surveys, a total of 72 surveys were distributed to families of young children with disabilities at both sites. Of the 72 surveys, 57 surveys were returned for a response rate of 79%. For the service providers' survey, a total of 81 surveys were distributed at both sites (48 surveys at HMC; 33 surveys at Shafallah Center). Of the 81 surveys, 66 surveys were returned for a response rate of 82%.

As a final point, completed surveys in each language were as follows: Four families completed the survey packets in English, and 53 families completed the surveys in Arabic. With regard to the service providers, a total of 16 service providers completed the survey in English and 50 completed the survey in Arabic. Thus, the total number of English surveys was 20 and the total number of Arabic surveys was 103 surveys.

Demographic Survey

Family Characteristics

Respondents who completed the family demographic survey were fifty-seven (n = 57) families, of whom 46 (81%) were biological mothers, ten (17%) were biological fathers, and one (2%) survey was completed by the child's sister. Family characteristics data were collected and are presented in Tables 6-8.

Table 6

Frequencies (Percentages) of Families According to Nationality (N = 57)

Variable	**n**	**Percent**
Nationality		
Qataris	19	33%
Non-Qataris	38	67%
Non-Qatari Nationality		
Arabian Gulf Region	4	7%
Other Arabic Countries	21	37%
Other Countries	4	7%
Did not specify	9	16%

Table 6 indicates that the majority of respondents were non-Qataris (38, 67%), with the rest of participants being Qataris (19, 33%). Of the non-Qataris families, 4 (7%) were from countries of the Gulf Cooperation Council (GCC), 21 (37%) were from other Arabic countries, 4 (7%) were from other countries, and 9 (16%) families did not specify their nationalities. Further, families from the GCC countries included Kingdom of Saudi Arabia, United Arab Emirates, and Kuwait. Families from other Arabic countries included: Egypt, Jordan, Palestine, Sudan, Yemen, and Syria. Families from other countries included Pakistan, Philippine, and India.

Table 7

Monthly Income of Families (N = 57)

Variable	**n**	**Percent**
Income (in US Dollars)		
Less than $1500	44	77%
Between $1501 - $1900	8	14%
More than $1901	3	5%
Did not specify	2	4%
Total	**57**	**100.0%**

Table 7 describes the household income levels of families who completed the survey. Nearly seventy-seven percent (77%, 44) of participants reported a monthly income less than $1500. Fourteen percent (14%, 8) of families reported a monthly income between $1501- $1900; while almost five percent (5%, 3) of families reported a monthly income greater than $1901, and nearly three percent (4%, 2) of families did not specify their income.

Table 8

Frequencies (Percentages) for Parents Age (N = 57)

Age	**Mothers** **n (Percent)**	**Fathers** **n (Percent)**	**Parents** **n (Percent)**
20 years old or younger	1 (2%)	0	1 (1%)
21-30 years old	16 (28%)	3 (5%)	19 (17%)
31-40 years old	33 (58%)	34 (60%)	67 (59%)
41-50 years old	6 (10%)	18 (32%)	24 (21%)
51-60 years old	1 (2%)	2 (3%)	3 (2%)
Total	**57**	**57**	**100%**

Table 8 displays age distribution of the parents participating in the study. The majority of parents (59%) were between the ages of 31-40 years old. Twenty-one percent (21%) were in the age range of 41-50 years old; seventeen percent (17%) were in the age range of 21-30 years old; two percent (2%) were in the age range of 51-60 years old; and only one percent (1%) was younger than 20 years old. The table also shows that the majority (58%) of mothers in the study were in the age range of 31-40 years old followed by (28%) the age range of 21-30 years old. On the other hand, the majority (60%) of fathers were in the age range of 31-40 years old followed by (32%) the age range of 41-50 years old.

Table 9

Educational Attainment Levels of Parents (N = 57)

Educational Level	**Mothers** **n (Percent)**	**Fathers** **n (Percent)**	**Parents** **n (Percent)**
Less than high school	9 (16%)	13 (23%)	22 (19%)
High school diploma	17 (30%)	8 (14%)	25 (22%)
Some college courses	1 (2%)	2 (3%)	3 (3%)
2-year college degree	2 (3%)	6(11%)	8 (7%)
Bachelor degree	22 (39%)	23 (41%)	45 (40%)
Some graduate courses	4 (7%)	2 (3%)	6 (5%)
Master degree	2 (3%)	2 (3%)	4 (3%)
Did not specify	0	1(2%)	1 (1%)
Total	**57**	**57**	**100%**

Table 9 describes the educational attainment levels of parents in the study. The majority (40%) of parents had earned a Bachelor's degree. Twenty-two percent (22%) of parents had a High school diploma, while nineteen percent (19%) of parents had an educational level less than high school. Seven percent (7%) of parents earned a 2-year college degree (Associate's degree), while five percent (5%) of parents earned some graduate courses. The highest level of education was a Master's degree earned by only five percent (5%) of parents.

Concerning employment status, almost all the entire fathers in the study (56, 98%) were employed and only one (2%) father was retired. On the other hand, only 17 (30%) of the mothers in the study were employed, while the majority 40 (70%) did not work outside of the home. Further, in terms of the number of children that the participating families have: 7 families (12%) had only one child, 13 families (23%) had two children, 8 families (14%) had three children, 13 families (23%) had four children, and 16 families (28%) had more than four children. The majority of families completed the surveys comprising 44 families (77%) had only one child with disability. The remaining 13 families (23%) had two children with disabilities. Families who had two children with disabilities completed the survey for only one of their children with disabilities.

Child characteristics

Data concerning characteristics of the children's of respondents were collected and are presented in Tables 10-11 & Figures 6-7.

Table 10

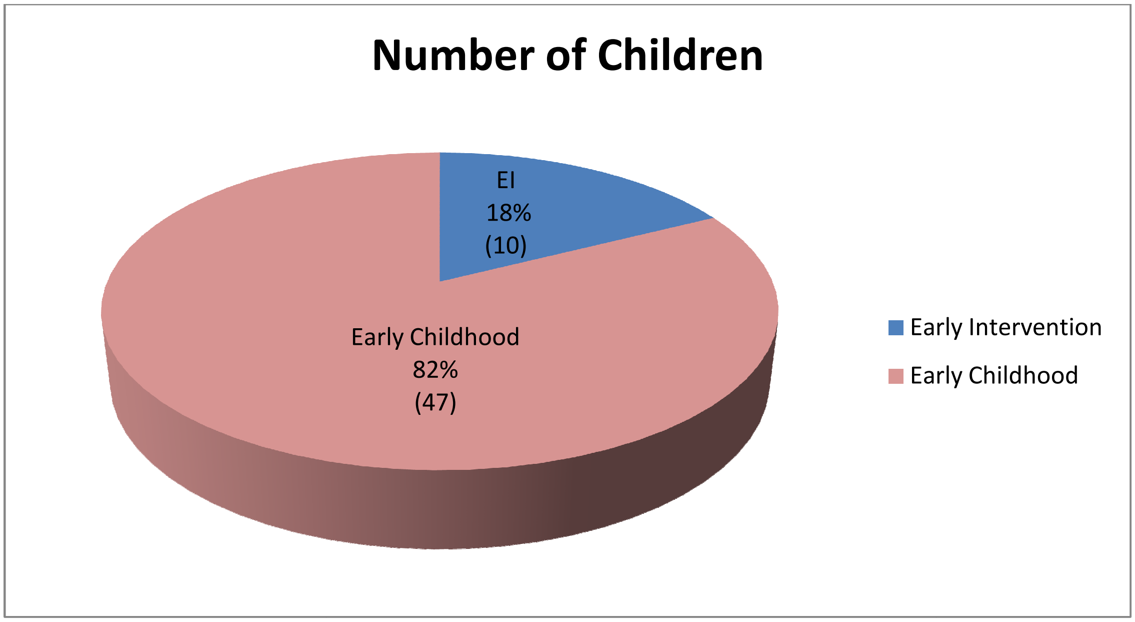
Frequencies and Percentages for Children Age (N = 57)

Age	**n**	**Percent**
Birth - 2years old	8	14%
2 - 3 years old	2	4%
3 - 4 years old	15	26%
4 - 5 years old	15	26%
5 - 6 years old	17	30%
Total	**57**	**100.0%**

Table 10 displays age distribution of children with disabilities of families participating in the study. The majority of children with disabilities comprising 17 (30%) were between the ages of 5-6 years old. Eight children (14%) were between birth and 2 years old; two (4%) children were between 2 and 3 years old; fifteen (26%) children were between 3 and 4 years old; and fifteen (26%) children were between 4 and 5 years old. The table also shows that the majority of children with disabilities comprising 47 (82%) children were between three to six years old, while the remaining 10 (18) children were between birth to three years old. Figure 6 provides a pie chart representation of the overall number of children according to the age groups of early intervention (birth-three years old) and early childhood (three-six years old).

Figure 6

Number of Children According to Age Groups of Early Intervention (EI) and Early Childhood (EC)



<u>Figure 7</u>

Number of Families According to Child’s Type of Disability

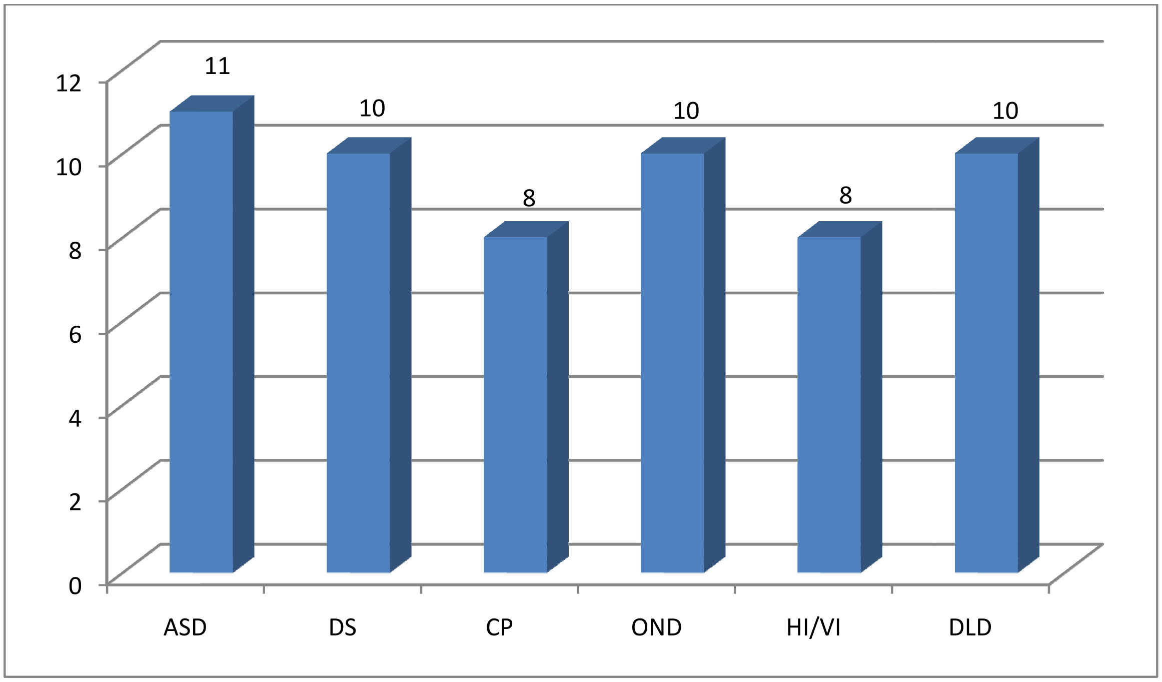


Figure 7 represents number of children of respondents according to type of disability. Out of the 57 children, 19% (n = 11) children had a primary diagnosis of Autism Spectrum Disorders (ASD), 17% (n = 10) children had Down Syndrome (DS), 15% (n = 8) children had Cerebral Palsy (CP), 17% (n = 10) children were diagnosed with Other Neurological Disorders (OND), 15% (n = 8) children had hearing/visual impairment (HI/VI), and 17% (n = 10) children had Developmental Language Disorders (DLD).

According to the ABILITIES Index results for severity of disability, 12 (21%) children where characterized as mild, 36 (63%) as moderate, and 9 (16%) as severe. Further, children of respondents comprised 37 boys (65%) and 20 girls (35%). Only 13

(23%) children used adaptive equipment, while the majority comprising 44 (77%) children did not use any medical device or adaptive equipment.

Table 11

Frequencies (Percentages) for Number Children According to Time of Diagnosis and Time Referred to Early Intervention Services (N = 57)

Variable	**n**	**Percent**
Time of Diagnosis		
At birth	10	18%
Less than one month after birth	2	3%
Older than one month	37	65%
At time of injury/accident	2	3%
Don't know	6	11%
Time Referred to EI		
At birth or immediately after diagnosis	14	25%
At time of injury/accident	2	3%
One - two months after diagnosis	4	7%
Two - three months after diagnosis	37	65%
Total	**57**	**100.0%**

Table 11 demonstrates two aspects related to the time when respondents' children were first diagnosed and time referred to EI services. Ten (18%) children were diagnosed at birth; only two (3%) children were diagnosed less than one month after birth; the majority of children comprising thirty-seven (65%) were older than one month when diagnosed; only two children (3%) were diagnosed with a disability at time of injury/accident; and six (11%) of the parents did not know the time their children were diagnosed with a disability.

The majority of parents reported that their children with disabilities comprising 37 children (65%) were referred to EI services two-three months after diagnosis. Fourteen (25%) parents reported that their children with disabilities were referred to EI services at birth or immediately after diagnosis; only two (2) parents (3%) reported their children were referred at time of injury/accident; and only four (7%) parents reported their children were referred one- two months after diagnosis.

Early Intervention/Early Childhood Services Inventory

Data concerning EIEC services that children of respondents were receiving at the time of the study were collected. These characteristics include: Type of early intervention services received, intensity of services, parents' satisfaction with quality and quantity of services that their children receiving, and parent involvement. Findings are presented in Tables 12-14 & Figures 8.

Table 12

Frequencies (Percentages) for Number Children According to Type of Early Intervention/Early Childhood Services Received (N = 57)

Variable	**n**	**Percent**
Medical Services		
Does not receive services	35	61%
Receive services	22	39%
Nursing Services		
Does not receive services	53	93%
Receive services	4	7%
Occupational Therapy		
Does not receive services	16	28%
Receive services	41	72%
Physical Therapy		
Does not receive services	27	47%
Receive services	30	53%
Speech & Language Pathology		
Does not receive services	11	19%
Receive services	46	81%
Special Education		
Does not receive services	33	58%
Receive services	24	42%
Behavior Support		
Does not receive services	40	70%
Receive services	17	30%
Family Counseling Services		
Does not receive services	48	84%
Receive services	9	16%
Nutrition/Dietitian Services		
Does not receive services	45	79%
Receive services	12	21%

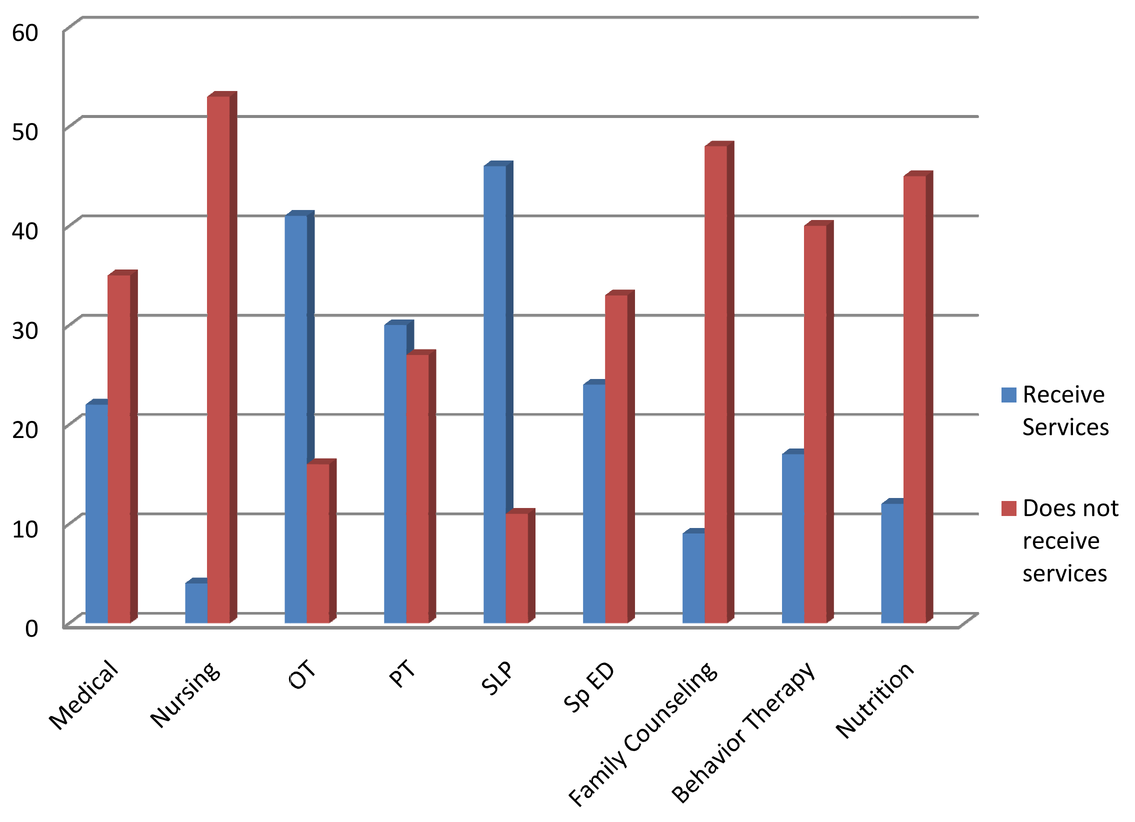
Table 12 shows the type of EIEC services that the children with disabilities were receiving at the time of the study. Thirty-five (61%) of the children with disabilities in the in the study did not receive medical services at the time of the study, while twenty-two (39%) were receiving medical services. The majority of children comprising fifty-three (93%) did not receive nursing services at the time of the study and only four (7%) children were receiving nursing services. In terms of nutrition services, only twelve (12) children comprising 21% were receiving nutrition services compared to forty-five children (79%) who weren't receiving nutrition services.

With regard to therapy services, forty-one (72%) of the children received occupational therapy services; forty-six (81%) of children received speech therapy; and only thirty (53%) children received physical therapy services at the time of the study. Physical therapy services was received the least (53%), while the most received therapy services was speech and language pathology services comprising 81%. Further, only twenty-four (42%) of the children were receiving special education services compared to thirty-three (58%) of the children who did not receive special education services. Only seventeen (30%) of the children were receiving behavior therapy services.

Lastly, the majority of families (n = 48, 84%) participating in the study did not receive any family counseling services compared to only nine (16%) families who were receiving family counseling services. Figure 8 provides a graph chart representation of the number of children with disabilities according to the type of EIEC services received.

Figure 8

Frequencies for Number Children According to Type of Early Intervention/Early Childhood Services Received



Abbreviations: OT, Occupational Therapy PT, Physical Therapy SLP, Speech & Language Pathology SP ED, Special Education

The majority (48, 84%) of the children with disabilities in the study received EI/EC services from one center/hospital. Eight of the children (14%) received services from at least two centers or hospitals, while only one (2%) child received services from three different centers/hospitals. In terms of the setting where services received was as followed: Seven children (12%) received services in a center-based setting (Shafallah Center); twelve children (21%) received services in a hospital-based setting mainly from Children Rehabilitation Department at HMC; and thirty-eight children (67%) received services in a hospital-based setting mainly in Outpatient Programs at HMC. Further, the majority (48) of the parents (84%) in the study reported that they do not pay for any EIEC services that their children with disabilities receive. Only nine parents (16%) were paying for EIEC services at the time of the study. With regard home-based services, only one child (2%) received home-based services (from a private hospital) compared to fifty-six children (98%) who were receiving either hospital-based and/or center-based services.

Table 13

Frequencies (Percentages) for Number of Hours of Early Intervention/Early Childhood Services Received by Children

Number of Hours	**n**	**Percent**
.5	6	11%
1.00	13	23%
1.25	1	2%
1.5	4	7%
2.00	7	12%
2.5	2	3%
3.0	4	7%
5.0	3	5%
23.0	8	14%
24.0	3	5%
25.0	6	11%

Table 13 describes the intensity of EI/EC services received by children with disabilities in the study. The mean average number of hours of EI/EC received was 8.8 hours per week (M = 8.8), the median was (2.0), and the mode was (1.0). The majority of children with disabilities (17, 30%) received between 23 – 25 hours of EI services per week, representing children with disabilities who were receiving services in both Shafallah Center and the Children Rehabilitation Department at HMC. Thirteen (23%) children received only one hour of early intervention services per week. Six children (11%) received only half an hour (.5) of EI services per week; only one child (2%) received 1.25 hours of EI services per week; four children (7%) received 1.5 hours of services per week; seven children (12%) received two hours of services per week; only two children (3%) received two-and-a half (2.5) hours of services per week; four children (7%) received three (3.0) hours of services per week; and only three children (5%) received five hours of services per week.

Table 14

Frequencies (Percentages) for Number of Days of Early Intervention/Early Childhood Services Received by Children

Variable	**n**	**Percent**
Number of days per week		
1	6	11%
2	19	33%
3	7	12%
4	2	4%
5	23	40%

Table 14 describes the intensity of EI/EC services, as it relate to the number of days per week, received by children with disabilities in the study. The mean average number of days of EI/EC received was 3 days per week (M = 3.0), the median was (3.0), and the mode was (5.0). The majority of children with disabilities comprising 23 children (40%) received early intervention services five days per week. Nineteen children (33%) received EI services twice a week; six children (11%) received EI services one day per week; seven children (12%) received EI services three days per week; and only two children (4%) received EI services four days per week.

With regards to parent involvement in the educational/therapeutic programs for their children, the majority of parents comprising twenty-five (44%) reported they were involved sometimes in their children's educational/therapeutic programs; six parents (10%) reported they were involved most of the times; seventeen parents (30%) reported they were always involved; and nine parents (16%) reported they were not involved at all or rarely involved. With regards to satisfaction with current level of parent involvement, the majority of parents (37, 65%) were not satisfied with their current level of involvement and would like to be more involved, while only twenty parents (35%) were satisfied with their current involvement in the educational/therapeutic programs for their children.

Concerning decisions regarding the types of services that the children received, respondents indicated decision was predominantly made by the child's pediatrician accounting for forty-one (72%) of the respondents. Six parents (10%) indicated that they were the decision maker for the type of services their children received; eight parents (14%) indicated that other professionals made the decision; and only two respondents

(4%) indicated it was a mutual decision between the parents and the child’s pediatrician. In addition, the majority of respondents (39, 68%) indicated that the decision was based on a team meeting compared to 18 (32%) respondents who indicated that the decision was made individually and wasn’t based on a team meeting.

Most families (33, 58%) indicated they were not satisfied with the amount of EIEC services that their children receive and that the services were less than what their children need. The remaining families (24, 42%) believed they were receiving enough services and the services were about the right amount their children need. The majority of respondents (47, 83%) indicated a need for additional services. The type of services needed include: Behavior support occupational therapy, physical therapy, speech therapy, special education, and psychological services.

With regard to the needed EIEC services, thirty-five parents (64%) indicated they needed additional speech therapy services; twenty parents (35%) indicated they needed additional occupational therapy services for their children; fourteen parents (25%) indicated they needed additional physical therapy services; nine parents (16%) indicated they needed behavior support services; seven parents (12%) indicated they needed additional special education services; and only one parent (2%) indicated their child needed psychological services.

Table 15

Frequencies (Percentages) for Satisfaction with Quality of Early Intervention /Early Childhood Services (N = 57)

Variable	n	Percent
Quality of Occupational Therapy Services		
Excellent	18	32%
Good	16	28%
Fair	5	9%
Poor	3	5%
Does not receive	15	26%
Quality of Physical Therapy Services		
Excellent	12	21%
Good	11	19%
Fair	3	5%
Poor	2	4%
Does not receive	29	51%
Quality of Speech Therapy Services		
Excellent	12	21%
Good	24	42%
Fair	6	11%
Does not receive	15	26%
Quality of Behavior Support Services		
Excellent	7	12%
Good	6	11%
Fair	3	5%
Poor	2	4%
Does not receive	39	68%
Quality of Special Education Services		
Excellent	7	12%
Good	12	21%
Fair	4	7%
Does not receive	37	60%

Table 15 presents the number and percentage of respondents according to their level of satisfaction with the quality of EIEC services their children received at the time of the study. Of the 42 respondents who received Occupational Therapy services, 18 (32%) parents believed the services were “Excellent” , 16 (28%) parents believed the services were “Good”, 5 (9%) parents believed the services were “Fair”, and 3 (5%) believed the services were “Poor”. Of the 28 respondents who received Physical Therapy services, 12 (21%) parents believed the services were “Excellent” , 11 (19%) parents believed the services were “Good”, 3 (5%) parents believed the services were “Fair”, and 2 (4%) believed the services were “Poor”. Of the 42 respondents who received Speech Therapy services, 12 (21%) parents believed the services were “Excellent”, 24 (42%) parents believed the services were “Good”, and 6 (11%) parents believed the services were “Fair”. Of the 18 respondents who received Behavior Support services, 7 (12%) parents believed the services were “Excellent”, 6 (11%) parents believed the services were “Good”, 3 (5%) parents believed the services were “Fair”, and only 2 (4%) parents believed the services were “Poor”. Finally, of the 20 respondents who received Special Education services, 7 (12%) parents believed the services were “Excellent”, 12 (21%) parents believed the services were “Good”, and 4 (7%) parents believed the services were “Fair”.

Service Providers Characteristics

Professionals who completed the Service Providers Demographic Survey included sixty-six (n = 66) service providers, of whom 46 (70%) females and 20 (30%) males. Out of the 66 service providers, 39 (59%) were from HMC and 27 (41%) were from Shafallah Center. The sixty-six service providers represented multiple disciplines in EI/ECSE programs including: 15 (23%) special education teachers, 31 (47%) related services therapists, 11 (17%) paraprofessionals, and 9 (13%) health and social services providers. Further, the majority of the service providers (31, 47%) were related services therapists including: ten (10, 15%) occupational therapists, eleven (11, 17%) physical therapists, and ten (10, 15%) speech and language pathologists. The smallest represented discipline group was the health and social services providers (9, 13%) included three (3, 4%) pediatricians, five (5, 7%) psychologists, and one (1, 2%) social worker. Figure 9 provides a chart graph representation of the number of service providers according to their disciplines. Table 16 presents the descriptive statistics for the demographic data of the subsample of service providers.

Figure 9

Frequencies for Number of Service Providers According to Discipline (N = 66)

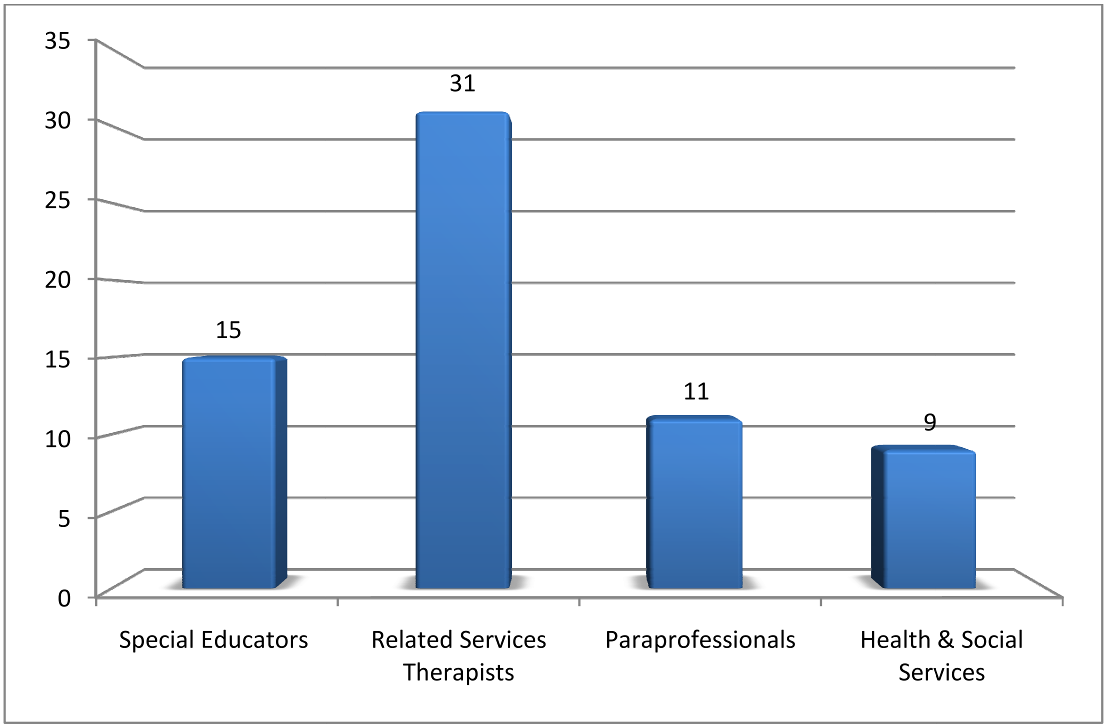


Table 16

Demographics of Service Providers (N = 66)

Variable	**n**	**Percent**
Nationality		
Qataris	19	29%
Non-Qataris	47	71%
Non-Qatari Nationality		
Arabic Countries	31	47%
Other Countries	16	24%
Gender		
Males	20	30%
Females	46	70%
Setting		
HMC	39	59%
Shafallah Center	27	41%
Age		
21-30 years old	20	30%
31-40 years old	30	46%
41-50 years old	11	17%
51-60 years old	5	7%
Educational Level		
Associate’s degree	18	27%
Bachelor’s degree	32	49%
Some graduate courses	14	21%
Master’s degree	2	3%

Table 16: *Continued*

Variable	n	Percent
Years of Experience		
Less than one year	2	3%
1-5 years	16	24%
5-10 years	20	31%
10-15 years	12	18%
15-20 years	10	15%
More than 20 years	6	9%
Years of Experience in Qatar Only		
Yes	17	26%
No	49	74%
Years of Experience in Qatar		
Less than one year	5	8%
1-5 years	21	32%
5-10 years	14	21%
10-15 years	4	6%
15-20 years	3	4%
More than 20 years	2	3%
All years of experience in Qatar	17	26%

At both sites the service providers varied in nationality, age, educational attainment level, and total years of experience. Table 15 indicates that the majority of service providers were non-Qataris (47, 71%), with the remaining 19 (29%) were Qataris. Of the 47 non-Qataris service providers, 31 (47%) were from Arabic countries (Jordan, Sudan, and Egypt), and 16 (24%) were from other non-Arabic speaking countries (mainly from India, Philippine, and Nigeria). Concerning age distribution of the service providers, the majority of respondents' age (30, 46%) was in the 31-40 years old category, followed by twenty respondents (30%) in the 21-30 years old category, eleven (17%) in the 41-50 years old category, and only five (7%) in the 51-60 years old category. Thus, the majority of respondents were in the middle-aged range.

With regard to the educational attainment levels of service providers in the study, the majority (32, 49%) of service providers had earned a Bachelor's degree; eighteen (18, 27%) earned an Associate's degree; fourteen (14, 21%) had some graduate courses; and only two (2, 3%) earned a Master's degree. The highest level of education earned by respondents, then, was a Master's degree. The majority of service providers (20, 31%) had total years of experience in the 5-10 category, followed by sixteen respondents (24%) in the 1-5 years category, twelve (18%) in the 10-15 years category, ten (15%) in the 15-20 years category, six (9%) had more than 20 years of experience, and only two (3%) had less than one year of experience.

Only seventeen (26%) service providers had all of their years of experience in Qatar compared to forty-nine (74%) respondents. Of the 49 respondents: twenty-one (32%) had 1-5 years of experience in Qatar, followed by fourteen (21%) in the 5-10 years category, five (8%) had less than one year of experience in Qatar, four (6%) in the 10-15 years category, only three (4%) in the 15-20 years category, and only two (3%) had more than 20 years of experience in Qatar.

In terms of pre-professional training, the majority (50, 76%) of service providers indicated that they had specific training in working with young children with disabilities (birth to five years) as part of their degree or study program, compared to only 16 (24%) did not had specific training. A majority of service providers (42, 64%) reported they received specific training in working with families of children with disabilities as part of their degree or study program, while only 24 (36%) did not have specific training. In terms of preparedness to work with young children with disabilities (birth to 5 years), twenty-four (36%) of service providers reported being “extremely well prepared”; thirty-five (54%) reported being “well prepared”; five (7%) reported being “somewhat prepared”; and only two (3%) reported they were “not at all prepared”. Further, with regard to preparedness to work with families of young children with disabilities, the majority of service providers (38, 58%) reported being “well prepared”. Sixteen (24%) respondents reported being “extremely well prepared”; seven (10%) reported being “somewhat prepared”; and only five (8%) reported they were “not at all prepared”.

Characteristics of Early Intervention Services Delivery

This section presents various aspects of EIEC service delivery including: Caseload, service location, service format, type of team work, and family involvement. Table 17 presents descriptive statistics related to service providers’ caseload, age range of children in their caseload, and type of disabilities of children in their caseload.

Table 17

Frequencies (Percentages) of Service Providers' Caseload (N = 66)

Variable	n	Percent
Number of children in caseload		
Less than 6 children	8	12%
Between 6-10 children	33	50%
Between 11-15 children	13	20%
Between 16-20 children	4	6%
More than 20 children	8	12%
Number of Children in Caseload (Birth-6 years)		
Less than 50%	14	21%
More than 50%	14	21%
Almost all	18	28%
Only work with children birth to 6years	20	30%
Type of Disability of children in caseload		
Children with all type of disabilities	56	85%
Only children with multiple disabilities	3	4%
Only children with behavioral/emotional disorders	1	2%
Only children with speech or language impairment	4	6%
Only children with developmental disabilities	2	3%

Table 17 shows that exactly half of the service providers (33, 50%) had a caseload between 6-10 children per day, followed by thirteen (20%) service providers had a caseload between 11-15 children. Only eight (12%) service providers had a caseload less than 6 children per day, four (6%) had a caseload between 16-20 children, and only eight (12%) had a caseload of more than 20 children. With regard to the number of children between birth to six years in the service providers' caseload, the majority of service providers (20, 30%) only work with children birth to six years, followed by eighteen (28%) had a caseload of children almost all between birth to six years, fourteen (21%) had a caseload of more than 50% of children between birth to six years, and fourteen (21%) had a caseload of less than 50% of children between birth to six years.

Concerning the type of disability of children in the service providers' caseload, the majority of service providers (56, 85%) reported they work with children with all type of disabilities. Four (6%) service providers work with children with speech or language impairment only, three (4) service providers work with children with multiple disabilities only, and two (3%) service providers work with only children with developmental disabilities. Only one (2%) service provider indicated working with only children with behavioral/emotional disabilities.

Table 18 presents descriptive statistics (frequencies and percentages) related to models of EI service delivery including EI approaches utilized by service providers (child-focused vs. family-focused), home-based and center-based services, and teamwork (IEP/Rehabilitation team meetings).

Table 18

Frequencies (Percentages) of EI Approaches Utilized by Service Providers (N = 66)

Variable	**n**	**Percent**
Child-focused and Family-focused Services		
Mostly children	13	20%
Mostly families	0	0%
Both children and their families	53	80%
Home-based Services		
No	66	100%
Yes	0	0%
Early Intervention/Early Childhood Setting		
Hospital inpatients only	2	3%
Hospital outpatients only	19	29%
Hospital (both inpatients and outpatients)	9	14%
Center (early intervention classroom) only	24	36%
Center (both classrooms and outpatients)	3	4%
Other (Children Rehabilitation Department)	3	4%
Early Intervention Approaches		
One-to-one only	21	32%
Groups (two or more children) only	0	0%
Both one-to-one and groups	45	68%

Table 18: *Continued*

Variable	**n**	**Percent**
IEP/Rehabilitation Team Meetings		
Hospital inpatients only	13	20%
Hospital outpatients only	0	0%
Hospital (both inpatients and outpatients)	5	7%
Center (early intervention classroom) only	21	32%
Center (both classrooms and outpatients)	6	9%
Other (Children Rehabilitation Department)	13	20%
No team meetings	8	12%
Attending IEP/Rehabilitation Team Meetings		
Never	10	15%
Once or twice	11	17%
Several times	9	13%
Regularly	36	55%

Table 18 shows that service providers varied in terms of the focus of early intervention services. The majority of service providers (53, 80%) were more likely to provide services that were focused on both the child and the family when working with young children with disabilities. The remaining 13 (20%) were more likely to provide mostly child-focused. In terms of home-based services none of the participating service providers provided services in the family home. All of EIEC services were provided either in a hospital-based or center-based setting as follows: two (3%) respondents provided services in HMC inpatients setting only; nineteen (29%) respondents provided services in HMC outpatients programs only; nine (14%) respondents provided services in both inpatients and outpatients programs at HMC; three (4%) respondents provided services in Children Rehabilitation Department; twenty-four (36%) respondents provided services in Shafallah Center early intervention classrooms only; and three (4%) respondents provided services in Shafallah Center both classrooms and outpatients program.

Concerning EI approaches, the majority (45, 68%) of service providers indicated they were more likely to provide both one-to-one and groups services for young children with disabilities. The remaining (21, 32%) respondents provided only one-on-one services. Furthermore, service providers varied in terms of IEP/Rehabilitation team meetings for children in their caseload. At HMC, thirteen (20%) service providers reported that only inpatient children had team meetings; five (7%) service providers reported both inpatients and outpatients children had team meetings; thirteen (20%) service providers reported that only children in Children Rehabilitation Department had team meetings. None of the children in the outpatient programs had team meetings. Also, eight (12%) of the service providers, mainly physical therapists, reported none of the children in the physical therapy outpatient program had team meetings. At Shafallah Center, twenty-one (32%) service providers reported that children in early intervention classrooms had team meetings, and six (9%) service providers reported that children in both classrooms and outpatients had team meetings. Lastly, the majority of service providers (36, 55%) attend team meetings regularly; eleven (17%) attend once or twice; ten (15%) never attended team meetings, and only nine (13%) attended several times.

With regard to Family Involvement in the different phases of the intervention program for their young children with disabilities, the majority (61, 92%) of service providers reported that the families of young children with disabilities were involved in the decision relating to the kind of services that their child receives, compared to only five (8%) who did not involve families. Fifty-nine (89%) of participating service providers reported that they involved families in the assessment process for their children with disabilities, while only seven (11%) service providers did not. Also, sixty-two (94%) of the service providers involved families in the planning process for setting the intervention program whereas only four (6%) did not.

In terms of service providers' perceptions regarding family and parent involvement in the decisions regarding the intervention strategies for their young children with disabilities, almost all service providers (64, 97%) stated that families should be involved at all stages including the assessment, identifying priorities and need, setting the intervention program goals, and carrying out the program at home. Conversely, only two (3%) service providers feel that family involvement should be limited to carrying out the intervention strategies at home only. As a final point, all of the participating service providers indicated that EI programs should provide services for the families of young children with disabilities such as training and counseling services.

Family-Professional Partnership Scale

The Family-Professional Partnership Scale was used to assess the quality of partnerships for families of young children with disabilities in EI/ECSE programs. All fifty-seven (57) participating families completed the family version of the Beach Center Family-Professional Partnership Scale. The scale consisted of 18-items that assessed the extent to which families were satisfied with the relationships they had with professionals serving their children with disabilities. Further, the Scale contained two subscales with nine items per subscale: 1) Child-Focused Relationships (focused on the child's relationship to the service provider), and 2) Family-Focused Relationships (focused on the family's relationship to the service provider).

First, means across items were calculated for each participant to determine the total partnership scale score and the two subscale scores (Child-Focused Relationships Subscale and Family-Focused Relationships Subscale). The total partnership score was calculated by determining the mean of all 18 items for each participant. Also, the means for each subscale were calculated by averaging responses to the nine items in that subscale. Second, satisfaction ratings across family groups were calculated according to: 1) type of the child's disability, and 2) level of severity of disability. Last, independent analyses of variance (ANOVA) were used to compare satisfaction ratings mean scores of family groups.

The overall mean satisfaction rating across all 18 items of the Beach Center Family–Professional Partnership Scale for the total family sample was 4.31 (SD = .66). The mean satisfaction ratings for the Family-Focused Relationships subscale and the Child-Focused Relationships subscale were 4.38(SD = .65) and 4.23 (SD = .70) respectively. With regards to the two settings, the HMC family sample had higher mean satisfaction ratings for the overall partnership scale (M = 4.33), child-focused subscale (M = 4.27), and the family-focused subscale (M = 4.38), than the Shafallah Center family sample (Partnership Scale Overall M = 4.22; Child-Focused Subscale M = 4.08; and Family-Focused Subscale M = 4.36). Table 19 presents the overall and subscale means and standard deviations for families' satisfaction ratings on the Partnership Scale.

Table 19

Satisfaction Ratings on the Family-Professional Partnership Scale (Family Version)

Variable	**N**	**M**	**SD**	**Min**	**Max**
Total Family Sample					
Partnership Scale Overall	57	4.31	0.66	2.56	5.00
Child-Focused Subscale	57	4.23	0.70	2.33	5.00
Family-Focused Subscale	57	4.38	0.65	2.78	5.00
HMC					
Partnership Scale Overall	46	4.33	0.66	2.56	5.00
Child-Focused Subscale	46	4.27	0.69	2.33	5.00
Family-Focused Subscale	46	4.38	0.65	2.78	5.00
Shafallah Center					
Partnership Scale Overall	11	4.22	0.71	2.67	4.94
Child-Focused Subscale	11	4.08	0.75	2.44	4.89
Family-Focused Subscale	11	4.36	0.68	2.89	5.00

Satisfaction ratings scores for items in the Partnership Scale ranged from 3.61 to 4.58; the item with the highest satisfaction rating was that the service providers treat child with dignity (M = 4.58, SD = 0.73). In contrast, the item with the lowest satisfaction was service providers speaking up for the child's best interests when working with other service providers (M = 3.61, SD = 0.99). Other items with low satisfaction ratings below the mean (M = 4.31) include: The service provider helps family gain skills or information to get what their child needs (M = 4.07, SD = 0.88); provides services that meet the individual needs of the child (M = 4.12, SD = 0.95), service providers have the skills to help the child succeed (M = 4.23, SD = 0.87), values parents' opinion about their child's needs (M = 4.25, SD = 0.89), service providers are available when parents need them (M = 4.25, SD = 0.95), and service providers are honest, even when they have bad news (M = 4.30, SD = 0.80). Table 20 presents mean scores for families' satisfaction ratings for each item on the Partnership Scale.

Table 20

Satisfaction Ratings for Each Item on the Family-Professional Partnership Scale

Variable	M	SD
Child-Focused Relationships Subscale		
1. Help you gain skills or information to get what your child needs	4.07	0.88
2. Have the skills to help your child succeed	4.23	0.87
3. Provide services that meet the individual needs of your child	4.12	0.95
4. Speak up for your child's best interests when working with other service providers	3.61	0.99
5. Let you know about the good things your child does	4.40	0.88
6. Keep your child safe when your child is in their care	4.54	0.60
7. Treat your child with dignity	4.58	0.73
8. Build on your child's strengths	4.30	0.87
9. Value your opinion about your child's needs	4.25	0.89

Table 20: *Continued*

Variable	M	SD
Family-Focused Relationships Subscale		
10. Is honest, even when they have bad news	4.30	0.80
11. Is available when you need them	4.25	0.95
12. Use words that you understand	4.47	0.80
13. Protect your family’s privacy	4.42	0.71
14. Shows respect for family’s values and beliefs	4.35	0.70
15. Listen without judging your child or family	4.32	0.81
16. Is a person family can depend on and trust	4.42	0.87
17. Pay attention to what you have to say	4.37	0.86
18. Is friendly	4.53	0.66

Table 21 presents descriptive statistics for satisfaction ratings on the overall Partnership Scale, child-focused subscale, family-focused subscale, and satisfaction ratings for all 18 items across the six disability groups: Autism Spectrum Disorders (ASD), Down syndrome (DS), Cerebral Palsy (CP), Other Neurological Disorders (OND), Hearing/Visual Impairment (HI/VI), and Developmental Language Disorders (DLD).

Table 21

Satisfaction Ratings on the Family-Professional Partnership Scale across Family Groups According to Type of Disability

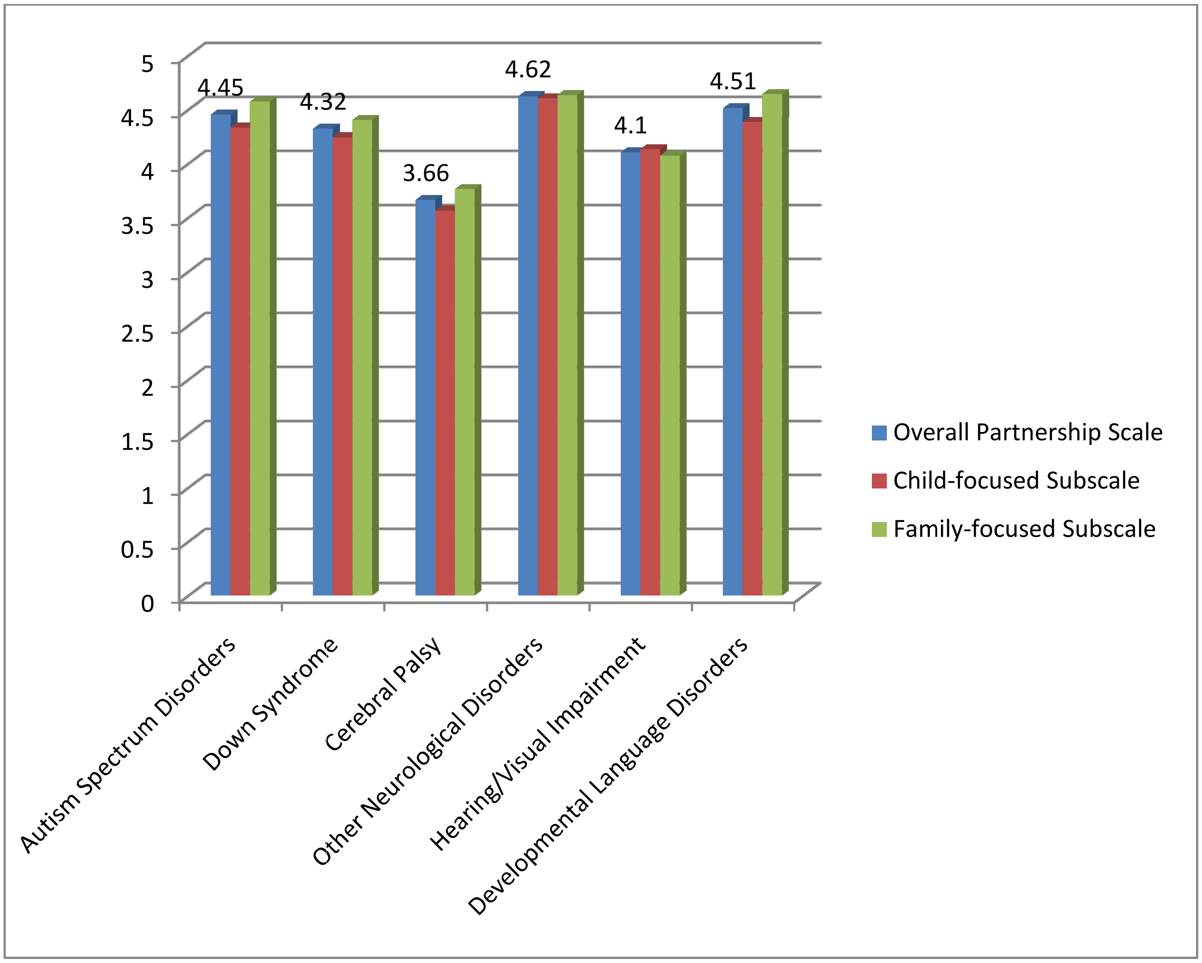
Variable	**ASD**		**DS**		**CP**		**OND**		**HI/VI**		**DLD**	
	n=11		**n=10**		**n=8**		**n=10**		**n=8**		**n=10**	
	M	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**
Partnership Scale												
Overall	4.45	0.52	4.32	0.71	3.66	1.03	4.62	0.28	4.10	0.55	4.51	0.43
Child-focused	4.33	0.56	4.24	0.80	3.56	1.09	4.60	0.29	4.13	0.58	4.38	0.45
Family-focused	4.57	0.50	4.40	0.66	3.76	1.01	4.63	0.34	4.07	0.54	4.64	0.45
Child-Focused Relationships Subscale												
Item 1	4.27	0.91	4.00	1.16	3.38	1.07	4.40	0.70	3.88	0.64	4.30	0.48
Item 2	4.36	0.67	4.30	1.06	3.50	1.31	4.40	0.70	4.13	0.64	4.50	0.53
Item 3	4.36	0.81	4.10	1.10	3.50	1.41	4.30	0.68	4.00	0.76	4.30	0.82
Item 4	3.82	0.87	3.50	1.18	2.87	1.36	4.00	0.82	4.00	0.54	3.40	0.84
Item 5	4.55	0.69	4.30	1.06	3.63	1.30	4.90	0.32	4.37	0.74	4.50	0.71
Item 6	4.55	0.52	4.50	0.53	4.13	0.84	4.80	0.42	4.38	0.74	4.80	0.42
Item 7	4.55	0.52	4.80	0.63	4.00	1.31	4.90	0.32	4.25	0.71	4.80	0.42
Item 8	4.27	0.79	4.40	0.84	3.50	1.31	4.90	0.32	4.13	0.64	4.40	0.70
Item 9	4.27	0.65	4.30	0.95	3.50	1.20	4.80	0.42	4.00	0.54	4.40	1.08
Family-Focused Relationships Subscale												
Item 10	4.45	0.69	4.20	0.92	3.75	0.89	4.70	0.48	4.00	0.93	4.50	0.71
Item 11	4.36	0.92	4.20	1.14	3.75	1.28	4.50	0.71	3.63	0.74	4.80	0.42
Item 12	4.64	0.51	4.70	0.48	3.88	1.13	4.70	0.68	4.13	0.84	4.60	0.97
Item 13	4.64	0.51	4.60	0.52	3.75	1.04	4.50	0.52	4.13	0.84	4.70	0.48
Item 14	4.64	0.51	4.50	0.71	3.75	0.89	4.50	0.71	4.13	0.64	4.40	0.52
Item 15	4.36	0.67	4.40	0.70	3.88	1.00	4.50	0.71	4.13	0.64	4.50	1.08
Item 16	4.64	0.51	4.30	0.95	3.63	1.51	4.80	0.42	4.13	0.64	4.80	0.42
Item 17	4.64	0.51	4.20	0.92	3.50	1.41	4.70	0.48	4.13	0.64	4.80	0.42
Item 18	4.73	0.47	4.50	0.71	4.00	0.93	4.80	0.42	4.25	0.71	4.70	0.48

As seen in Table 21, the highest overall mean satisfaction rating across all 18 items of the Beach Center Family–Professional Partnership Scale was for families of children with OND (M = 4.62, SD = 0.28), followed by families of children with DLD (M = 4.51, SD = 0.43). The lowest overall mean satisfaction rating was for families of children with CP (M = 3.66, SD = 1.03). Concerning the two subscales: the highest mean satisfaction rating across all 9 items of the Child-focused Subscale was for families of children with OND (M = 4.60, SD = 0.29), and for the Family-focused Subscale was for families of children with DLD (M = 4.64, SD = 0.45). Families of children with CP had the lowest satisfaction ratings for both the Child-focused and Family-focused subscales respectively (M = 3.65, SD = 1.09; M = 3.76, SD = 1.01).

In effect, families of children with CP had the lowest mean satisfaction ratings across all 18 items on the Partnership Scale with the exception of item 11 relating to service provider is available when you need them, where families of children with hearing/visual impairment had the lowest mean satisfaction rating (M = 3.63, SD = 0.74). Mean satisfaction ratings for families of children with CP ranged from 2.87 to 4.13 and were all below the overall mean satisfaction rating for the total family sample (M = 4.31). Furthermore, the lowest mean satisfaction rating for families of children with CP was for item 4 concerning service providers speaking up for child's best interests when working with other service providers (M = 2.87, SD = 1.36), and the highest mean satisfaction rating was for item 6 concerning service providers keeping child safe when child is in their care (M = 4.13, SD = 0.84). Hence, both the lowest and highest mean satisfaction ratings were for items on the child-focused relationships subscale. Figure 10 provides a chart graph representation of mean satisfaction ratings across the six family groups for the overall partnership scale, child-focused relationships subscale, and family-focused relationships subscale.

Figure 10

Satisfaction Ratings across Family Groups According to Type of Disability (N = 57)



In addition to satisfaction ratings across type of disability groups, descriptive statistics were analyzed across severity of disability groups of mild, moderate, and severe. Table 22 presents descriptive statistics (mean and standard deviation) across family group according to the child's level of disability.

Table 22

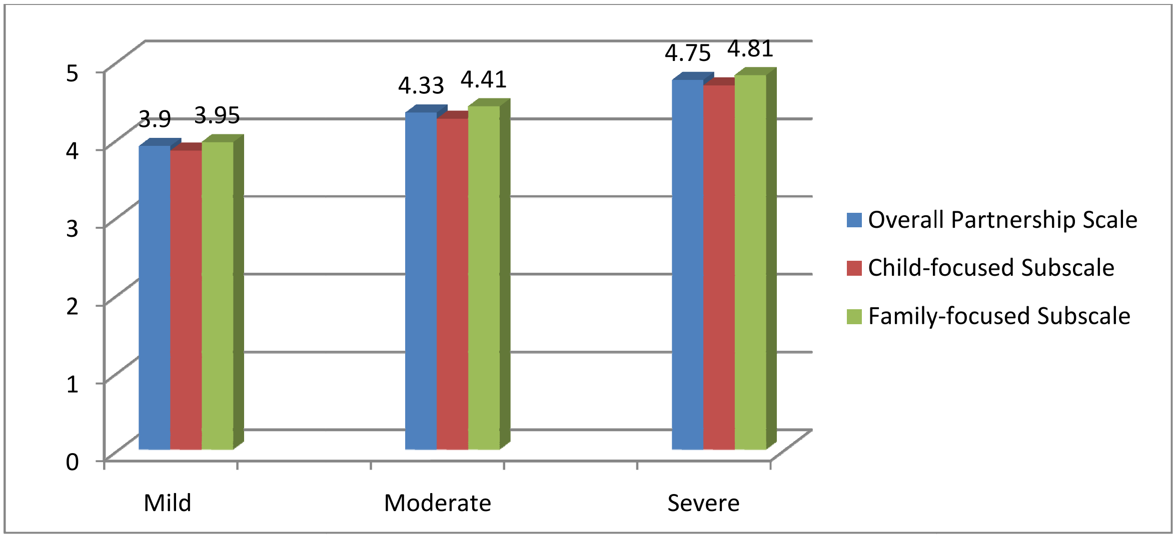
Satisfaction Ratings on the Family-Professional Partnership Scale across Family Groups According to Severity of Disability

Variable	**Mild** **n=12** **M**	 **SD**	**Moderate** **n=36** **M**	 **SD**	**Severe** **n=9** **M**	 **SD**
Partnership Scale						
Overall	3.90	0.76	4.33	0.63	4.75	0.18
Child-focused	3.84	0.79	4.25	0.69	4.68	0.23
Family-focused	3.95	0.77	4.41	0.62	4.81	0.16
Child-Focused Relationships Subscale						
Item 1	3.83	0.84	4.06	0.96	4.44	0.53
Item 2	3.83	1.03	4.25	0.84	4.67	0.44
Item 3	3.33	0.89	4.22	0.90	4.78	0.44
Item 4	3.08	0.80	3.75	1.06	3.78	0.83
Item 5	4.00	1.04	4.42	0.87	4.89	0.33
Item 6	4.25	0.76	4.53	0.56	5.00	0.00
Item 7	4.25	0.97	4.61	0.69	4.89	0.33
Item 8	4.17	1.03	4.22	0.83	4.78	0.67
Item 9	3.83	1.12	4.22	0.83	4.89	0.33
Family-Focused Relationships Subscale						
Item 10	4.17	0.84	4.31	0.82	4.44	0.73
Item 11	3.75	0.97	4.25	0.97	4.89	0.33
Item 12	3.83	1.03	4.56	0.70	5.00	0.00
Item 13	4.00	0.85	4.44	0.65	4.89	0.33
Item 14	4.00	0.85	4.42	0.65	4.56	0.53
Item 15	3.67	0.99	4.42	0.69	4.78	0.44
Item 16	4.00	1.13	4.44	0.81	4.89	0.33
Item 17	3.92	1.08	4.36	0.80	5.00	0.00
Item 18	4.25	0.87	4.53	0.61	4.89	0.33

The highest overall mean satisfaction rating across all 18 items of the Partnership Scale was for families of children with severe disability (M = 4.75, SD = 0.18), followed by families of children with moderate disability (M = 4.33, SD = 0.63). The lowest overall mean satisfaction rating was for families of children with mild disability (M = 3.90, SD = 0.76). The same trend was evident concerning the two subscales with the highest mean satisfaction rating of the Child-focused Subscale the Family-focused Subscale were for families of children with severe disability followed by families of children with moderate disability. Families of children with mild disability had the lowest satisfaction ratings for both the Child-focused and Family-focused subscales respectively (M = 3.84, SD = 0.79; M = 3.95, SD = 0.77). Figure 11 provides a chart graph representation of mean satisfaction ratings across the three family groups for the overall partnership scale, child-focused relationships subscale, and family-focused relationships subscale.

<u>Figure 11</u>

Satisfaction Ratings across Family Groups According to Severity of Disability (N = 57)



Families of children with mild disabilities had the lowest mean satisfaction ratings across all 18 items on the Partnership Scale. Mean satisfaction ratings for families of children with mild disabilities ranged from 3.08 to 4.25 and were all consistently below the overall mean satisfaction rating for the total family sample (M = 4.31). The lowest mean satisfaction rating for families of children with mild disability was for item 4 concerning service providers speaking up for child's best interests when working with other service providers (M = 3.08, SD = 0.80), and the highest mean satisfaction ratings (M = 4.25) were for items 6, 7, and 18 concerning service providers keeping child safe when child is in their care, treating child with dignity, and are friendly respectively. A significant finding is the fact that all three groups (mild, moderate, and severe) had low mean satisfaction ratings for item 4 concerning service providers keeping child safe when child is in their care, where all three groups scored below the overall mean satisfaction rating for the total family sample (M = 4.31). The highest mean satisfaction ratings (M = 5.00) were for families of children with severe disability for items 6, 12, and 17 concerning service providers keeping child safe when child is in their care, using words that family understand, and paying attention to what family have to say.

Satisfaction Ratings across Type of Disability Groups

Using analysis of variance (ANOVA), mean differences in satisfaction ratings were examined across family groups according to: 1) type of disability groups (six groups), and 2) severity of disability groups (three groups). A one-way ANOVA was used to analyze differences among groups (type of disability groups and severity of disability groups) for the: (a) overall Partnership Scale mean scores, (b) child-focused subscale mean scores, (c) family-focused subscale mean scores, and (d) for each of the 18 items in the Partnership Scale. Statistical significance was set at the 95% level ($p < 0.05$). An alpha level of .05 was used for all analyses. Mean differences analysis among type of disability groups on the overall Partnership Scale mean scores, child-focused subscale mean scores, and family-focused subscale mean scores are presented in Table 23-25.

Table 23

Mean Differences Analysis on Overall Partnership Scale Satisfaction Ratings for Type of Disability Group Comparisons

Comparison Groups	**ASD** ***p* value**	**DS** ***p* value**	**CP** ***p* value**	**OND** ***p* value**	**HI/VI** ***p* value**	**DLD** ***p* value**
ASD		1.000	.116	1.000	1.000	1.000
DS			.403	1.000	1.000	1.000
CP				.027*	1.000	.076
OND					1.000	1.000
HI/VI						1.000
DLD						

Abbreviations: ASD = Autism Spectrum Disorders, DS = Down syndrome, CP = Cerebral Palsy, OND = Other Neurological Disorders, HI/VI = Hearing/Visual Impairment, DLD = Developmental Language Disorders

*Significant difference at $p < .05$

Table 23 presents the analysis of variance for the overall Partnership Scale mean scores among the six family groups according to child's type of disability. ANOVA results highlighted significant group differences in the overall satisfaction ratings. The Levene test for homogeneity of variance assumption was statistically significant (F = 4.20; p = .003) and the Bonferroni post hoc test for examining group differences was used. The overall F test (F (5, 51) = 2.83, *p* = .025) points to statistically significant differences among the type of disability groups. Bonferroni post-hoc comparisons of the six groups indicate that families of children with Cerebral Palsy were significantly less satisfied (M = 3.66, 95% CI [2.80, 4.52]) than were families of children with Other Neurological Disorders (M = 4.62, 95% CI [4.42, 4.81]), p = .027, for the overall Partnership Scale mean. Comparisons among other groups indicated no significant differences (all *p*s > .05).

Table 24

Mean Differences Analysis on Child-Focused Subscale Satisfaction Ratings for Type of Disability Group Comparisons

Comparison Groups	**ASD**	**DS**	**CP**	**OND**	**HI/VI**	**DLD**
	***p* value**	***p* value**	***p* value**	***p* value**	***p* value**	***p* value**
ASD		1.000	.214	1.000	1.000	1.000
DS			.483	1.000	1.000	1.000
CP				.024*	1.000	.170
OND					1.000	1.000
HI/VI						1.000
DLD						

*Significant difference at *p* < .05

Table 24 presents the analysis of variance for the Child-Focused subscale mean scores among the six family groups according to child's type of disability. ANOVA results indicated significant group differences in the child-focused satisfaction ratings.

The Levene test for homogeneity of variance assumption was statistically significant (F = 5.23; *p* = .001) and the Bonferroni post hoc test for examining group differences was used. The overall F test (F (5, 51) = 2.50, *p* = .042) points to statistically significant differences among the type of disability groups. Bonferroni post-hoc comparisons of the six groups indicate that families of children with Cerebral Palsy were significantly less satisfied (M = 3.56, 95% CI [2.65, 4.47]) than were families of children with Other Neurological Disorders (M = 4.60, 95% CI [4.39, 4.81]), p = .024, for the child-focused subscale mean. Comparisons among other groups indicated no significant differences (all *p*s > .05).

Table 25

Mean Differences Analysis on Family-Focused Subscale Satisfaction Ratings for Type of Disability Group Comparisons

Comparison Groups	**ASD**	**DS**	**CP**	**OND**	**HI/VI**	**DLD**
	***p* value**	***p* value**	***p* value**	***p* value**	***p* value**	***p* value**
ASD		1.000	.089	1.000	1.000	1.000
DS			.451	1.000	1.000	1.000
CP				.054	1.000	.049*
OND					.800	1.000
HI/VI						.734
DLD						

*Significant difference at *p* < .05

Table 25 presents the analysis of variance for the Family-Focused subscale mean scores among the six family groups according to child's type of disability. ANOVA results indicated significant group differences in the child-focused satisfaction ratings. The Levene test for homogeneity of variance assumption was statistically significant (F = 4.25; p = .003) and the Bonferroni post hoc test for examining group differences was used. The overall F test (F (5, 51) = 3.06, p = .017) points to statistically significant differences among the type of disability groups. Bonferroni post-hoc comparisons of the six groups indicate that families of children with Cerebral Palsy were significantly less satisfied (M = 3.76, 95% CI [2.92, 4.61]) than were families of children with Developmental Language Disorders (M = 4.64, 95% CI [4.32, 4.97]), p = .049, for the family-focused subscale mean. Comparisons among other groups indicated no significant differences (all *p*s > .05).

Analysis of variance for items on the Child-Focused subscale mean scores among the six types of disability groups indicated significant group differences for three items: item 5 (Let you know about the good things your child does), item 8 (Build on your child's strengths), and item 9 (Value your opinion about your child's needs). Bonferroni post-hoc comparisons indicated that families of children with CP were significantly less satisfied with service providers letting them know about the good things that their child does (M = 3.63, *p* = .035) than were families of children with Other Neurological Disorders (M = 4.90, *p* = .035). For item 8, families of children with CP were significantly less satisfied with service providers building on the child's strengths (M = 3.50, *p* =.008) than were families of children with OND (M = 4.90, *p* =.008). For item 9, families of children with CP were significantly less satisfied with service providers valuing the family opinion about their child's needs (M = 3.50, *p* =.031) than were families of children with OND (M = 4.80, *p* = .031). Comparisons among other groups indicated no significant differences (all *p*s > .05). Table 26 presents the analysis of variance group comparisons findings for all 9 items on the Child-Focused subscale mean scores according to type of disability.

Table 26

Mean Differences Analysis for Type of Disability Groups on Child-Focused Items

Comparisons	**Item 1**	**Item2**	**Item 3**	**Item4**	**Item5**	**Item6**	**Item7**	**Item8**	**Item9**
Groups	***p* value**	***p* value**	***p* value**	***p* value**	***p* value**	***p* value**	***p* value**	***p* value**	***p* value**
ASD vs. DS	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
ASD vs. CP	.427	.486	.824	.603	.333	1.000	1.000	.646	.811
ASD vs. OND	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
ASD vs. HI/VI	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
ASD vs. DLD	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
DS vs. CP	1.000	.777	1.000	1.000	1.000	1.000	.272	.326	.763
DS vs. OND	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
DS vs. HI/VI	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
DS vs. DLD	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
CP vs. OND	.222	.437	1.000	.260	**.035***	.265	.124	**.008***	**.031***
CP vs. HI/VI	1.000	1.000	1.000	.354	1.000	1.000	1.000	1.000	1.000
CP vs. DLD	.406	.238	1.000	1.000	.490	.265	.272	.326	.432
OND vs. HI/VI	1.000	1.000	1.000	1.000	1.000	1.000	.790	.700	.763
OND vs. DLD	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
HI/VI vs. DLD	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

*Significant difference at *p* < .05

Table 27

Mean Differences Analysis for Type of Disability Groups on Family-Focused Items

Comparisons **Groups**	**Item 10** ***p*** **value**	**Item11** ***p*** **value**	**Item 12** ***p*** **value**	**Item13** ***p*** **value**	**Item14** ***p*** **value**	**Item15** ***p*** **value**	**Item16** ***p*** **value**	**Item17** ***p*** **value**	**Item18** ***p*** **value**
ASD vs. DS	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
ASD vs. CP	.827	.991	.603	.080	.086	1.000	.133	**.041***	.231
ASD vs. OND	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
ASD vs. HI/VI	1.000	.669	1.000	1.000	1.000	1.000	1.000	1.000	1.000
ASD vs. DLD	1.000	.948	1.000	1.000	1.000	1.000	1.000	1.000	1.000
DS vs. CP	1.000	1.000	.448	.129	.309	1.000	1.000	.944	1.000
DS vs. OND	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
DS vs. HI/VI	1.000	.974	1.000	1.000	1.000	1.000	1.000	1.000	1.000
DS vs. DLD	1.000	.904	1.000	1.000	1.000	1.000	1.000	1.000	1.000
CP vs. OND	.186	.936	.448	.293	.309	1.000	**.047***	**.030***	.140
CP vs. HI/VI	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
CP vs. DLD	.687	.579	.825	.054	.651	1.000	**.047***	**.013***	.329
OND vs. HI/VI	.925	.296	1.000	1.000	1.000	1.000	.790	1.000	1.000
OND vs. DLD	1.000	.991	1.000	1.000	1.000	1.000	1.000	1.000	1.000
HI/VI vs. DLD	1.000	**.035***	1.000	1.000	1.000	1.000	1.000	1.000	1.000

*Significant difference at $p < .05$

Table 27 presents analysis of variance for all 9 items on the Family-Focused subscale mean scores among the six types of disability groups. Findings indicated statistically significant group differences for three items: item 11 (Available when family need them), item 16 (Is a person family can depend on and trust), and item 17 (Pays attention to what family have to say). Bonferroni post-hoc comparisons indicated that families of children with Hearing/Visual Impairment were significantly less satisfied with service providers are available when family need them (M = 3.63, *p* = .035) than were families of children with DLD (M = 4.80, *p* = .035). For item 16 (Is a person family can depend on and trust), families of children with CP were significantly less satisfied (M = 3.63, *p* =.047) than were families of children with OND (M = 4.80, *p* =.047) and families of children with DLD (M = 4.80, *p* =.047). Lastly, for item 17 (Pays attention to what family have to say), families of children with CP were significantly less satisfied (M = 3.50, *p* =.030) than were families of children with OND (M = 4.70, *p* =.030) and families of children with DLD (M = 4.80, *p* =.013). Comparisons among other groups indicated no significant differences (all *p*s > .05).

Satisfaction Ratings across Severity of Disability Groups

Using analysis of variance (ANOVA), mean differences in satisfaction ratings were examined across family groups according to the severity of child's disability: Mild (n = 12), Moderate (n = 36), and Severe (n = 9). A one-way ANOVA was used to analyze differences among the three groups for the: (a) overall Partnership Scale mean scores, (b) child-focused subscale mean scores, (c) family-focused subscale mean scores, and (d) for each of the 18 items in the Partnership Scale. Statistical significance was set at the 95% level ($p < 0.05$) and an alpha level of .05 was used for all analyses. Mean differences analysis among severity of disability groups on the overall Partnership Scale mean scores, child-focused subscale mean scores, and family-focused subscale mean scores are presented in Table 28.

Table 28

Mean Differences Analysis on Partnership Scale Satisfaction Ratings for Severity of Disability Group Comparisons

Comparisons Groups	**Mild** ***p* value**	**Moderate** ***p* value**	**Severe** ***p* value**
Overall Partnership Scale			
Mild		.250	.008*
Moderate			.005*
Child-Focused Subscale			
Mild		.332	.012*
Moderate			.012*
Family-Focused Subscale			
Mild		.219	.008*
Moderate			.003*

*Significant difference at $p < .05$

Table 28 presents the analysis of variance for the overall Partnership Scale mean scores, Child-Focused subscale mean scores, and Family-Focused subscale mean scores among the three family groups according to child’s severity of disability. ANOVA results highlighted statistically significant group differences in the overall satisfaction ratings. The Levene test for homogeneity of variance assumption was statistically significant (F =

5.41; *p* = .007) and the Bonferroni post hoc test for examining group differences was used. The overall F test (F (2, 54) = 4.93, *p* = .011) points to statistically significant differences among the severity of disability groups. Bonferroni post-hoc comparisons of the three groups indicate that families of children with mild disability were significantly less satisfied (M = 3.90, 95% CI [3.42, 4.38]) than were families of children with severe disability (M = 4.75, 95% CI [4.61, 4.89]), *p* = .008, for the overall Partnership Scale mean. In addition, families of children with moderate disability were significantly less satisfied (M = 4.33, 95% CI [4.12, 4.55]) than were families of children with severe disability (M = 4.75, 95% CI [4.61, 4.89]), *p* = .005, for the overall Partnership Scale mean.

For the child-focused satisfaction ratings, ANOVA results indicated significant group differences. The Levene test for homogeneity of variance assumption was statistically significant (F = 4.11; *p* = .022) and the Bonferroni post hoc test for examining group differences was used. The overall F test (F (2, 54) = 4.09, *p* = .022) points to statistically significant differences among the severity of disability groups. Bonferroni post-hoc comparisons of the three groups indicate that families of children with mild disability were significantly less satisfied (M = 3.90) than were families of children with severe disability (M = 4.75), *p* = .012, and families of children with moderate disability were significantly less satisfied (M = 4.33) than were families of children with severe disability (M = 4.75), *p* = .012, for the child-focused subscale.

For the family-focused satisfaction ratings, ANOVA results indicated significant group differences. The Levene test for homogeneity of variance assumption was statistically significant (F = 6.13; *p* = .004) and the Bonferroni post hoc test for examining group differences was used. The overall F test (F (2, 54) = 5.29, *p* = .008) points to statistically significant differences among the severity of disability groups. Bonferroni post-hoc comparisons of the three groups indicate that families of children with mild disability were significantly less satisfied (M = 3.90) than were families of children with severe disability (M = 4.75), *p* = .008, and families of children with moderate disability were significantly less satisfied (M = 4.33) than were families of children with severe disability (M = 4.75), *p* = .003, for the family-focused subscale.

Table 29

Mean Differences Analysis for Severity of Disability Groups on Child-Focused Items

Comparisons **Groups**	**Item 1** ***p* value**	**Item2** ***p* value**	**Item 3** ***p* value**	**Item4** ***p* value**	**Item5** ***p* value**	**Item6** ***p* value**	**Item7** ***p* value**	**Item8** ***p* value**	**Item9** ***p* value**
Mild vs. Moderate	1.000	.432	.008*	.135	.545	.593	.409	1.000	.633
Mild vs. Severe	.363	.088	.001*	.335	.045*	.016*	.144	.332	.024*
Moderate vs. Severe	.722	.572	.249	1.000	.042*	.000*	.908	.260	.002*

*Significant difference at *p* < .05

Table 29 presents analysis of variance for all 9 items on the Child-Focused subscale mean scores among the severity of disability groups. ANOVA findings indicated statistically significant group differences for four items: item 3 (Provides services that meet individual needs of child), item 5 (Let you know about the good things your child does), item 6 (Keep child safe when child in his/her care), and item 9 (Value your opinion about your child's needs). Bonferroni post-hoc comparisons indicated that families of children with mild disability were significantly less satisfied with service providers providing services that meet individual needs of child (M = 3.33) than were families of children with moderate disability (M = 4.06, *p* = .008) and families of children with severe disability (M = 4.44, *p* = .001). For item 5, families of children with mild disability were significantly less satisfied with service providers letting parents know about the good things their child does (M = 4.00, *p* =.045) than were families of children with severe disability (M = 4.89, *p* =.045), and families of children with moderate disability were significantly less satisfied (M = 4.42, *p* =.042) than were families of children with severe disability (M = 4.89, *p* =.042).

For item 6 (Keep child safe when child in their care) families of children with mild disability were significantly less satisfied (M = 4.25, *p* = .016) than were families of children with severe disability (M = 5.00, *p* =.016), and families of children with moderate disability were significantly less satisfied (M = 4.53, *p* <.001) than were families of children with severe disability (M = 5.00, *p* <.001). Lastly, for item 9 (Builds on child's strengths) families of children with mild disability were significantly less satisfied (M = 3.83, *p* =.024) than were families of children with severe disability (M = 4.89, *p* =.024), and families of children with moderate disability were significantly less satisfied (M = 4.22, *p* =.002) than were families of children with severe disability (M = 4.89, *p* =.002). Group comparisons on other items of the child-focused subscale indicated no significant differences (all *p*s > .05).

Analysis of variance for all 9 items on the Family-Focused subscale mean scores among the severity of disability groups indicated statistically significant group differences for five items: item 11 (Is available when you need them), item 12 (Use words that you understand), item 13 (Protect your family's privacy), item 15 (Listen without judging your child or family), and item 17 (Pays attention to what you have to say). Bonferroni post-hoc comparisons indicated that families of children with mild disability were significantly less satisfied that service providers are available when parents need them (M = 3.75) than were families of children with moderate disability (M = 4.25, *p* = .006) and families of children with severe disability (M = 4.89, *p* = .007). For item 12, families of children with mild disability were significantly less satisfied with service providers using words that parents understand (M = 3.83, *p* =.007) than were families of children with severe disability (M = 5.00, *p* =.007), and families of children with moderate disability were significantly less satisfied (M = 4.56, *p* =.001) than were families of children with severe disability (M = 5.00, *p* =.001).

For item 13, families of children with mild disability were significantly less satisfied with service providers protecting family's privacy (M = 3.83, *p* =.015) than were families of children with severe disability (M = 5.00, *p* =.015), and families of children with moderate disability were significantly less satisfied (M = 4.56, *p* =.025) than were families of children with severe disability (M = 5.00, *p* =.025). For item 15, families of children with mild disability were significantly less satisfied with service providers listening without judging child or family (M = 3.67) than were families of children with severe disability (M = 4.78, *p* =.009). Lastly, for item 17 (Pay attention to what you have to say) families of children with mild disability were significantly less satisfied (M = 3.92, *p* = .016) than were families of children with severe disability (M = 5.00, *p* =.016), and families of children with moderate disability were significantly less satisfied (M = 4.36, *p* <.001) than were families of children with severe disability (M = 5.00, *p* <.001). Group comparisons on other items of the family-focused subscale indicated no significant differences (all *p*s > .05). Table 30 provides findings of analysis of variance for all 9 items on the Family-Focused subscale mean scores among the severity of disability groups.

Table 30

Mean Differences Analysis for Severity of Disability Groups on Family-Focused Items

Comparisons **Groups**	**Item 10** ***p* value**	**Item11** ***p* value**	**Item 12** ***p* value**	**Item13** ***p* value**	**Item14** ***p* value**	**Item15** ***p* value**	**Item16** ***p* value**	**Item17** ***p* value**	**Item18** ***p* value**
Mild vs. Moderate	.946	.357	.114	.316	.215	.080	.350	.508	.595
Mild vs. Severe	.811	.006*	.007*	.015*	.208	.009*	.058	.016*	.083
Moderate vs. Severe	.948	.007*	.001*	.025*	1.000	.191	.479	.000*	.407

*Significant difference at $p < .05$

Family-Professional Partnership Self-Assessment

The Family-Professional Partnership Self-Assessment, which is the professional version of the Beach Center Family-Professional Partnership Scale, was completed by all sixty-six (66) participating service providers. The scale consist of 18-item that assess the attitudes and skills of a positive family-professional partnership and mirrors those in the family version of the scale. As with the family version of the Partnership Scale, means across items were calculated for each respondent to determine the total partnership scale score as well as the two subscale scores (Child-Focused Relationships Subscale and Family-Focused Relationships Subscale). Next, satisfaction ratings across service providers groups were calculated according to their discipline. Analyses of variance (ANOVA) for discipline groups were used to examine if there were significant differences in the mean satisfaction ratings between groups. Last, independent-samples t-test was used to examine if there were significant differences in the mean satisfaction ratings between families and service providers' samples.

The overall mean satisfaction rating across all 18 items of the Beach Center Family-Professional Partnership Self-Assessment for the entire service providers sample was 4.36 (SD = .46). The mean satisfaction ratings for the Child-Focused Relationships subscale (M = 4.38, SD = .53) were slightly greater than the mean satisfaction ratings for the Family-Focused Relationships subscale (M = 4.34, SD = .47). Concerning the two settings, the HMC service providers sample (n = 39) had a lower mean satisfaction ratings for the overall partnership scale (M = 4.31, SD = .54), child-focused subscale (M = 4.30, SD = .60), and the family-focused subscale (M = 4.32, SD = .54), than the Shafallah Center service providers sample (n = 27) (Overall Partnership Scale M = 4.43, SD = .29; Child-Focused Subscale M = 4.49, SD = .39; and Family-Focused Subscale M = 4.37, SD = .34).

Satisfaction ratings scores for all 18 items on the Family-Professional Partnership Self-Assessment ranged from 3.45 to 4.77; item 6 (keep child safe when in their care) had the highest satisfaction rating (M = 4.77, SD = 0.52) amongst service providers. In contrast, the item with the lowest satisfaction was item 11 concerning service providers are available when family need them (M = 3.45, SD = 1.32). Other items with low satisfaction ratings below the overall mean (M = 4.36) included: Helps parents gain the skills or information to be able to get what their child needs (M = 4.03, SD = 0.94); is honest with parents, even when I have bad news (M = 4.08, SD = 0.93); and treats children with dignity at all times (M = 4.14, SD = 1.01). Table 31 presents mean scores for service providers' satisfaction ratings for each item on the Partnership Scale.

Table 31

Satisfaction Ratings for All 18 Items on the Family-Professional Partnership Self-Assessment

Variable	M	SD
Child-Focused Relationships Subscale		
1. Help parents gain skills or information to get what your child needs	4.03	0.94
2. Have the skills to help children succeed	4.42	0.66
3. Provide services that meet the individual needs of each child	4.26	0.77
4. Speak up for children's best interests when working with other service providers	4.26	0.87
5. Let parents know about the good things their children do	4.64	0.60
6. Keep children safe at all times when in our care	4.77	0.52
7. Treat children with dignity at all times	4.14	1.01
8. Build on children's strengths	4.55	0.73
9. Value parents' opinions about children's needs	4.33	0.69
Family-Focused Relationships Subscale		
10. Honest, even when I have bad news	4.08	0.93
11. Available when parents need me	3.45	1.32
12. Use words that the parent understands	4.45	0.73
13. Protect the family's privacy	4.71	0.49
14. Show respect for the family's values and beliefs	4.62	0.58
15. Listen without judging the child or family	4.27	0.89
16. I am dependable	4.47	0.66
17. Pay attention to what parents have to say	4.58	0.56
18. Is friendly to parents	4.42	0.73

Table 32

Satisfaction Ratings on the Family-Professional Partnership Self-Assessment across Service Providers Groups According to Discipline

Variable	**Special Educators**		**Related Services Therapists**		**Paraprofessionals**		**Social & Health Services**	
	n=15		**n=31**		**n=11**		**n=9**	
	M	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**
Partnership Scale								
Overall	4.59	0.30	4.44	0.42	4.15	0.41	3.96	0.57
Child-focused	4.61	0.41	4.47	0.45	4.15	0.51	3.94	0.68
Family-focused	4.57	0.31	4.40	0.44	4.14	0.45	3.99	0.57
Child-Focused Relationships Subscale								
Item 1	4.07	1.22	4.29	0.64	3.27	1.01	4.00	0.87
Item 2	4.67	0.62	4.42	0.62	4.36	0.67	4.11	0.78
Item 3	4.67	0.49	4.39	0.72	3.73	0.65	3.78	0.97
Item 4	4.53	0.74	4.39	0.76	4.00	0.78	3.67	1.23
Item 5	4.80	0.41	4.74	0.51	4.36	0.67	4.33	0.87
Item 6	4.93	0.26	4.81	0.48	4.91	0.30	4.22	0.83
Item 7	4.40	1.12	4.23	0.81	4.09	0.83	3.44	1.42
Item 8	4.80	0.41	4.61	0.62	4.45	0.93	4.00	1.00
Item 9	4.67	0.49	4.35	0.66	4.18	0.87	3.89	0.60
Family-Focused Relationships Subscale								
Item 10	4.20	0.86	4.35	0.76	3.18	1.17	4.00	0.71
Item 11	3.80	1.37	3.42	1.36	3.00	1.34	3.56	1.01
Item 12	4.80	0.41	4.39	0.76	4.55	0.69	4.00	0.87
Item 13	4.87	0.35	4.68	0.48	4.91	0.30	4.33	0.71
Item 14	4.80	0.41	4.61	0.50	4.82	0.41	4.11	0.93
Item 15	4.53	0.52	4.42	0.89	3.73	1.20	4.00	0.71
Item 16	4.60	0.51	4.58	0.62	4.45	0.69	3.89	0.78
Item 17	4.80	0.41	4.61	0.50	4.55	0.52	4.11	0.78
Item 18	4.73	0.46	4.55	0.68	4.09	0.83	3.89	0.78

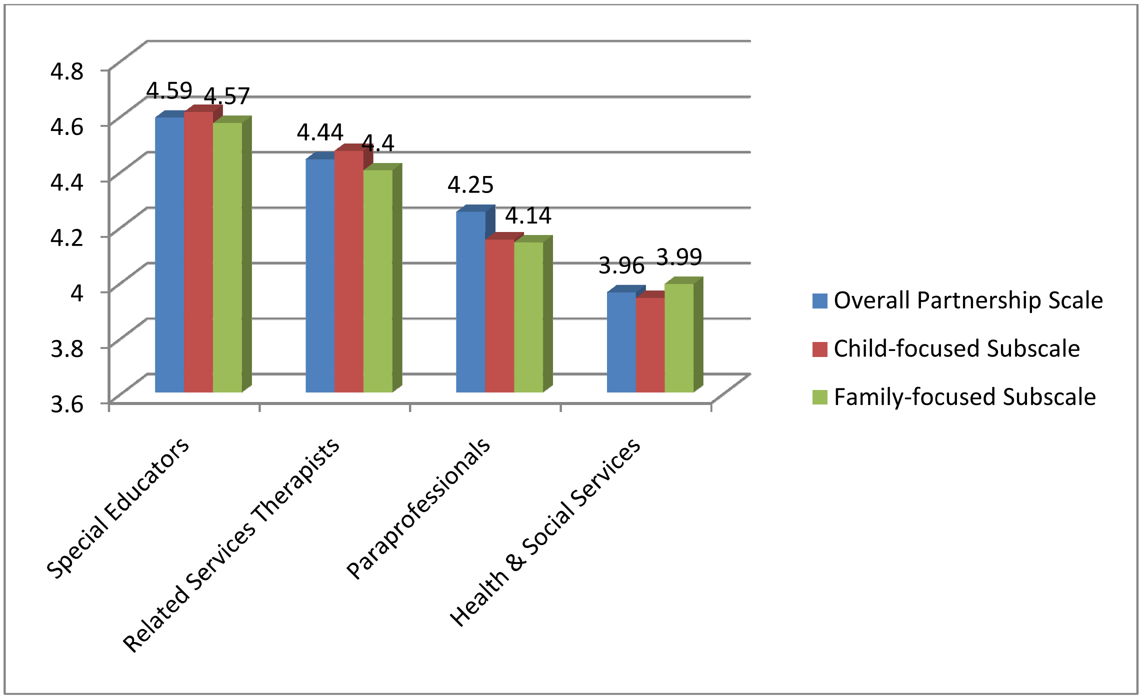
Table 32 presents descriptive statistics reported by the four service providers discipline groups of Special Educators, Related Services Therapists, Paraprofessionals, and Health and Social Services Providers, across all 18 items of the Family–Professional Partnership Self-Assessment. The highest overall mean satisfaction rating across all 18 items of the Partnership Self-Assessment was for special educators (M = 4.59, SD = 0.30), followed by related services therapists (M = 4.44, SD = 0.42). The lowest overall mean satisfaction rating was for health and social services providers (M = 3.96, SD = 0.57).

Concerning the two subscales: the highest mean satisfaction rating across all 9 items of the Child-focused Subscale and the Family-focused Subscale were for special educators with a mean scores of 4.61 and 4.57 respectively (M = 4.61, SD = 0.41; M = 4.57, SD = 0.31). Health and social services providers had the lowest satisfaction ratings for both the Child-focused (M = 3.94, SD = 0.68) and Family-focused subscales. (M = 3.99, SD = 0.57). Service providers ranged in mean satisfaction ratings across all 18 items on the Partnership Self-Assessment with mean satisfaction ratings ranged from 3.00 to 4.93. The lowest mean satisfaction rating score was for paraprofessionals on item 11 (Available when parents need me) and the highest mean satisfaction rating score was for special educators on item 6 (Keep children safe at all times when in our care). Other low mean score satisfaction ratings were for paraprofessionals on item 10 concerning service providers honest even with bad news (M = 3.18, SD = 1.17) and item 1 concerning service providers helping parents gain skills or information to get what your child needs (M = 3.27, SD = 1.01). Moreover, other high mean score satisfaction ratings were for paraprofessionals on item 6 (Keeps children safe at all times when in our care) and item

13 (Protect the family's privacy) with a mean score of 4.91 for both items (M = 4.91, SD = 0.30). Also, special educators had a high mean score satisfaction ratings on item 13 concerning protecting the family's privacy (M = 4.87, SD = 0.35). A noteworthy mean satisfaction rating scores (M = 4.80, SD = 0.41) were reported by special educators on the following items: (a) item 5 (Let parents know about the good things their children do); (b) item 8 (Build on children's strengths); (c) item 12 (Use words that the parent understands); (d) item 14 (Show respect for the family's values and beliefs); and (e) item 17 (Pay attention to what parents have to say). Figure 12 provides a visual representation of mean satisfaction ratings across the four service providers groups for the overall partnership scale, child-focused relationships subscale, and family-focused relationships subscale.

<u>Figure 12</u>

Satisfaction Ratings across Service Providers Groups According to Discipline (N = 66)



Satisfaction Ratings across Discipline Groups

Using analysis of variance (ANOVA), mean differences in satisfaction ratings were examined across service providers groups according to their discipline: Special educators, related services therapists, paraprofessionals, and health and social services providers. A one-way ANOVA was used to analyze differences among the four groups for the: (a) overall Partnership Self-Assessment Scale mean scores, (b) child-focused subscale mean scores, (c) family-focused subscale mean scores, and (d) for each of the 18 items in the Partnership Self-Assessment Scale. Statistical significance was set at the 95% level ($p < 0.05$) and an alpha level of .05 was used for all analyses. Mean differences analysis among discipline groups on the overall Partnership Scale mean scores, child-focused subscale mean scores, and family-focused subscale mean scores are presented in Table 33-35.

Table 33

Mean Differences Analysis on Overall Partnership Self-Assessment Scale Satisfaction Ratings for Service Providers Discipline Group Comparisons

Variable	**Special Educators**	**Related Services Therapists**	**Paraprofessionals**	**Health & Social Services**
	***p* value**	***p* value**	***p* value**	***p* value**
Special Educators		1.000	.055	.004*
Related Services Therapists			.317	.024*
Paraprofessionals				1.000

*Significant difference at $p < .05$

Table 33 presents the analysis of variance for the overall Partnership Self-Assessment Scale mean scores among the service providers groups. ANOVA results highlighted statistically significant group differences in the overall satisfaction ratings. The overall F test (F (3, 62) = 5.57, *p* = .002) points to statistically significant differences among the discipline groups. Bonferroni post-hoc comparisons of the four groups indicate that health and social services providers were significantly less satisfied (M = 3.96, 95% CI [3.52, 4.40]) than were special educators (M = 4.59, 95% CI [4.43, 4.76]), *p* = .004, for the overall Partnership Scale mean. Health and social services providers were also significantly less satisfied (M = 3.96, 95% CI [3.52, 4.40]) than were related services therapists (M = 4.44, 95% CI [4.28, 4.59]), *p* = .024, for the overall Partnership Scale mean.

Table 34

Mean Differences Analysis on Child-Focused Subscale Satisfaction Ratings for Service Providers Discipline Group Comparisons

Variable	**Special Educators** *p* **value**	**Related Services Therapists** *p* **value**	**Paraprofessionals** *p* **value**	**Health & Social Services** *p* **value**
Special Educators		1.000	.121	.010*
Related Services Therapists			.414	.034*
Paraprofessionals				1.000

*Significant difference at $p < .05$

Table 34 presents the analysis of variance for the Child-Focused subscale mean scores among the service providers groups. ANOVA results highlighted statistically significant group differences in the overall satisfaction ratings. The overall F test (F (3, 62) = 4.74, $p = .005$) points to statistically significant differences among the discipline groups. Bonferroni post-hoc comparisons of the four groups indicate that health and social services providers were significantly less satisfied (M = 3.94, 95% CI [3.42, 4.51]) than were special educators (M = 4.61, 95% CI [4.39, 4.84]), $p = .010$, and related services therapists (M = 4.47, 95% CI [4.30, 4.64]), $p = .034$, for the child-focused subscale mean.

Table 35

Mean Differences Analysis on Family-Focused Subscale Satisfaction Ratings for Service Providers Discipline Group Comparisons

Variable	**Special Educators**	**Related Services Therapists**	**Paraprofessionals**	**Health & Social Services**
	***p* value**	***p* value**	***p* value**	***p* value**
Special Educators		1.000	.094	.014*
Related Services Therapists			.559	.087
Paraprofessionals				1.000

*Significant difference at $p < .05$

Table 35 presents the analysis of variance for the Family-Focused subscale mean scores among the service providers groups. ANOVA results highlighted statistically significant group differences in the overall satisfaction ratings. The overall F test (F (3, 62) = 4.35, $p = .008$) points to statistically significant differences among the discipline groups. Bonferroni post-hoc comparisons of the four groups indicate that health and social services providers were significantly less satisfied (M = 3.99, 95% CI [3.55, 4.43]) than were special educators (M = 4.57, 95% CI [4.40, 4.74]), *p* = .014, for the family-focused subscale mean.

Table 36

Mean Differences Analysis for Service Providers Discipline Groups on Child-Focused Items

Comparisons **Groups**	**Item 1** ***p* value**	**Item2** ***p* value**	**Item 3** ***p* value**	**Item4** ***p* value**	**Item5** ***p* value**	**Item6** ***p* value**	**Item7** ***p* value**	**Item8** ***p* value**	**Item9** ***p* value**
SPED vs. Therapists	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	.827
SPED vs. Para	.173	1.000	.008*	.673	.377	1.000	1.000	1.000	.412
SPED vs. H&S	1.000	.285	.023*	.099	.367	.005*	.149	.053	.041*
Therapists vs. Para	.011*	1.000	.056	1.000	.408	1.000	1.000	1.000	1.000
Therapists vs. H&S	1.000	1.000	.150	.155	.406	.012*	.242	.146	.400
Para vs. H&S	.450	1.000	1.000	1.000	1.000	.013*	.896	.926	1.000

Abbreviation: SPED = Special Educators, Therapists = Related Services Therapists, Para = Paraprofessionals, H&S = Health and Social Services Providers

*Significant difference at $p < .05$

Table 36 presents results from an analysis of variance for all 9 items on the Child-Focused subscale mean scores amongst the four discipline specific groups. ANOVA findings indicated statistically significant group differences for four items: (a) item 1 (Help parents gain skills or information to get what your child needs); (b) item 3 (Provides services that meet individual needs of each child); (c) item 6 (Keep children safe at all times when in our care); and (d) item 9 (Value parents' opinions about children's needs). Bonferroni post-hoc comparisons indicated that paraprofessionals were significantly less satisfied with helping parents gain skills or information to get what your child needs (M = 3.27) than were related services therapists (M = 4.29, *p* = .011). For item 3, paraprofessionals (M = 3.73, *p* =.008) and health and social services providers (M = 3.78, *p* =.023) were significantly less satisfied with providing services that meet individual needs of each child than were special educators (M = 4.67). For item 6, health and social services providers (M = 4.22) were less satisfied with keeping children safe at all times when in their care than were special educators (M = 4.93, *p* =.005), paraprofessionals (M = 4.91, p = .013), and related services therapists (M = 4.81, *p* = .012). Lastly, for item 9 (Value parents' opinions about children's needs) health and social services personnel were less satisfied (M = 3.89, *p* = .041) than were special educators (M = 4.67, *p* = .041). Group comparisons on other items of the child-focused subscale indicated no significant differences (all *p*s > .05).

Table 37

Mean Differences Analysis for Service Providers Discipline Groups on Family-Focused Items

Comparisons Groups	**Item 10 *p* value**	**Item11 *p* value**	**Item 12 *p* value**	**Item13 *p* value**	**Item14 *p* value**	**Item15 *p* value**	**Item16 *p* value**	**Item17 *p* value**	**Item18 *p* value**
SPED vs. Therapists	1.000	1.000	.395	1.000	1.000	1.000	1.000	1.000	1.000
SPED vs. Para	.023*	.793	1.000	1.000	1.000	.125	1.000	1.000	.119
SPED vs. H&S	1.000	1.000	.053	.051	.023*	.868	.058	.018*	.026*
Therapists vs. Para	.001*	1.000	1.000	.965	1.000	.148	1.000	1.000	.352
Therapists vs. H&S	1.000	1.000	.899	.332	.105	1.000	.032*	.090	.075
Para vs. H&S	.221	1.000	.531	.046*	.031*	1.000	.305	.436	1.000

*Significant difference at $p < .05$

Table 37 presents analysis of variance for all 9 items on the Family-Focused subscale mean scores among the four groups. ANOVA findings indicated statistically significant group differences for four items: (a) item 10 (Honest, even when I have bad news); (b) item 13 (Protect the family's privacy); (c) item 14 (Show respect for the family's values and beliefs); (d) item 16 (I am dependable); (e) item 17 (Pay attention to what parents have to say); and (f) item 18 (Is friendly to parents). Bonferroni post-hoc comparisons indicated that paraprofessionals were significantly less satisfied with their ability to be honest with parents (M = 3.18) than were related services therapists (M = 4.35, *p* = .001), and special educators (M = 4.20, *p* = .023). For item 13, health and social services providers (M = 4.33, *p* =.046) were significantly less satisfied with protecting the family's privacy than were paraprofessionals (M = 4.91, *p* =.046).

For item 14, health and social services providers (M = 4.11) were less satisfied with showing respect for the family's values and beliefs than were special educators (M = 4.80, *p* =.023) and paraprofessionals (M = 4.82, *p* = .031). For item 16 (I am dependable), health and social services providers were significantly less satisfied (M = 3.89, *p* = .032) than were special educators (M = 4.60). Health and social services provides were also significantly less satisfied (M = 4.11, *p* = .018) with paying attention to what parents have to say than were special educators (M = 4.80). Finally, health and social services provides were significantly less satisfied with being friendly to parents (M = 3.89, *p* = .026) than were special educators (M = 4.73). Group comparisons on other items of the child-focused subscale indicated no significant differences (all *p*s > .05).

Satisfaction Ratings across Families and Service Providers Groups

An independent samples t-test was conducted to examine differences in the satisfaction ratings mean scores among service providers and families of young children with disabilities. Statistical significance was set at the 95% level ($p < 0.05$) and an alpha level of .05 was used for all analyses. Independent samples t-test analyses were conducted to examine differences among the two groups for the: (a) overall Partnership Scale mean scores, (b) child-focused subscale mean scores, (c) family-focused subscale mean scores, and (d) for each of the 18 items in the Partnership Scale. Mean differences analysis among the two groups on the overall Partnership Scale mean scores, child-focused subscale mean scores, and family-focused subscale mean scores are presented in Table 38.

Table 38

Mean Differences Analysis for Service Providers Discipline Groups on Family-Focused Items

Variable	**Service Providers** **n = 66, M (SD)**	**Families** **n = 57, M (SD)**	**t value**	**df**	***p* value**
Overall	4.36 (.46)	4.31 (.66)	.495	121	.622
Child-Focused	4.38 (.53)	4.23 (.70)	1.29	121	.201
Family-Focused	4.34 (.47)	4.38 (.65)	-.385	121	.701

As seen in Table 38, findings of the independent samples t-test analysis indicated no significant differences in the overall partnership mean scores for service providers (M =4.36, SD = .46) and families of young children with disabilities (M = 4.31, SD = .66); t (121) = .495, *p* = .622. With regard to the child-focused subscale mean scores, the t-test demonstrated no significant difference (t (121) = 1.29, *p* = .201) between the mean score in the service providers group (M = 4.38, SD = .53) and families group (M = 4.23, SD = .70). Likewise, there was no significant difference (t (121) = -.385, p = .701) between the mean score in the service providers group (M = 4.34, SD = .47) and families group (M = 4.38, SD = .65) on the family-focused-subscale mean scores.

To further investigate the differences between the two samples, independent samples t-tests was conducted for all 18 items in the Partnership Scales. The t-test analyses demonstrated significant differences between families of young children with disabilities and service providers on 6 items including: item 4 (Speak up for children's best interests when working with other service providers), item 6 (Keep children safe at all times when in our care), item 7(Treat children with dignity at all times), item 11 (Available when parents need me), 13 (Protect the family's privacy), and item 14(Show respect for the family's values and beliefs). The t-tests also demonstrated no significant difference between the two groups for the other items on the Partnership Scale. Mean differences analysis among the two groups on all items of the child-focused subscale mean scores and family-focused subscale mean scores are presented in Table 39-40.

Independent Samples t-tests findings for the Child-Focused Subscale indicated families of young children with disabilities were significantly less satisfied (M = 3.61, t (121) = 3.84, *p* < .001) with service providers speaking up for children's best interests when working with other service providers than were services provides (M = 4.28). T-tests results also indicates a statistically significant difference (t (121) = 2.24, p = .027) for item 6 (Keep children safe at all times when in our care) between the mean score in the service providers group (M = 4.77, SD = .52) and families group (M = 4.54, SD = .60). Lastly, service providers were significantly less satisfied (M = 4.14, SD = 1.01, t (121) = -2.82, *p* = .006) with their ability to treat children with dignity at all times than were families of young children with disabilities (M = 4.58, SD = .73).

Table 39

Mean Differences Analysis on Child-Focused Subscale for Service Providers and Families Group Comparisons

Variable	**Service Providers n = 66, M (SD)**	**Families n = 57, M (SD)**	**t value**	**df**	***p* value**
Item 1	4.03 (.94)	4.07 (.88)	-.241	121	.810
Item 2	4.42 (.66)	4.23 (.87)	1.43	121	.157
Item 3	4.26 (.77)	4.12 (.95)	.870	121	.386
Item 4	4.26 (.87)	3.61 (.99)	3.84	121	.000*
Item 5	4.64 (.60)	4.40 (.88)	1.68	121	.095
Item 6	4.77 (.52)	4.54 (.60)	2.24	121	.027*
Item 7	4.14 (1.01)	4.58 (.73)	-2.82	121	.006*
Item 8	4.55 (.73)	4.30 (.87)	1.72	121	.088
Item 9	4.33 (.69)	4.25 (.89)	.615	121	.540

*Significant difference at *p* < .05

T-tests conducted on the Family-Focused Subscale indicated service providers were significantly less satisfied (M = 3.45, t (121) = -3.86, *p* < .001) with item 11 (Available when family need me) than were families (M = 4.25). T-tests results also indicates a statistically significant difference (t (121) = 2.62, p = .010) for item 13 (Protect the family's privacy) between the mean score in the service providers group (M = 4.71, SD = .49) and families group (M = 4.42, SD = .71). Lastly, families were significantly less satisfied (M = 4.35, t (121) = 2.33, *p* = .022) with service providers showing respect for the family's values and beliefs than were service providers (M = 4.62).

Table 40

Mean Differences Analysis on Family-Focused Subscale for Service Providers and Families Group Comparisons

Variable	**Service Providers n = 66, M (SD)**	**Families n = 57, M (SD)**	**t value**	**df**	***p* value**
Item 10	4.08 (.93)	4.30 (.80)	-1.41	121	.162
Item 11	3.45 (1.32)	4.25 (.95)	-3.86	121	.000*
Item 12	4.45 (.73)	4.47 (.80)	-.139	121	.890
Item 13	4.71 (.49)	4.42 (.71)	2.62	121	.010*
Item 14	4.62 (.58)	4.35 (.70)	2.33	121	.022*
Item 15	4.27 (.89)	4.32 (.81)	-.280	121	.780
Item 16	4.47 (.66)	4.42 (.87)	.353	121	.725
Item 17	4.58 (.56)	4.37 (.86)	1.56	121	.122
Item 18	4.42 (.73)	4.53 (.66)	-.813	121	.418

*Significant difference at *p* < .05

Satisfaction Ratings across Settings

An independent samples t-test was conducted to examine differences in the satisfaction ratings mean scores for service providers and families of young children with disabilities across the two settings, HMC and Shafallah Center. Statistical significance was set at the 95% level ($p < 0.05$) and an alpha level of .05 was used for all analyses. As with the previous analyses, independent samples t-test analyses were conducted to examine differences among the two settings for the: (a) overall Partnership Scale mean scores, (b) child-focused subscale mean scores, (c) family-focused subscale mean scores, and (d) across all 18 items in the Partnership Scale. Mean differences analysis among the two settings on the overall Partnership Scale mean scores, child-focused subscale mean scores, and family-focused subscale mean scores are presented in Table 41.

Table 41

Mean Differences Analysis on Partnership Satisfaction Ratings Across Settings

Variable	**HMC** n = 85, M (SD)	**Shafallah Center** n = 38, M (SD)	**t value**	**df**	***p* value**
Overall	4.32 (.60)	4.37 (.45)	-.503	121	.616
Child-Focused	4.28 (.65)	4.37 (.54)	-.761	121	.448
Family-Focused	4.35 (.60)	4.37 (.46)	-.168	121	.867

As seen in Table 41, findings of the independent samples t-test analysis indicated no significant differences in the overall partnership mean scores for HMC sample (M =4.32, SD = .60) and Shafallah Center Sample (M = 4.37, SD = .45); t (121) = -.503, *p* = .616. With regard to the child-focused subscale mean scores, the t-test demonstrated no significant difference (t (121) = -.761, *p* = .448) between the mean score in the HMC group (M = 4.28, SD = .65) and Shafallah Center group (M = 4.37, SD = .54). Likewise, there was no significant difference (t (121) = -.168, p = .867) between the mean score in the HMC group (M = 4.35, SD = .60) and Shafallah Center group (M = 4.37, SD = .46) on the family-focused-subscale mean scores.

A follow-up independent samples t-test across the two settings for all the 18 items in the Partnership Scale indicated a statistically significant difference between the two settings for items: item 10 (Is honest, even when there is bad news), item 12 (Uses words that family understands), and item 13 (Protects family's privacy). T-tests indicated respondents from Shafallah Center were significantly less satisfied (M = 3.82, t (121) = 3.18, *p* = .002) with item 10 (Is honest, even when there is bad news) than were respondents from HMC (M = 4.34, SD = .75). Findings also points to a statistically significant difference (t (121) = -2.34, *p* = .021) for item 12 (Uses words that family understands) between the mean score in HMC group (M = 4.38, SD = .85) and Shafallah Center group (M = 4.66, SD = .48) with HMC group being less satisfied than Shafallah Center group. Lastly, respondents from HMC were significantly less satisfied (M = 4.49, t (121) = -2.68, *p* = .009) with service providers protecting family's privacy than were respondents from Shafallah Center (M = 4.76). No significant differences were found for group comparisons on other items (all *p*s > .05). Results are presented in Table 42.

Table 42

Mean Differences Analysis on All 18 Items of Partnership Scale Across Settings

Variable	**HMC** **n = 85, M (SD)**	**Shafallah Center** **n = 38, M (SD)**	**t value**	**df**	***p* value**
Item 1	4.14 (.82)	3.84 (1.08)	1.69	121	.093
Item 2	4.29 (.77)	4.42 (.76)	-.850	121	.397
Item 3	4.18 (.88)	4.24 (.82)	-.360	121	.719
Item 4	3.86 (1.01)	4.18 (.87)	-1.72	121	.088
Item 5	4.51 (.78)	4.58 (.68)	-.498	121	.620
Item 6	4.64 (.60)	4.74 (.50)	-.916	121	.362
Item 7	4.33 (.93)	4.37 (.88)	-.218	121	.828
Item 8	4.34 (.85)	4.63 (.63)	-2.10	121	.063
Item 9	4.26 (.83)	4.37 (.68)	-.713	121	.447
Item 10	4.34 (.75)	3.82 (1.04)	3.18	121	.002*
Item 11	3.85 (1.23)	3.76 (1.22)	.315	121	.726
Item 12	4.38 (.85)	4.66 (.48)	-2.34	121	.021*
Item 13	4.49 (.67)	4.76 (.43)	-2.68	121	.009*
Item 14	4.44 (.68)	4.63 (.54)	-1.71	121	.091
Item 15	4.32 (.85)	4.24 (.85)	.488	121	.627
Item 16	4.45 (.79)	4.45 (.69)	-.002	121	.998
Item 17	4.45 (.75)	4.55 (.65)	-.753	121	.453
Item 18	4.47 (.70)	4.47 (.69)	-.023	121	.982

*Significant difference at $p < .05$

Family Outcomes Survey

All fifty-seven families of young children with disabilities completed the Family Outcomes Survey (FOS). The FOS consisted of 15 items, 3 items for each of the five family outcomes, and 3 additional items that provided information about family's perception of the efficacy of EI/ECSE programs in meeting their needs. A number of analyses were conducted to address data collected on the FOS. First, descriptive statistics, including means and standard deviations, were calculated for each item on the FOS and the five outcome areas to provide a description of the outcomes reported by families as a whole and in each group according to child's type of disability. Second, an overall achievement of family outcomes for the total FOS was calculated for the total family respondents and the six types of disability groups. Finally, the percentages of families below and above cut-off point were calculated for each item on the FOS, the five family outcomes, and attainment of all outcomes.

Mean scores for each of the 15 items on the FOS were calculated and are presented in Table 43. The highest rated item was item 5 (comfortable participating in meetings; M = 5.07, SD = 1.99), whereas the lowest rated item was item 15 (child participates in activities; M = 2.77, SD = 1.35). Other highest rated items were item 9 (help child learn and practice new skills; M = 4.39, SD = 1.63), item 10 (has support; M = 4.26, SD = 2.32), and item 13 (has access to medical care; M = 4.26, SD = 1.75). Other lowest rated items were item 6 (knows rights; M = 3.14, SD = 2.11) and item 7 (helps child develop and learn; M = 3.42, SD = 1.90). Figure 13 provides a chart graph representation of mean scores for each of the 15 items on the FOS.

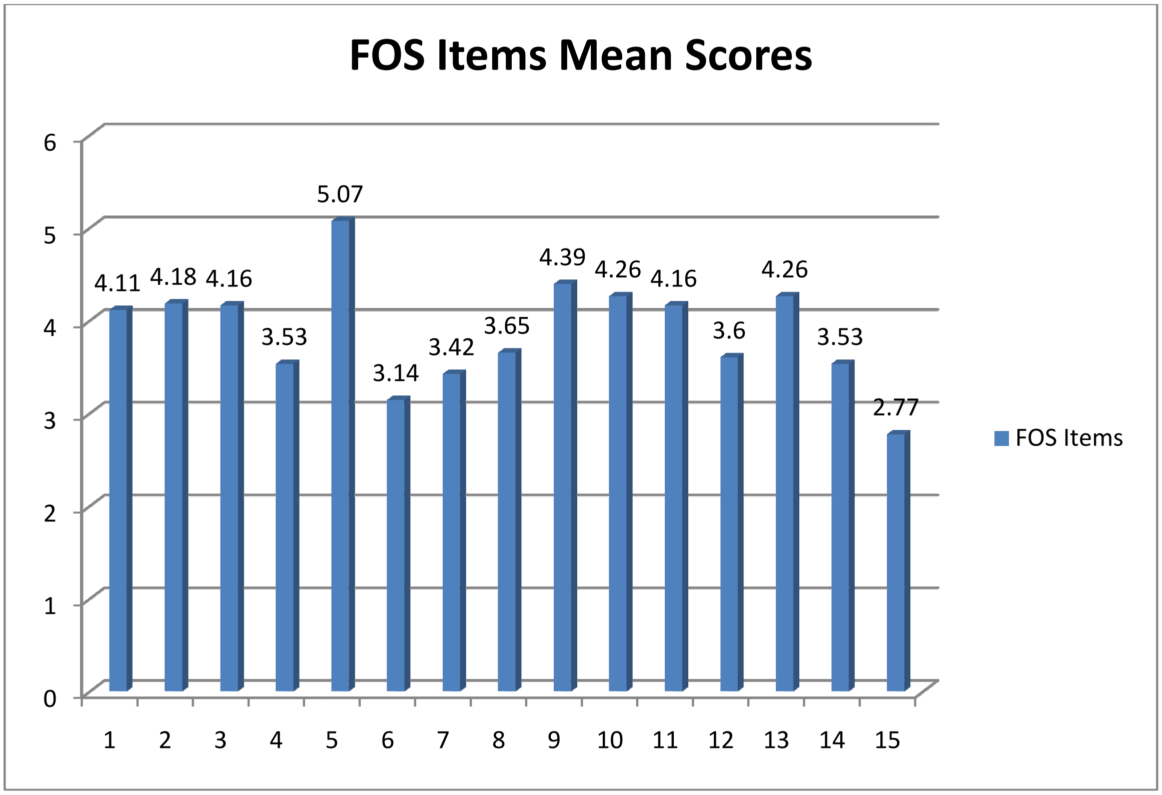
Table 43

Mean Scores for Each Item on the Family Outcomes Survey

Variable	**M (SD)**	**Cut-off Score**	
		% Above	**% Below**
1. Understands child’s development	4.11 (1.74)	51%	44%
2. Understands child’s special needs	4.18 (1.56)	42%	47%
3. Understands child’s progress	4.16 (1.84)	56%	37%
4. Know about services	3.53 (2.03)	60%	35%
5. Comfortable participating in meetings	5.07 (1.99)	25%	70%
6. Know rights	3.14 (2.11)	70%	26%
7. Help child develop and learn	3.42 (1.90)	67%	32%
8. Help child behave	3.65 (2.12)	61%	37%
9. Help child learn and practice new skills	4.39 (1.63)	40%	53%
10. Have support	4.26 (2.32)	40%	56%
11. Someone to call for help	4.16 (2.17)	47%	51%
12. Able to do things family enjoys	3.60 (1.78)	67%	30%
13. Access to medical care	4.26 (1.75)	39%	56%
14. Access to child care	3.53 (1.31)	77%	19%
15. Child participates in activities	2.77 (1.35)	83%	12%
16. Early intervention helped family know rights	4.14 (1.73)	42%	49%
17. EI helped family communicate child’s needs	4.40 (1.56)	37%	53%
18. EI helped family help child develop and learn	4.67 (1.44)	33%	60%

Figure 13

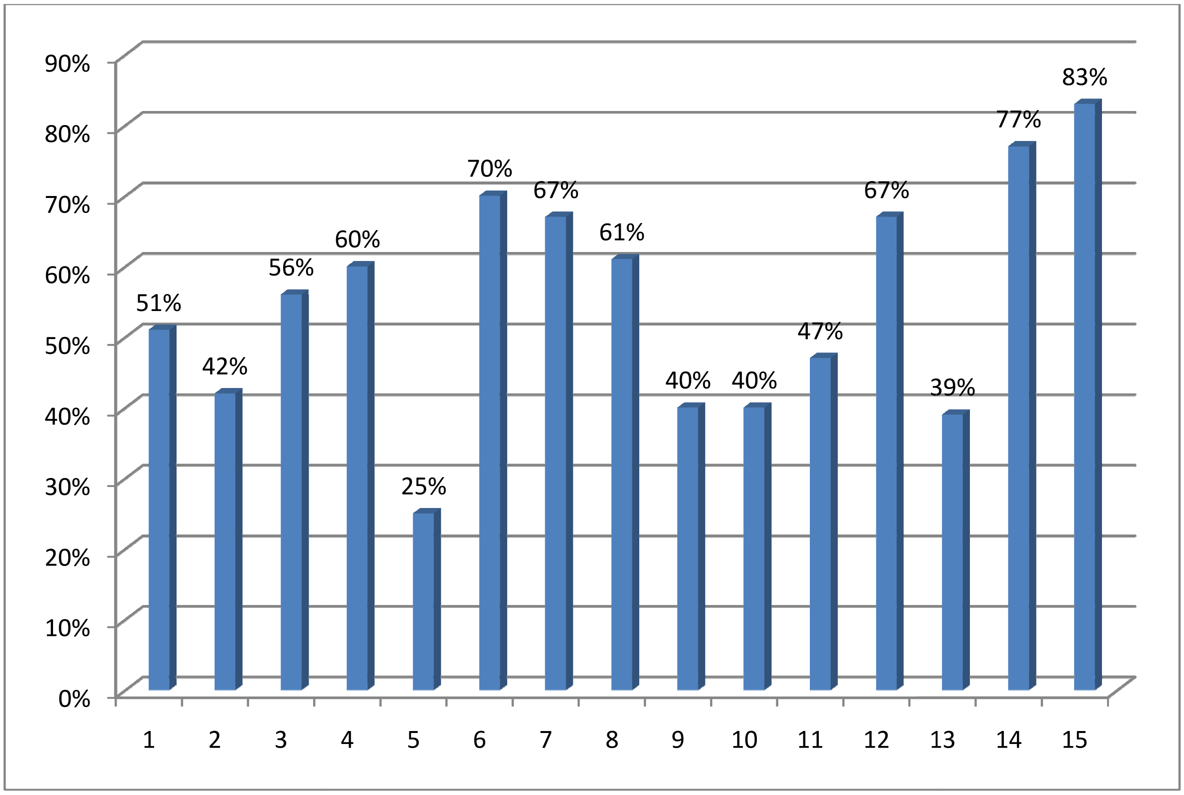
Mean Scores for All 15 Items on FOS



To calculate the percentages of families who achieved an outcome, a cut-off point of a score of 5 or higher was used as an indicator of achievement of an outcome. The data in Table 42 for items 1 to 15 demonstrated that families had the highest achievement of outcomes on items 15 (child participates in activities) with eighty-three percent (83%) of families scored 5 or greater. Followed by item 14 (access to child care) where seventy-seven percent (77%) of families scored above the cut-off score, and item 6 (know rights) with seventy percent (70%) of families scored above the cut-off score. Figure 14 presents a visual presentation of the percentages of families responding 5 or higher on each item on the FOS.

Figure 14

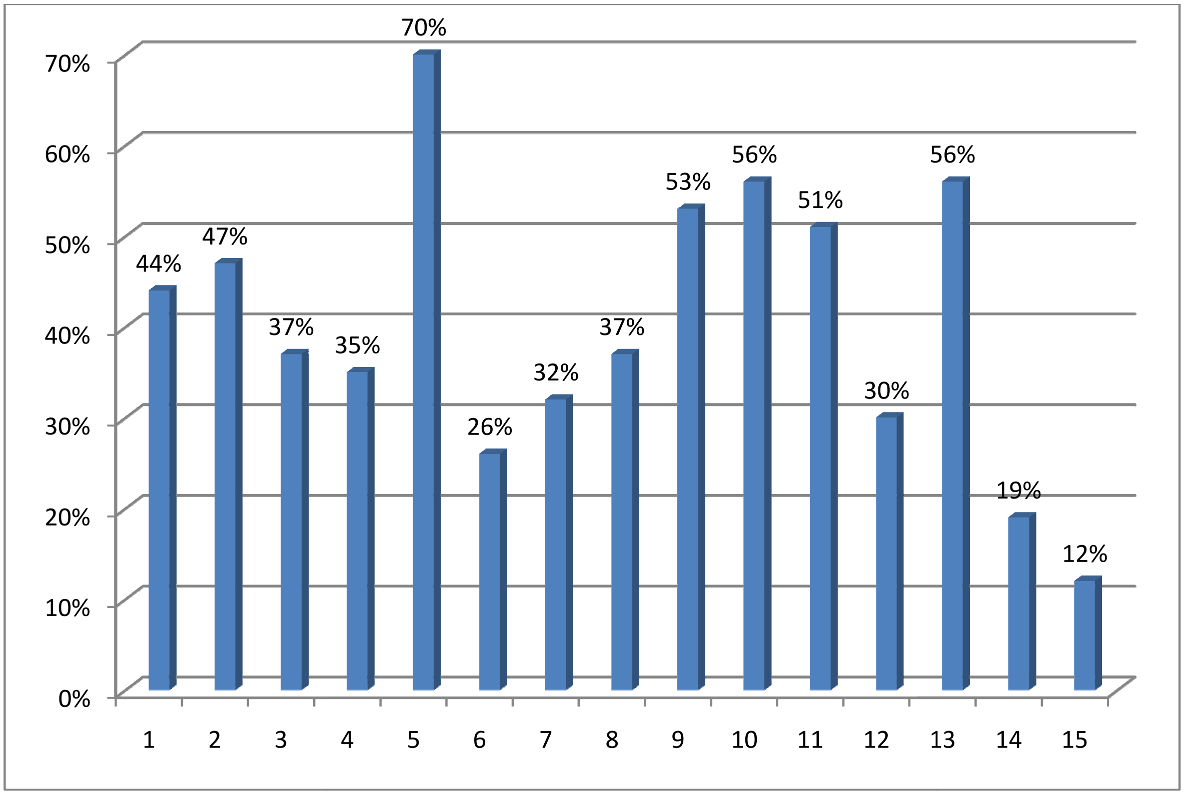
Percentages of families responding 5 or higher on each item on the FOS



In addition to the percentages of families who achieved an outcome (scored above cut-off point), the percentages of families who scored 3 or lower were calculated. The data in Table 42 for items 1 to 15 demonstrated that items with the largest percentages of families rating themselves 3 or lower include: Item 5 (comfortable participating in meetings) with seventy percent (70%) of families below the cut-off point, followed by item 10 (have support) and item 13 (access to medical care) with fifty-six percent (56%) of families scoring below the cut-off point for both items. Figure 15 presents a visual presentation of the percentages of families responding 3 or lower on each item on the FOS.

Figure 15

Percentages of families responding 3 or lower on each item on the FOS



Concerning the last three items on the FOS that examine families' perceptions of the helpfulness of EIEC, findings indicated that forty-two (42%) of families scored above the cut-off point on item 16 (EIEC helped family know rights), followed by thirty-seven percent (37%) of families on item 17 (EIEC helped family communicate child's needs), and thirty-three percent (33%) of families on item 18 (EIEC helped family help child develop and learn). In contrast sixty percent (60%) of families scored below the cut-off point on item 18, followed by fifty-three (53%) of families on item 17, and forty-nine percent (49%) of families on item 16.

The Five Family Outcomes

Mean scores for each of the five family outcomes were calculated and are presented in Table 44. The highest mean score (M = 4.15, SD = 1.42) was for outcome 1 (understands child's strengths, abilities, and needs), whereas the lowest mean score (M = 3.65, SD = 1.32) was for outcome 5 (accessing desired services in the community). The mean score for outcome 2 (knowing rights and advocating effectively) was 3.91, mean score for outcome 3 (helping child develop and learn) was 3.82, and mean score for outcome 4 (having support systems) was 3.65.

Table 44

Mean Scores on the Five Family Outcomes

Variable	**M (SD)**	**Cut-off Score**	
		% Above	**% Below**
1. Understands child's strengths, abilities, & needs	4.15 (1.42)	35%	35%
2. Knowing rights and advocating effectively	3.91 (1.54)	40%	33%
3. Helping child develop and learn	3.82 (1.54)	49%	30%
4. Having support systems	4.01 (1.67)	39%	35%
5. Accessing desired services in the community	3.65 (1.32)	45%	17%
Overall achievement of family outcomes	3.91 (1.15)	39%	32%

With regard to achievement of outcomes, approximately one-third (35%) of participating families reported achievement of outcome 1 (understands child's strengths, abilities, and needs), forty percent (40%) of families reported achievement of outcome 2 (knowing rights and advocating effectively), whereas approximately half of the families (49%) achieved outcome 3 (help child develop and learn). Only thirty-nine percent (39%) of families indicated achievement of outcome 4 (having support systems), and forty-five percent (45%) of families achieved outcome 5 (accessing desired services in the community). Lastly, only thirty-nine percent (39%) of families indicated an overall achievement of the five family outcomes. Figure 16 provides a visual presentation of the percentages of families who achieved each outcome by scoring a 5 or higher on each item on each outcome.

<u>Figure 16</u>

Percentages of families who achieved each outcome

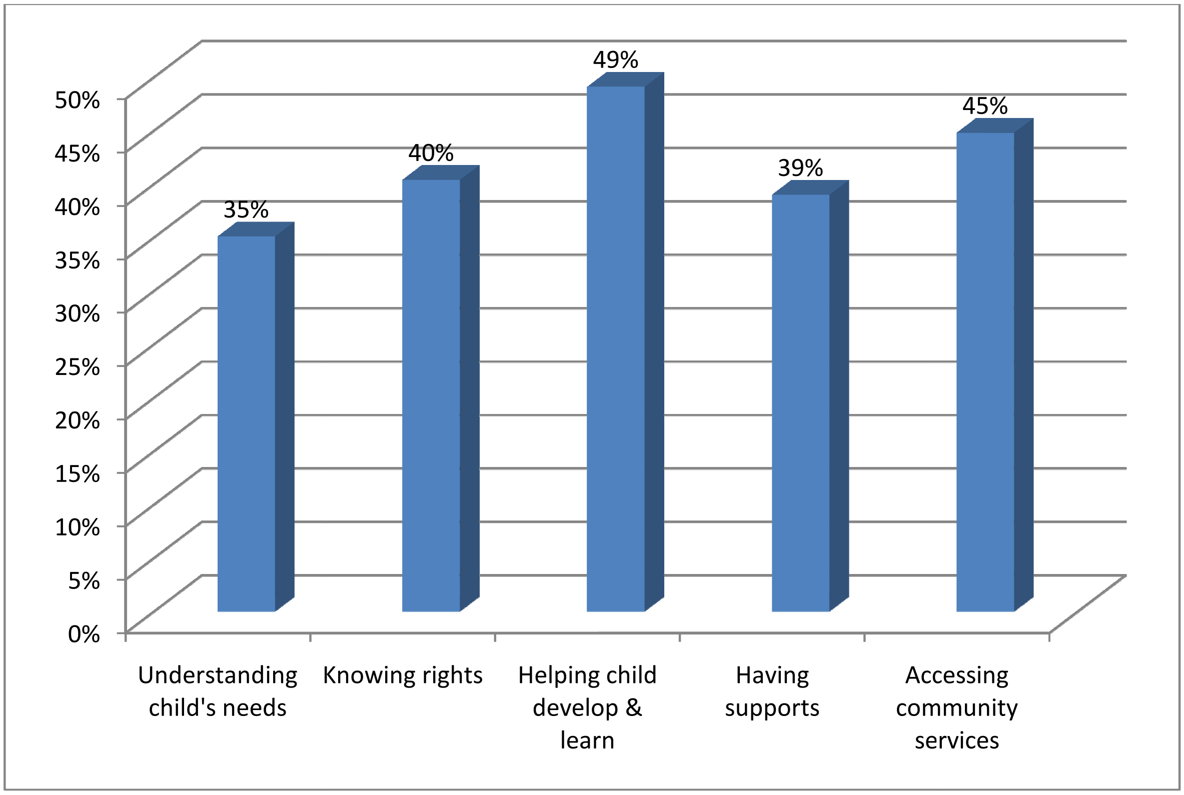


Table 45

Mean Scores on the Five Family Outcomes Across Family Groups According to Type of Disability

Variable	**ASD** **n=11** **M (SD)**	**DS** **n=10** **M (SD)**	**CP** **n=8** **M (SD)**	**OND** **n=10** **M (SD)**	**HI/VI** **n=8** **M (SD)**	**DLD** **n=10** **M (SD)**
Outcome 1	4.15 (1.64)	4.47 (1.40)	4.58 (1.12)	4.03 (1.12)	3.63 (1.12)	4.02 (1.95)
Outcome 2	4.30 (1.55)	3.67 (1.81)	3.54 (1.61)	4.30 (1.53)	3.75 (1.31)	3.77 (1.59)
Outcome 3	3.58 (1.47)	4.17 (1.57)	3.71 (1.64)	3.40 (1.58)	4.33 (1.46)	3.83 (1.74)
Outcome 4	4.24 (1.50)	4.83 (1.43)	2.96 (1.94)	4.33 (1.66)	3.21 (1.17)	4.07 (1.87)
Outcome 5	3.58 (1.38)	3.77 (1.43)	3.04 (1.54)	3.88 (1.36)	3.58 (1.02)	4.30 (1.31)

Table 45 provides mean scores on the five family outcomes across family groups according to child's type of disability. The highest mean score was for families of children with Down syndrome (M = 4.83, SD = 1.43) on outcome 4 relating to family having supports system, whereas the lowest mean score was for families of Cerebral Palsy (M = 2.96, SD = 1.94) on the same outcome. Other high mean scores were for outcome 1 (understands child's strengths, abilities, and needs) for both families of children with CP (M = 4.58, SD = 1.12) and families of children with DS (M = 4.47, SD = 1.40). Moreover, other low mean scores were for families of children of CP (M = 3.04, SD = 1.54) for outcome 5 (accessing desired services in the community), and families of children with Hearing/Visual Impairment (M = 3.21, SD = 1.17) for outcome 4 concerning family having support systems. Figures 17-21 provides a bar graph presentation of the mean scores on the five family outcomes across family groups according to child’s type of disability.

Figure 17

Mean Scores on Outcome 1 Across Family Groups According to Type of Disability

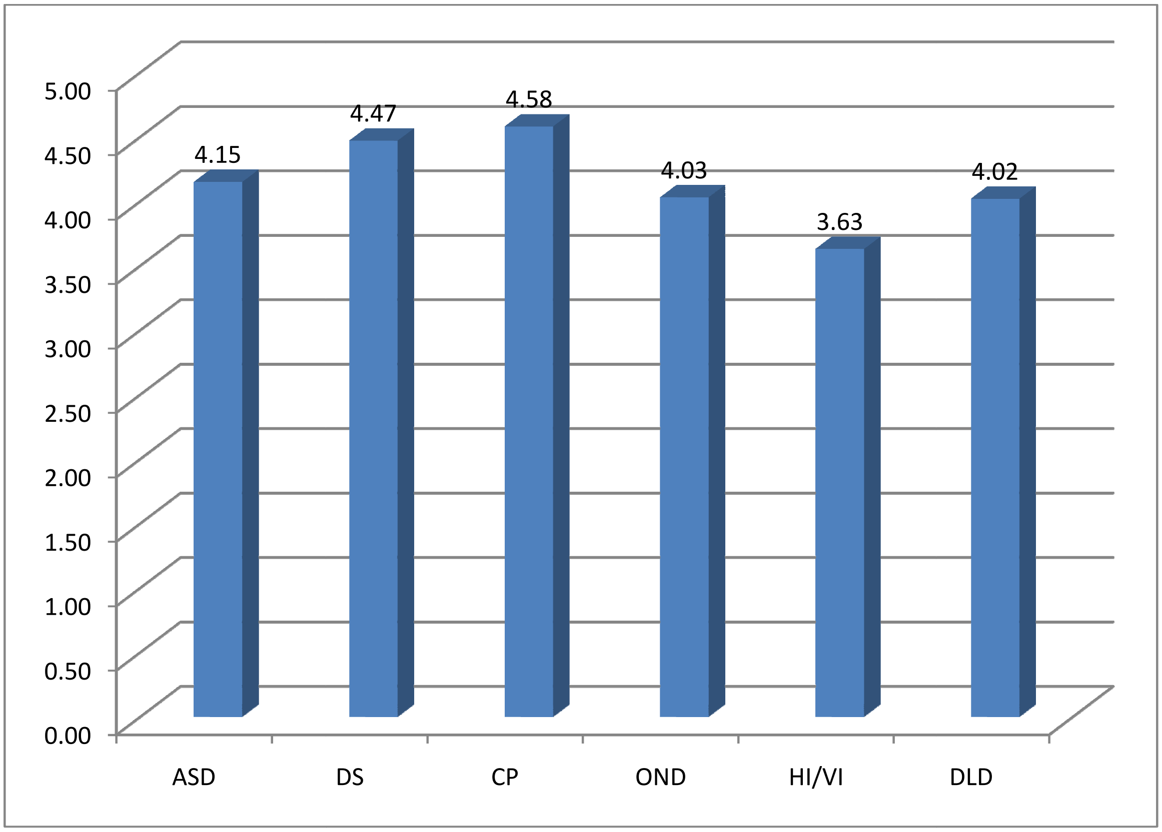


Figure 17 demonstrated both the highest and lowest mean score for outcome 1 (understands child’s strengths, abilities, and needs) across family groups according to child’s type of disability. The highest mean score was for families of children with Cerebral Palsy (M = 4.58, SD = 1.12), whereas the lowest mean score was for families of children with Hearing/Visual Impairment (M = 3.63, SD = 1.12).

Figure 18

Mean Scores on Outcome 2 Across Family Groups According to Type of Disability

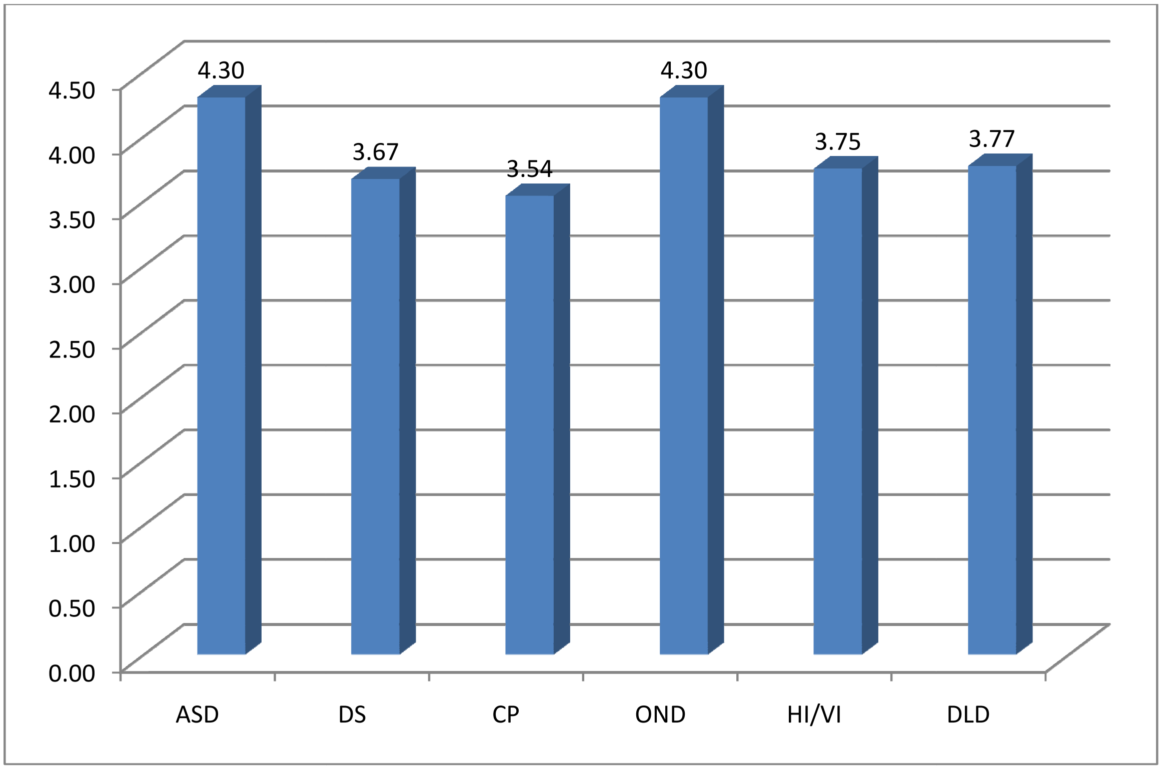


Figure 18 demonstrated both the highest and lowest mean score for outcome 2 (knowing rights and advocating effectively) across family groups according to child's type of disability. The highest mean score was for both families of children with Autism Spectrum Disorders (M = 4.30, SD = 1.55) and families of children with Other Neurological Disorders (M = 4.30, SD = 1.53), whereas the lowest mean score was for families of children with Cerebral Palsy (M = 3.54, SD = 1.31).

Figure 19

Mean Scores on Outcome 3 Across Family Groups According to Type of Disability

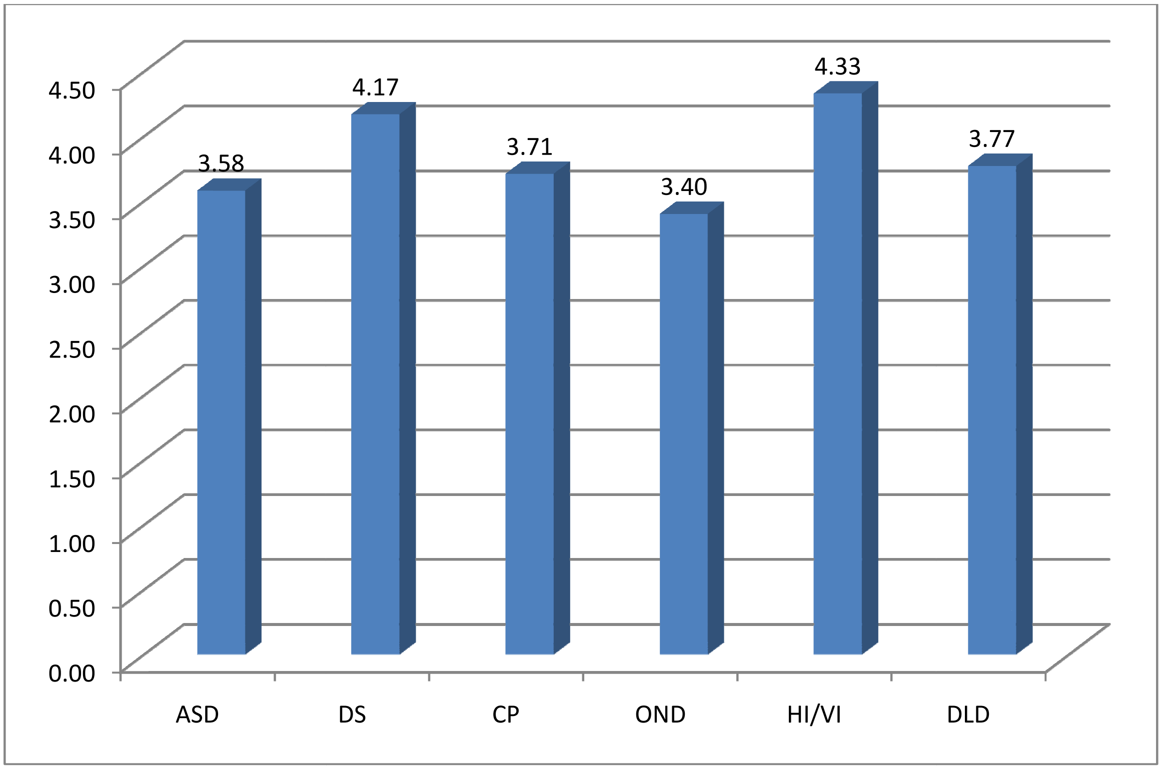


Figure 19 demonstrated both the highest and lowest mean score for outcome 3 (help child develop and learn) across family groups according to child's type of disability. The highest mean score was for families of children with Hearing/Visual Impairment (M = 4.33, SD = 1.46), whereas the lowest mean score was for families of children with Other Neurological Impairment (M = 3.40, SD = 1.58).

Figure 20

Mean Scores on Outcome 4 Across Family Groups According to Type of Disability

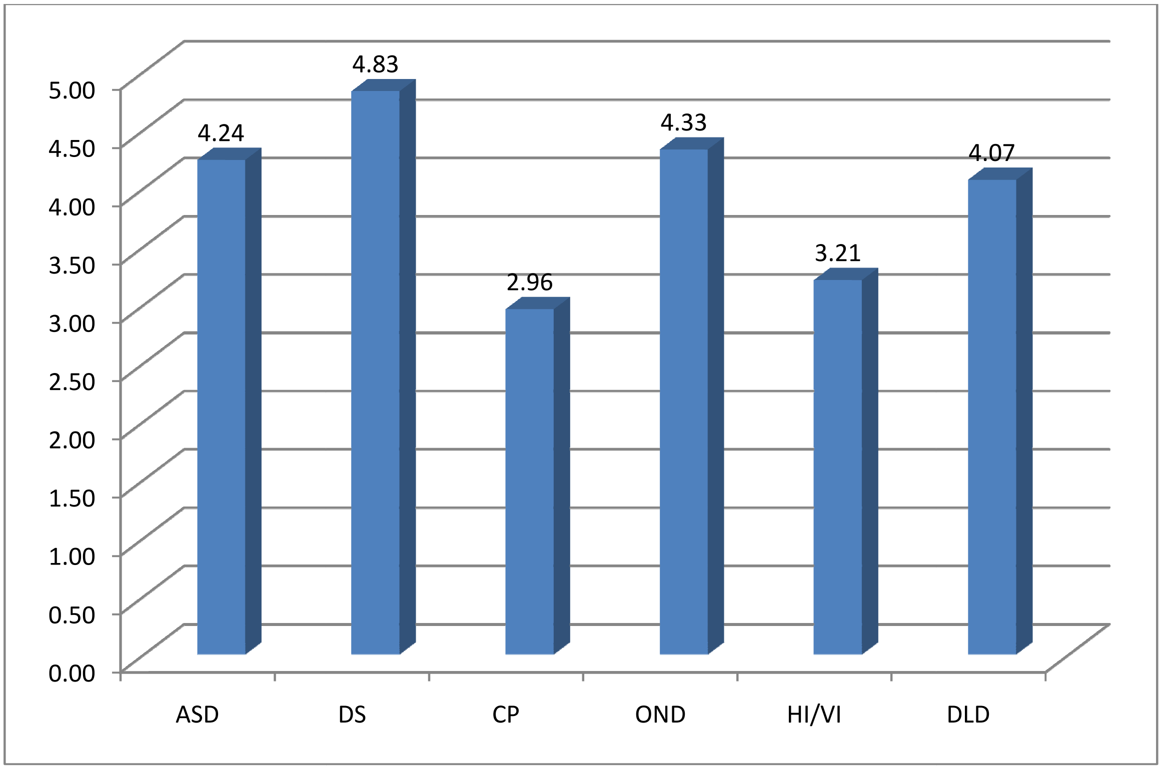


Figure 20 demonstrated both the highest and lowest mean score for outcome 4 (having support systems) across family groups according to child's type of disability. The highest mean score was for families of children with Down syndrome (M = 4.83, SD = 1.43), followed by families of children with Other Neurological Disorders (M = 4.33, SD = 1.66). The lowest mean score was for families of children with Cerebral Palsy (M = 2.96, SD = 1.94).

Figure 21

Mean Scores on Outcome 5 Across Family Groups According to Type of Disability

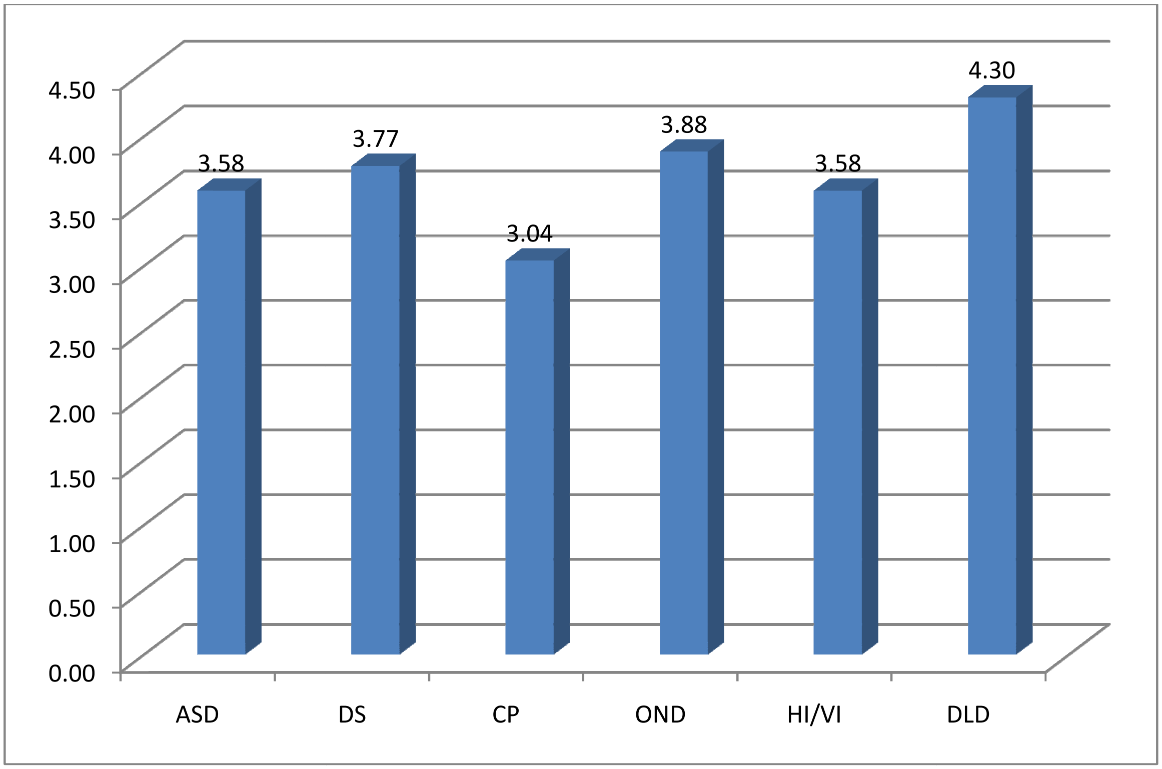


Figure 21 demonstrated both the highest and lowest mean score for outcome 5 (accessing desired services in the community) across family groups according to child's type of disability. The highest mean score was for families of children with Developmental Language Disorders (M = 4.30, SD = 1.31), whereas the lowest mean score was for families of children with Cerebral Palsy (M = 3.04, SD = 1.54). Furthermore, both families of children with Autism Spectrum Disorders and families of Hearing/Visual Impairment had the same mean score on item 5 (M = 3.58).

Qualitative Semi-structured Interviews

An important aspect of this study was to describe the experiences of key stakeholders including families of young children with disabilities, service providers, and program directors. A phenomenological approach was utilized to understand key stakeholders' "lived experiences" about factors that promote or hinder successful partnerships (Patton, 2002). Hence, semi-structured interviews were used as the major avenue of gaining a more in-depth description of key stakeholders' experiences. Using a snowball purposeful sampling scheme, eight participants were selected for the one-on-one semi-structured interviews. In addition, qualitative data were collected from service providers on the professional version of the partnership scale. Service providers were asked to identify factors that helped or hindered successful partnership for each item on the scale. The demographic surveys also provided an opportunity to collect additional qualitative data from all participants through the additional comments or information that participants shared regarding family-professional partnership or early intervention services in general.

Data analysis followed a phenomenological inductive approach to qualitative inquiry as described by Creswell (2007). Data from all sources were aggregated and a thematic analysis was conducted to determine salient themes that represent the essence of participants' experiences. Factors influencing successful family-professional partnership identified from the literature and the framework that examined these factors at two levels (interpersonal and structural) guided the coding process. Additional codes were added as new ideas emerged from the data. Table 46 presents an overview of the eight themes and their corresponding indicators that represent barriers and facilitators of successful family-professional partnerships.

Table 46

Five Themes of Interpersonal Factors Influencing Successful Family-Professional Partnerships and Relevant Indicators

Theme
Communication
▪ Being open-minded
▪ Active listening
▪ Having frequent communication
▪ Being honest
▪ Language barrier
▪ Sharing information with parents
▪ Having positive and two-way communication
▪ Avoiding use of professional jargons
Commitment
▪ Showing commitment to child and parents
▪ Considering work as “more than just a job”
▪ Being accessible to children and their parents
▪ Having shared responsibility
Respect
▪ Demonstrating positive attitudes
▪ Respecting cultural differences
▪ Acceptance and valuing of child and family
▪ Having non-judgmental attitudes
Skills
▪ Demonstrating competency in meeting child’s needs
▪ Achieving positive outcomes for children intervention programs
▪ Building on child’s strengths
Equality
▪ Advocating for child interests
▪ Treating parents as equal partners

Table 47

Four Themes of Structural Factors Influencing Successful Family-Professional Partnerships and Relevant Indicators

Theme
Administrative vision/leadership
▪ Effective leadership of administrators
▪ Differing philosophies for serving families
▪ Program practices and policies that support family involvement and reflect family-centered practices
▪ Provision of professional development opportunities in collaboration
▪ Seeking parent input into agency policies
▪ Provision of various options regarding early intervention services / Flexibility of the program
Organizational climate
▪ Size of caseloads
▪ Shared ownership and sensitivity to power and control concerns of others
▪ Flexibility in working hours to accommodate family's schedule
▪ Availability of service coordinators for families
▪ Limited resources within agency
Environmental factors within the community and/or agency
▪ Lack of coordination between agencies/understanding of other agencies' policies
▪ Limited service offerings within the community/agency

As presented in Table 46-47, there were eight themes within the two major categories of factors that influenced successful partnerships between families of young children with disabilities and service providers working with them in EI/ECSE programs. Indicators within each theme reflect the different perspectives of families, service providers, and administrators. The eight themes were interrelated in the sense that indicators within one theme are linked to indicators within the other themes. For example, having positive communication was seen as a means of demonstrating respect and equality between families and service providers. Also, under the theme of commitment being accessible is affected by organizational climate and related to the service providers' caseload and time allocated for coordination and collaboration between team members. Examples of the qualitative results were organized based on participants' perspectives related to the eight themes:

Theme 1: Communication

The majority of participants stressed the importance of having quality communication between families of young children with disabilities and service providers as a factor that promotes successful partnerships. In fact participants viewed good communication as the foundation of successful partnerships. Families, service providers, and administrators described a range of behaviors that they perceived to define good communication. These behaviors include: (a) positive, two-way, and frequent communication, (b) active listening, (c) access to information, and (d) clear communication. Sarah, Managing Director of Shafallah Center, discussed the importance of having frequent communication with families of young children with disabilities:

> I always say that our programs here at Shafallah Center will never ever be successful without having this bridge of communication between us in the center

> and the families…. and really continuous communication along with an open door policy for all the families …. Any time a family wants to meet with me or the social worker our offices are open for them.

Parents also stressed that service providers with good listening skills and willingness to listen to them were important factors to successful partnerships. Active listening was described by families as having a two-way communication in which professionals are actively engaging in conversation with families. Talal, a father of five year old child with Hearing Impairment described the importance of having a two-way communication:

> The first thing is that they listen to the family. If you hear the family, you can hear the child. But if you did not hear what the family is thinking you cannot hear the child. You see our observations of the child at home is important as much as the therapist's observation. They should be asking us what the child did yesterday and did he go anywhere in the community and how did he do.

In contrast, many service providers viewed the lack of positive communication between parents and service providers as one of the major barriers to successful partnerships. Leela, Rehabilitation Coordinator at HMC, emphasized the need for quality communication within pediatric rehabilitation:

> We do some communication but it is not a good quality communication for an integrated service. It has to be a more comprehensive type of communication like parents should be aware what the condition of their child is and what they should expect from rehab.

Additionally, participants highlighted the lack of access to information and educational materials as an influencing factor that impedes positive communication. Service providers emphasized the importance of providing parents with information about their child's disability, child's needs, and expectations of rehabilitation outcomes. Leela, Rehabilitation Coordinator at HMC, explained the importance of educating parents about their child's condition as well as what is expected from rehabilitation:

> It doesn't matter the education of the parents, if parents are told from the beginning their expectations will be different and they will understand that rehab services are there to teach them how to take care of their child at home and to guide them to what to do and how to do it. As a therapist we can tell the parents that in this condition your child can functions this way or that way.

Like professionals, parents also emphasized their need to access information about their child's disability, influence on setting the goals of intervention, and assistance to help their child's development and learning. Parents stressed there is a scarcity of information available to them in Arabic language. Parents reported needs for professionals that take the time to explain tests results, intervention goals, and home programs. Asma, a mother of a child with ASD, described her experience in accessing needed information:

> You know it is not always easy to get the information you want; I searched the internet and I asked around and even called other specialists in other countries to get the information I need to help my son …. we are already under stress and do not know what to do but we cannot find anybody to tell us what to do and how to

> do it. But when I sat with the behavior therapist and he started telling me about the condition of my child and what to do and how to do, I was able to understand my child's needs and how to deal with my child's behavior. These are the things that we as families need …. the information that I need about the goals they are working on and what I am supposed to do and follow-up at home they don't give me …. you know even when I ask the therapist where can I get the same toys and activities they are using with my son, they always tell me that these are not available here in Qatar and the hospital provide it for the therapists.

Professionals also highlighted the need to communicate in a clear manner and to avoid the use of professional jargons and technical terms with parents of children with disabilities. Ali, a pediatric occupational therapist, described one of his experiences with a family of an infant diagnosed with Down syndrome:

> Recently I got a child with Down syndrome and the doctor came and I was there and told the parents that the results of the tests showed that the child had chromosomal abnormalities and he will need special care and you need a lot of work with him and you will have difficulty with the child and the child will be abnormal and all of these information. It is medical information and it was too much for the parents to handle. I had to sit with the family at that time and explain to the family where we should start right now and what shall we do for the child and how much care we should give to the child at home, how much training we should give. So, we explain to them exactly how the program will be as well as what is the future expectations for the child, and this is really make the family feel some comfort.

Like professionals, parents also expressed their need for professionals to communicate in a clear manner and use words that can be understood by families who may not be familiar with medical and technical terms. Asma, a mother of a child with ASD, explained her experience with an occupational therapist from the Philippine working with her child:

> You know I know English but some of the terms they use I really have a hard time understanding what it means especially those terms they use in the occupational therapy. So, I usually ask my husband to come and meet with the therapist.

Lastly, the majority of professionals viewed language differences as a major barrier to having quality communication between parents of children with disabilities and service providers. Multiple languages are spoken in Qatar (Arabic, English, Tagalog, and others) were identified as a barrier by participants from both Shafallah Center as well as HMC. Participants perceived the language barrier as a consequence of having many service providers from culturally and linguistically different backgrounds. They also viewed this problem as reflective of the shortage of qualified Arabic-speaking therapists and special educators in Qatar. Further, many professionals indicated the lack of interpreter services as a major challenge faced by service providers when working with families of children with disabilities. In an attempt to remediate this issue, service providers stated that they often try to get assistance in interpretation from other colleagues working with them. However, miscommunication difficulties result due to problematic translations of medical and technical terms to families. Ali, pediatric occupational therapist at HMC, described how the language barrier affects good communication:

> The language barrier here, it is really a barrier and we cannot ignore that. Really all the therapists need to communicate properly with the child and with the family. Even when we are speaking the same language, Arabic, the accent may be different. So, we have to put more effort to speak with the same accent in order to make the family and the child understand …. If we cannot communicate properly we will not function properly and it really makes a difference …. We don’t have the luxury of hiring Arabic-speaking therapists because we are hardly getting qualified therapists; it is very difficult …. There is a shortage of Arabic-speaking therapists in the Arabic region. So, hiring is based on what is available in the market.

Farah, supervisor of pediatric occupational therapist at HMC, also reiterates the challenge of language barrier in pediatric rehabilitation stating:

> We are in an Arabic-speaking culture and the therapists are from different countries and do not speak Arabic. I would say that 70% of the therapists do not speak the language. So, this is a barrier. Even for Arabic-speaking therapists, there are barriers like you will have a family who speak Indian language but do not know English or Arabic and you don’t speak Indian. In fact, we are having difficulty recruiting Arabic-speaking therapists.

Theme 2: Commitment

Many of participants indicated that the most successful partnerships occur when both service providers and families have demonstrated commitment. Participants described indicators of commitment as: (a) having a shared responsibility for the child with disabilities, (b) view of work as “more than just a job”, and (c) being accessible to child and parents. Service providers supposed that the success of family-professional partnership relied on having a shared responsibility for the child with a disability. Service providers viewed families as the primary source of nurturing for the child and the primary goal of intervention programs is to assist the parents as the primary caregivers in helping their child develop and learn. In support of this view, both service providers and administrators talked about the importance of parent education and training to help them acquire the needed skills to care for their child with disabilities. Participants also described a shared responsibility as sharing the same goals and expectations for the child. Leela, Rehabilitation Coordinator at HMC, commented that:

> We are equally responsible for the child’s development; I mean both the professional working with the child and the parents. They need to collaborate together consistently, continually with a good communication all the time and focusing everything on the child.

Ali, a pediatric occupational therapist at HMC, explained the need for service providers to understand the term “shared responsibility” within the Qatari society and to educate the parents about their role in the intervention program for their children with disabilities. He also explained that there is a great need to increase awareness of this issue among parents and service providers equally because many service providers do not realize the expectations of a shared responsibility:

> We need parents to understand the culture of making a contract when coming to any health provider especially in rehabilitation because when they are coming to rehabilitation they do not know what the needs are of the child and what to expect from rehabilitation. And this is a major problem that they don't know what they want and what to expect …. Whatever the therapist is telling them they accept it because they don't know …. So, we need to increase their awareness about the idea that when they come to the hospital there is a contract between you and the therapist that includes what is the expectations, what are the goals, and what is the period, and based on that they will be more involved and know exactly what do their children need. This attitude is not clear here; really very few parents who are coming to the hospital and know what they are expecting form the therapist. So, we need to increase awareness in this issue …. At the same time we need to increase awareness of this issue among rehabilitation services practitioners because many of them they don't know this.

Many participants described committed service providers as those who value their work as "more than just a job" and "more than a paycheck". These service providers were described as "creative" in their work to meet the needs of the child to ensure achievement of intervention goals. Carol, Assistant Director for Rehabilitation Services at HMC, expressed services providers' commitment to work as:

> I think you have to accept that the reward of the job is focused on helping these children and their families more than the salary. And I think people should not be satisfied that they have done their service just because they have to do it. They should be satisfied that every day they create a new objective, every day they create something they want to reach.

The same view was also expressed by Sarah, Managing Director for Shafallah Center, in that:

> Some of the professionals work with families like this is a job they have to do it and I personally think this is more than just a job.

Parents held a similar description of service providers' commitment to their work using statements such as "going all the way" and "doing more than expected" to meet their child's needs. Parents described those service providers as being "enthusiastic", "passionate" about their work, and devoted to achieving positive outcomes for their children with disabilities. Talal, a parent of a child with Hearing Impairment, talked about the behavior therapist who worked with his child:

> The therapist helped us with my son's preschool and he actually came all the way to visit the school and talked to the teacher on how to work with my son. You know I live in Dukhan and the behavior therapist commuted about 50 miles all the way just to come to my son's school.

Participants stressed the importance of being accessible for parents during and outside of regular working hours when parents need them. Professionals described being accessible as allowing parents to phone them when needed. They also described being accessible as having an “open door” policy. Hani, Director of Psychological Services at Shafallah Center, commented that:

> I really have good relationships with the families and they can call me any time even outside of the work hours and even during the summer vacation when the center is closed.

Like professionals, parents held a similar description of service providers being accessible when they need them. Asma, the mother of a three and a half year old child with ASD, describes her positive experience with the behavior therapist working with her child as:

> I mean the behavior therapist was really good working with me and my child …. He was available for me at any time I need him or I have a problem; I was able to call him any time on the phone …. I have his phone number and I can call him at any time and he is really very helpful.

Theme 3: Respect

For many participants, respect and demonstrating respectful behaviors were considered essential facilitators of successful partnerships. Participants often discussed respect as related to positive communication and commitment. Additionally, most service providers described respect in the sense of being non-judgmental and accept families from culturally and linguistically diverse backgrounds. In fact, many professionals described this aspect as challenging to establishing positive partnerships while working with in EI/ECSE programs. Service providers also indicated that respect was enhanced when professionals make an effort to understand and accommodate cultural differences to best serve families of children with disabilities. Another difficulty discussed by administrators was that of working with service providers who have a wide range of personalities and different values. Sarah, Managing Director for Shafallah Center, discussed her experience relating to the lack of mutual respect between service providers and families, the importance of using culturally respectful language, and the Center’s zero-tolerance toward negative attitudes of service providers:

> I really wish that all of the professionals who are working in this field and with the families that they work with the families and treat them with respect and not just with sympathy … You always have the positive end the negative in any place and in any professionals. The center is not different in that especially when you have newly employed professionals from different cultures and nationalities. Sometimes the professional would say something that we in this culture would consider it a verbal abuse whereas from where they came and their cultural background they don’t consider it the same way we do. For example when a special educator slaps a child on his hand or tells him some kind of a negative word. I would be lying if I tell you that all of the professionals working in the center have positive attitudes towards children with disabilities and their families, and the prove is we have few incidents last year that one of the special educator hit a child and another verbally abused one of the children and these two were terminated immediately from the center.

Like professionals, parents also expressed that negative attitudes in professionals and their lack of acceptance of the child were major impediments to establishing positive partnerships. Asma, a mother of a child with ASD, described her negative experience with the speech therapist who was not accepting her child and disrespected her suggestions and contributions in the child’s intervention program:

> There is no problem actually but from the first time I felt she did not accept my son at all. The therapists here do not like to work with each other like one time I asked the behavior therapist to talk to the speech therapist how she can work with my son but she did not like that and she got upset and she said that my son need behavior therapy and he will not benefit from speech therapy now and then she said she will stop the therapy for one month. She does not want to collaborate and I don’t even think she wanted to work with my son because of his behavioral problems.

Theme 4: Skills

Service providers expressed the importance of having the necessary skills, knowledge, and competency to meet the needs of young children with disabilities. Their own competence was key element to their successful partnerships with families of children with disabilities. Many service providers described the importance of having a solid knowledge base and advanced clinical skills in their professional field. Service providers described skilled therapists as those who are “flexible” in terms of being willing to adapt their approaches to meet the child’s needs. They also viewed service providers’ competency and skills as a function of their ability to achieve intervention goals and positive outcomes for children with disabilities. Ali, a pediatric occupational therapist at HMC, expressed his experience in working with other therapists who lack experience working with children with disabilities:

> It is just about inexperience of the therapists because sometimes it is difficult to judge the therapists' experience. This is because some of the therapist will bring a letter that they have worked in a children development center but we cannot judge on that unless we see the therapists are practicing here with us after we hire them of course and then we find they are inexperienced …. I saw therapists who have good theories and able to set goals but unable to achieve their goals. They do not have the capability to deal with the child and understand the needs of the child. Sometimes the child is not in a good mood and I have to change the structure of the treatment session to meet the child's needs at this specific time.

Unlike professionals, parents talked about skills and competency of service providers in their ability to build on their child's strengths. Talal, a parent of a child with Hearing Impairment described his negative experience with the speech therapist working with his son:

> You know the problem is the therapists concentrate on the negative things that the child may have and this is wrong because if you want the child to advance you should concentrate on the positive things.

Theme 5: Equality

The study participants perceived equality as being essential to achieving successful partnerships between service providers and families of young children with disabilities. Participants often talked about equality as being related to respectful and positive communication. Service providers described a wide range of behaviors and activities that influence the way in which parents feel a sense of equality when working with them. These activities include empowering parents and advocating for children's interests with other service providers. Farah, Supervisor Pediatric Occupational Therapist, described the activities and strategies she utilized to empower parents of children with disabilities:

> We are trying really to empower parents and we are doing a lot of educational sessions with them and workshops. In fact, we are empowering them by always telling them it is your child's right to have the education and it is the child's right to have the equipment. And then we guide them where to go and whom to approach to get these services. So, it is mainly empowering them more than anything else.

Administrators also expressed the need for service providers to avoid acting like the expert when working with families of young children with disabilities. Sarah, Managing Director for Shafallah Center, emphasized this view:

> We need to look at the families from a different perspective that they have knowledge and educated and not to look at them that we are the experts and we know everything and they don't. It is very important when we work with the families that we advocate for their needs and for their children's needs.

Like professionals, parents also expressed the need to feel a sense of equality in the partnership with service providers working with their children with disabilities. Talal, a parent of child with ASD described his negative experience:

> Because the therapists do not listen to us, they treat us as if we do not know anything and therefore they speak to us in a level much lower than our level.

> People are different and have different level of understanding like for me coming from the medical side I have no problem with the medical terminology. They just did not take the time to know us the parents.

Theme 6: Administrative vision/leadership

Overall, the study participants identified a wide range of structural factors that promoted or impeded successful partnerships between families of young children with disabilities and service providers. Participants identified key characteristics of administrative vision and leadership that influenced successful partnerships. These characteristics include: (a) program practices and policies that support family involvement and family-centeredness, (b) effective leadership administrators, (c) different philosophies for provision of services for families, (d) provision of professional development opportunities in teamwork and partnerships, (e) parent involvement into agency policies, and (f) flexibility of the program in the provision of different options of early intervention services.

The majority of service providers identified having program practices and policies that reflected family-centeredness and supported family involvement were a key factor that facilitates successful partnerships. Service providers believed that in addition to the policies that support family involvement, administrators' understanding of the importance of family involvement and understanding of the family's role in the intervention programs for their children with disabilities was also considered essential to implementation of family-centered practices. Participants expressed that having policies that support family involvement may facilitate the process of family involvement and decrease the psychological stress on the parents but it did not necessarily increase parents' active participation in decision making regarding intervention programs for their children with disabilities. Carol, Assistant Director for Rehabilitation Services at HMC, explained the effect of having policies that support family involvement:

> For sure family role in the rehab program for their children is important and again the JCI [Joint Commission International] has set that standard where families have to be educated …. It is an international standard. We know it is not a choice for us; we have to do it…. There are policies that are set at the corporate level which is the patient and family education policy on the rights of parents and making sure that they know all the information they must have at each interval, plus everything that is happening is being told to them and these are required by our staff to document.

In addition to having program practices and policies that supported family involvement and reflected family-centeredness, participants indicated having effective leadership administrators as an essential factor that influenced positive partnerships. Service providers described two characteristics of administrators demonstrating effective leadership: having technical skills and experience, and making sure that all professionals are fulfilling their roles and responsibilities. The majority of service providers described effective leadership administrators in the sense of having the knowledge and technical skills in provision of EI services for children with disabilities and their families. They emphasized that administrators should have a solid understanding of the needs of children with disabilities and their families and must be committed to securing needed resources that support family involvement. Ali, a Pediatric Occupational Therapist, described the qualification of an administrator with effective leadership as:

> Well, when we have an administrator who understands our needs, he can really allocate resources and support us in terms where we can go but when we have an administrator who doesn't understand the role of the therapists in the different disciplines of rehabilitation things will not be clear and will be more difficult. we need a specialized person in the technical aspect of early intervention services and programs maybe someone like a pediatrician who has good experience about children rehabilitation and specialty in child development as well as experience in places like the United States, or Europe, or Canada where there is good level of services and we would like to reach for that standards.

Service providers also described administrators with effective leaderships as those who are skillful at training and supervising staff. Farah, Supervisor Pediatric Occupational Therapist at HMC, described how she was fulfilling her role concerning staff training and supervision:

> In fact, as a supervisor I am supposed to organize and run all the work in the pediatric unit as well as supervise the work of other therapists. I also provide training and education for all pediatric therapists and monitoring of the work of the staff within the department as well as the yearly performance appraisal for the staff. For example, it is part of monitoring the therapists and their performance is seeing how much they are involving the parents in their treatment programs. We have something like a specific monitoring tool to see whether there is

> communication between therapists and parents or not. We also have another tool in which the supervisor therapist will approach parent and ask them in detail how much information are they getting from the therapist. So, it is just a monitoring tool for the department to see whether the therapist are really communicating with families and whether they are doing it in the same way we want them to do it.

Conversely, administrators in the study were honest about the limitation they had in their technical as well as administrative skills in their current position. Sarah, Managing Director of Shafallah Center, described the challenges they faced at the Center concerning provision of EI services:

> You know, from my personal view in the center we have two central problems; one of them is the curricula for our school programs. We are facing a lot of difficulty in this area. Personally, I am not that experienced in Early Intervention programs and I really feel that we need to improve our early intervention services at the center. But what we have here at the center at the present time is much better than any other place in the country.

Likewise, Carol, Assistant Director for Rehabilitation services at HMC, described some of the difficulties she faced in her current position:

> You know, I am not satisfied because I thought I will be able to do more when I am in this position but I am unhappy with the progress in the programs. I am not good at planning that is setting strategic plans for the different programs in rehab. I have no patience to wait for three or five years to plan and implement a

> program. I am a day-to-day person and I don’t do will with these long term projects.

Besides having policies that support family involvement and effective leadership skills, different philosophies for provision of services for families were described by participants as an influencing factor of positive partnerships. Program philosophy at Shafallah Center reflects an emphasis on partnering with families of young children with disabilities in the educational program for their children. In fact, Shafallah Center had a strong emphasis on family involvement and had a specific program designated for family support services that provide support groups as well as educational opportunities designed specifically for families of children with disabilities. Service providers working at Shafallah Center strive to have families input on the type of workshops and educational opportunities provided to them. The background of the Managing Director also mirrored the Center’s philosophy, with a Bachelor Degree in Social Science and a Master’s Degree in Educational Leadership and sixteen years of experience working as a social worker. Sarah, Managing Director at Shafallah Center, described her philosophy, and that of the Center, as grounded in the belief that “parents are partners”:

> Well, generally speaking the center philosophy is to provide the best educational and rehabilitation services for children with disabilities. For the early intervention, the philosophy is to intervene as early as we can with emphasis is on providing all the services that the child need with emphasis on pre-academic skills as our program is more of a preschool program. We consider families as partners, it is important we have the same goal which is providing the best services for the children with special needs. I believe that families should be involved in setting

> strategies for programs and this is maybe one of the weaknesses at the center that we have not worked to involve the families in our programs 100% of the time.

In contrast, the program philosophy at HMC had a strong emphasis on service integration for children with disabilities and their families and implementation of evidence-based practices. In fact, the appointment of the Assistant director also demonstrated this philosophy. The Assistant Director for Rehabilitation Services in HMC had a Bachelor Degree in Occupational Therapy and a High Diploma in Leadership and Management. With sixteen years of experience working at HMC, she had a limited experience in school-based and community-based services for children with disabilities and their families. She described her appointment in this position for almost four years and the gradual reformation of the staff to embrace evidence-based practices:

> This position in of course new and it was created few years back as an Assistant Executive for Rehab services. It was created on behalf to be able to give more leadership and more management in order to re-focus how we function in our department in rehab. To kind of give a more integrative therapy to focus on how programs can actually be more beneficial than individual therapy. And this is our vision is to reach where the departments are actually intertwined and not individualized. And that’s where we are heading while I am in this position. My role is to see how they are operating and it is split into the clinical aspect and the management/administrative aspect, bringing information of where we are headed in our objectives to get all the heads involved as well as the direct staff to really gain more development in our clinical practice. You know, we focus on the JCI standards as our basics but again we have to make sure how we practice is

> focused toward the best practices. We have to make sure we are using reference-based practices.

Ironically, many service providers perceived that evidence-based practices were not being consistently implemented throughout the programs. The majority of service providers at HMC stressed that one of the challenges affecting delivery of early intervention services for young children with disabilities and their families was the lack of service integration. Farah, Supervisor Pediatric Occupational Therapist, described early intervention services at HMC:

> The service is there but it is not a combined service especially for outpatients. For inpatients it is more done where the team makes one treatment plan together for the child. But for outpatients it is fragmented services with different plans given to the child. In fact, the majority of the children we see in our department are outpatients. As I told you we are doing early intervention but we do not have an early intervention program. So, I wish we can have an early intervention program in which there is one plan developed by a team for the child and in collaboration with the parents and having those family meetings often and having the family education and family involvement more but on a team level not on a discipline level. This is something I would like to change. If we get this, it is going to be ideal.

Similar views were also expressed by Leela, Rehabilitation Coordinator at HMC as she described the lack of an integrated early intervention program at HMC:

> If you see in Rumaillah Hospital in our rehab program, there is no early intervention program for zero to three. Early intervention program is a multi-disciplinary program. I am not saying we don't do any early intervention; we do early intervention as soon as the child is identified specially in inpatients. Fine we do early intervention for outpatients but we do it independently each discipline separate because services are under different roof and in different places. But there is a lot of work to be done; it is not ideally what it should be. I mean as an intervention we are doing good independently but the only thing that is missing is integration of services.

Nevertheless, many service providers at Shafallah Center also perceived the lack of "evidence-based practice" had a negative effect on the delivery of services and supports to families of young children with disabilities. Hani, Head of Psychological Services at the Center, expressed this view:

> One of the barriers is the lack of a planned and organized program for family support services which is built on evidence-based practices that will help in building positive partnerships with families.

Besides having different philosophies for provision of services for families, provision of professional development opportunities in teamwork and partnerships was described by participants as an influencing factor of positive partnerships. Administration at Shafallah Center has identified the lack of professional skills in working with families of children with disabilities as an area of need. This perception was shared by both the Managing Director and the Head of Psychological Services at Shafallah Center:

Sarah, Managing Director of Shafallah Center, explained:

> So, training that is required for the professionals include active listening skills and how to interact and communicate with the families. That's why we are planning for the next year to do training for the social workers in this area.

Hani, Head of Psychological Services at Shafallah Center, explained:

> We provide training for the professionals on how to work with the families of children with disabilities especially when it comes to respecting the culture of the families. We are now trying to organize training in family counseling for social workers.

Further, administrator at Shafallah Center emphasized the lack of parent involvement into the Center policies impedes the level of partnership with families of children with disabilities. She described her role in seeking families' involvement in the Center programs:

> I believe in the importance of engaging all the stakeholders in the center programs. For example, I would say that families are involved approximately 50% in the center programs as a decision makers. But to be honest with you, the families need to be more involved in setting the general policies for the center and this can be solved if they are represented in the Board of Directors. I really wish that in the future, and I actually proposed this to the Board of Director for the center, that families become partners with us and actually have a member represented in the Board of Directors.

Lastly, service providers described flexibility of the program in the provision of different options of early intervention services as an influencing factor in successful partnerships. Although neither HMC nor Shafallah Center provide home-based early intervention services, service providers expressed that home visits services are provided for families on a need basis only. Hani, Head of Psychological Services at Shafallah Center, described their home-visits services:

> In addition to the on-on-one training for the mothers and the educational workshops, we do home-visits for the child and it is usually coordinated between the psychologist, the social worker, and the special educator. Home visits are conducted depending on the child’s needs. Until now we do not provide organized services for children from zero to three years. However, we started to work with few children between 2-3 years as an outpatient services and mainly for assessment and diagnosis.

Participants also stressed that one of the major challenges they are facing in developing home-based services was the cultural issues related to the Qatari society acceptance of having female service providers going into the families’ homes. Another challenge includes the shortage of specialized professionals. Leela, Rehabilitation Coordinator at HMC, explained:

> But right now we are not staffed for the home-based intervention and going in the homes here has many cultural issues. Plus it is better for parents to come to the hospital and communicate with other parents.

Sarah, Managing Director of Shafallah Center, described her experience with developing a home-based early intervention services at the Center:

> One program we introduced for early intervention is the Portage program. Let me be frank with you, one of the reasons for choosing the Portage program was to solve the long waiting list of children with disabilities that we have in the center. The idea is for the child to receive some services is better than no services at all. That was the same reason we started an outpatient clinic as well as the evening program in order to provide some services for those children on the waiting list. Right now we have approximately eighty-eight Qatari children in the waiting list, while the non-Qataris reach more than three hundreds. Not looking at the nationalities, we have approximately 388 children on the waiting list. So, the Portage is a program that is based on home visits and we provided training in it but unfortunately because of the culture here Qatari females do not want to go into the child home and do home visits. Since we were having this difficulty, we had another idea of having the mothers of young children with disabilities come to the center to receive the Portage program as well as family counseling services. Right now we have an occupational therapist that goes along with the special educators for the home visits in the Portage program.

Theme 7: Organizational Climate

Many of participants indicated that the most successful partnerships occur when there is an organizational environment that is conducive of successful partnerships. Participants described indicators of such environment: (a) size of caseloads, (b) shared ownership and sensitivity to power and control concerns of others, (c) flexibility in working hours to accommodate family's schedule, (d) availability of service coordinators for families, (e) limited resources within agency.

The majority of participants perceived the increased size of their caseload impede their ability to have successful partnerships with families of children with disabilities. Almost all service providers reported that their caseloads were difficult to manage and made it difficult for them to provide quality services for young children with disabilities and their families. They also reported feeling stressed and overwhelmed with their caseloads. Service providers (mainly occupational therapists, physical therapists, and speech therapists) reported that their increased caseload made it difficult and often almost impossible to spend additional time with families and to engage in advocacy activities for children with disabilities and their families. Farah, Supervisor Pediatric Occupational Therapist, described her frustration with the increased caseload:

> Sometimes, I believe we are offering a 30-minutes sessions and this time is not enough to discuss and treat the child and to demonstrate for the parents. So, sometimes the duration of the sessions is short but we have a caseload that we need to have it limited to 30-minutes. We can't exceed the 30-minutes to be able to cover the whole population of children referred to the department. It works with some cases but with others it does not work depending on the condition and the needs of the child. But you know the majority of our caseload is cerebral palsy and Down syndrome. I would say 40% of the children we see are children with cerebral palsy who really need more time for therapy and working with the parents.

Administrators identified ownership and sensitivity to power and control concerns of others as a key factor impeding positive partnerships. Participants perceived one way to manage issues related to ownership is through neutralizing territory issues related to different disciplines. Carol, Assistant Director for Rehabilitation Services at HMC, described her experience relating to ownership:

> I think the best thing that we could do as a team is to stop owning things that don't belong to us. I think that professionals need to understand it is not about ownerships. It is not about owning your own room, your department, your clients and children. It is about being open-minded to comments and suggestions. It is about opening the door further to see is your therapy going to benefit the child into something he may utilize in the future. It is very important to understand it is not about ownership but it is about having an open facility and work within that and having other colleagues from different specialties working with you.

The majority of participants viewed having flexibility in working hours to accommodate family's schedule as an essential factor to increase family involvement and to positive partnerships. Service providers reported increased family involvement when parents workshops and support groups were offered in the evening or the weekend to accommodate family's schedule. Farah, Supervisor pediatric occupational therapist at HMC, described her experience with the workshops offered to parents of children with disabilities:

> It was a whole day workshop and the first year we did it on weekday but the following year we did it on the weekend because they weren't able to attend the

> first year. We try to do it at a time that is more appropriate and suitable for the parents.

Several participants indicated the need to have service coordinators for families of children with disabilities to enhance positive partnerships. Service providers viewed service coordination as an area that is currently lacking in early intervention programs. Leela, Rehabilitation Coordinator at HMC, described the need for service coordination at HMC:

> From the rehab perspective, if I would speak, because we don’t have one key leader for the parents whenever there is a problem with the child, the family does not know whom to contact. This person should know the child and all the services child receive because he is the main mediator because the child who comes to rehab has multiple problems. So, there should be that one person that parents can contact and there should be a good partnership between the two and this person should know everything whatever is going around and whom to direct the family to; otherwise, parents will always be lost because one person tell them something and the other tells them another thing so the parents are confused on what to do and where to go and that is one thing that is missing.

Lastly, participants identified limited resources as essential factors that impede successful partnerships. Service providers perceived limited facility space, shortage of qualified personnel, and lack of Arabic educational materials for parents as the main resources that are affecting having successful partnerships with families of children with disabilities. Carol, Assistant Director for Rehab Services at HMC, described the effect of limited facility space and shortage of qualified therapists:

> I think that our facility layout having physical therapy in another facility, and occupational therapy here, and speech therapy up there. This doesn't allow for early intervention to really grow as a program and it puts a barrier on the therapists because when you cannot see the other therapists, you can't have that relation in there. So, I think that's how we can break the gaps is by creating a better facility that we could work in …. But for staffing it is a major problem for us here because the facility is the easiest thing, it is about creating a building and if money is there then you can create the building. But to really get the right staff in the right position, especially that Qatar relies on the majority of expatriates and because of our salaries we rely on expatriates who come from Asia they have skills but not that well-developed. They have skills but I think therapists who come from India really top them especially in the area of pediatrics. It is a struggle to get those competent therapists to come to Qatar.

The same view was shared by Ali, pediatric occupational therapist in his description of the limited space and its effect on service integration:

> We really need more space allocation. The space we have right now was designed for the population of half a million and now the population number has tripled but we are still in the same space. We also have a problem with the physical presence of the services under one roof because we have the physical therapists in a separate building, the occupational therapists in another building, and the

> physicians in a third building. Really this is affecting the integration of services. If we have all the services in same building, it will be easier to communicate, easier to meet with the team, and easier to make combined intervention sessions for the child which is really very rare here. But now it is really reflecting on a negative way on the services…. we don't need to establish a center because we have buildings here in HMC. What we need is to re-assign and re-allocate the spaces properly. We need to get an appropriate space that is appropriate for population number in the meantime and for the coming ten years.

He also described the difficulty that therapists have in allocating Arabic educational materials for families of children with disabilities:

> We also need educational materials for family education that is in Arabic. Part of what is going on here right now is that we are doing the educational materials ourselves; we have to print, we have to type, and we are not the professional people to do this in the proper way. So, we need to have specialized people to have these handouts and educational materials such as videos in the proper way.

Theme 8: Environmental Factors within Community/Agency

Participants reported two environmental factors within the community that has a significant impact on positive partnerships: (a) lack of coordination between agencies, and (b) limited service offerings within the community. The majority of participants reported that lack of coordination between agencies that are providing services for children with disabilities and their families presented a challenge when working with families. Carol, Assistant Director for Rehab Services at HMC, described her negative experience attempting to establish a collaborative relationship with Shafallah Center:

> With Shafallah, we tried to be more coordinated and more collaborative and it did not go beyond a meeting or a discussion. I am not sure but I think the process of the system in that who can talk to who; so I guess at my level I cannot talk to someone who is at a higher level at Shafallah maybe as we say the people who make the decisions. I don't believe in such a system but it is a system that is placed in this country and I find my ways to break it if I need to break it. You know Shafallah cannot attend to all children with disabilities and they have over one thousand on their waiting list and I think the classrooms are very limited. I haven't seen how the special education program there is set because from my few visits it is very difficult to understand how they are running their classrooms. I cannot see how the special education program is working for them over there.

Similarly, administrators at Shafallah Center shared the same view of lack of coordination and collaboration between agencies that provide services for young children with disabilities and their families. Hani, Head of Psychological Services at Shafallah Center, described his experience:

> Frankly speaking, the six years I spent here is Qatar working with the families I really had a very positive experience. The only negative experience I had is the lack of coordination and collaboration between organizations that provide services for children with disabilities and their families. And this really affects the partnership we have with the families as well as our work as professionals in the

> field. I am not sure why that is but maybe it is competition between the organizations or the professionals. I am being honest about this because the collaboration does not come from one side only; it is us and the other organizations. I wish there is one day that I see in the newspaper there is a partnership between Shafallah Center and HMC.

Almost all participants reported the limited service offerings within the community as a major factor impeding successful partnerships. Participants indicated because there are limited services offered for children with disabilities and their families in the community, it was very difficult for them to refer families for services that are either limited or non-existing. Carol, Assistant Director for Rehab Services at HMC, described her experience with the limited community resources:

> As the child grows you look out there and what is out there, and then it is so difficult to get your answers and trying to reach people who are working on resources; it is so difficult to get anything in the community. And I told this to the therapists you haven't done any service if you work for this long with the child and then tell them to go to Shafallah knowing they will not be accepted there because of the long waiting list; how can you just discharge them into the cold blue. The community needs to be more open but I think resources are still being developed in the community.

CHAPTER 5: Discussion

Introduction

This study aimed to provide an insight into two key aspects of EI/ECSE programs in Qatar: Family-professional partnerships and family outcomes. The purposes of this study were three fold. First, it examined satisfaction with partnership between families of young children with disabilities and professionals working in EI/ECSE programs in Qatar. Differences were reported in the levels of satisfaction between families according to their child's type and severity of disability, and between service providers according to their discipline. Secondly, the research identified the factors that promoted or impeded successful family-professional partnership in EI/ECSE programs from the perspectives of families of young children with disabilities, service providers, and program directors. Lastly, this study examined parents' perceived family outcomes in early intervention programs in Qatar.

The study utilized a mixed-methods approach of Exploratory Concurrent Triangulation Design in which the quantitative and qualitative data were collected and analyzed concurrently during the research study (Creswell et al., 2003). Data for the quantitative strand were collected via: 1) The Beach Center Family-Professional Partnership Scale (Blue-Banning et al., 2004; Summers et al., 2005a; Summers et al., 2005b); 2) The Family Outcomes Survey (Early Childhood Outcomes Center, 2006b); and 3) Demographic Survey. In addition, as part of the Family Demographic Survey, the ABILITIES Index was used to calculate the overall severity level of children's disability (Simeonsson & Bailey, 1991). For the qualitative strand, data collection relied primarily on semi-structured in-depth interviews with families of young children with disabilities, service providers working in EI/ECSE programs, and program directors. In addition, qualitative data were collected from service providers on the professional version of the Partnership Scale.

Data analysis and results were presented in the previous chapter. This chapter will provide discussion of the research questions and findings from the survey responses and interviews. Implications for practice and recommendations for further research will be discussed. Additionally, discussion of study limitations will be presented.

Discussion of Findings

Research Question 1: *How satisfied are families of children with disabilities and service providers working in EI/ECSE programs in Qatar with their levels of partnership?*

Overall, the study revealed a high level of satisfaction with the partnerships for both families of children with disabilities and service providers. This level of satisfaction was consistent for the overall partnerships, child-oriented partnerships, and family-oriented partnerships. The overall mean satisfaction score for partnerships for families of children with disabilities was 4.31, with a range from 3.61 to 4.58 (on a 5-point scale). Present research results were consistent with the findings of Summers et al. (2007). They studied 180 families of children from birth to age five who received early childhood services in a Midwestern state in the United States. The overall mean satisfaction score for partnerships reported in Summers et al. (2007) was 4.33, with a range from 3.77 to 4.67. Researchers have noted that families of young children with disabilities tended to give fairly high satisfaction ratings in evaluations of early intervention services (Bailey, Scarborough, & Hebbeler, 2003; Johnson, Duffett, Farkas, & Wilson, 2002). This may also be explained by the fact that despite promises of confidentiality, families may be hesitant to report dissatisfaction with the performance of the service provider working with their child (Bailey & Bruder, 2005). Alternative interpretations of positive family perceptions were: 1) families of young children who received EIEC services have no previous experiences for comparison, or; 2) families were grateful for any support and assistance received.

Research Question 2: *Is the level of satisfaction with partnership similar or different for families of young children with disabilities and service providers working with them in EI/ECSE programs in Qatar?*

The study showed that families of young children with disabilities (M = 4.31) and service providers (M =4.36) reported nearly similar levels of satisfaction ratings on the overall Partnership Scale. In fact, there were no statistically significant differences in the level of satisfaction between families of young children with disabilities and service providers on the overall Partnership Scale, Child-Focused Subscale, and Family-Focused Subscale. Conversely, analyses of the 18 items in the Partnership Scale revealed that families were significantly less satisfied (M = 3.61, t (121) = 3.84, $p < .001$) with service providers speaking up for children's best interests when working with other service providers, service providers' abilities to maintain child safety at all times when in their care (M = 4.54, SD = .60, t (121) = 2.24, $p = .027$), protecting the family's privacy (M = 4.42, SD = .71, t (121) = 2.62, $p = .010$), and showing respect for the family's values and beliefs (M = 4.35, t (121) = 2.33, $p = .022$). In fact, families' satisfaction level that service providers were speaking up for their child's best interests when working with other service providers was the lowest scored item on the Partnership Scale (M = 3.61). The highest ranked satisfaction item for the service providers was the dignity for the child in treatment (M = 4.58). Ironically, service providers were significantly less satisfied with their ability to treat children with dignity at all times (M = 4.14, SD = 1.01, t (121) = -2.82, *p* = .006), and the degree of availability to families when needed (M = 3.45, t (121) = -3.86, *p* < .001). In fact, service providers' lowest rating was on being available when families need them (M = 3.45).

Accessibility of service providers when families need them has been affected by many factors, primarily time constraints and increase in their caseload (Blue-Banning et al., 2004; Bruder, 2010; and Park & Turnbull, 2003). Consistent with previous research, the majority of service providers reported feeling stressed and overwhelmed with their caseloads, which made spending the necessary time to develop partnerships with families an additional source of stress (Blue-Banning et al., 2004; Summers et al., 2003; Summers et al., 2005). Lack of availability to parents of children with disabilities was also identified by service providers as a factor that decreased opportunities to have successful partnerships with families.

Lastly, families were significantly less satisfied with the service providers' protecting the family's privacy (M = 4.42, SD = .71, t (121) = 2.62, *p* = .010), and service providers' showing respect for the family's values and beliefs (M = 4.35, t (121) = 2.33, *p* = .022). This may be reflective of the shortage of qualified Arabic-speaking therapists and special educators in Qatar accounting for culturally diverse EIEC programs.

Research Question 3: *Is the level of satisfaction with partnership similar or different for families of young children according to the child's type and severity of disability?*

The study revealed statistically significant differences among the six of disability families groups according to the child's type [Autism Spectrum Disorders (ASD); Down Syndrome (DS); Cerebral Palsy (CP); Other Neurological Disorders (OND); Hearing Impairment/visual impairment (HI/VI); and Developmental Language Disorders (DLD)] for the overall Partnership Scale (F (5, 51) = 2.83, *p* = .025), Child-Focused Subscale (F (5, 51) = 2.50, *p* = .042), and Family-Focused Subscale (F (5, 51) = 3.06, p = .017). Overall, families of children with CP were significantly less satisfied (M = 3.66, 95% CI [2.80, 4.52]) than were families of children with OND (M = 4.62, 95% CI [4.42, 4.81]), *p* = .027, for the overall Partnership Scale. They were also significantly less satisfied (M = 3.56, 95% CI [2.65, 4.47]) than were families of children with OND (M = 4.60, 95% CI [4.39, 4.81]), *p* = .024, for the Child-Focused Subscale. Additionally, study results demonstrated that families of children with CP were significantly less satisfied (M = 3.76, 95% CI [2.92, 4.61]) than were families of children with DLD (M = 4.64, 95% CI [4.32, 4.97]), *p* = .049, for the Family-Focused Subscale. Comparisons among other groups indicated no significant differences (all *p*s > .05).

In fact, families of children with CP had the lowest mean satisfaction ratings for the overall Partnership Scale (M = 3.66) and both Child-Focused (M = 3.56) and Family-Focused (M = 3.76) Subscales, while families of children with OND had the highest mean satisfaction ratings for the overall Partnership Scale (M = 4.62) and the Child-Focused Subscale (M = 4.60). For the family-focused subscale families of children with DLD had the highest mean satisfaction ratings (M = 4.64). Further, the standard deviations within the category of families of children with CP were substantially larger with a range of 0.84 to 1.51 suggestive of the greater variability in families' levels of satisfaction based on their child's type of disability. This variability in families' levels of satisfaction may be explained by the fact that children with CP represent an extremely heterogeneous group that encompasses a wide range of motor impairment as well as associated medical conditions (i.e. seizures, orthopedic conditions), sensory impairment, and cognitive impairment that can often be profound.

Likewise, analyses of the 18 items in the Partnership Scale among the six types of disability groups were consistent in that families of children with CP were significantly less satisfied than were families of children with OND with service provider's letting them know about the good things their child does (M = 3.63, *p* = .035), building on child's strengths (M = 3.50, *p* =.008), and valuing family opinion about their child's needs (M = 3.50, *p* =.031). Likewise, families of children with CP were significantly less satisfied (M = 3.63, *p* =.047) with service provider being a person they can depend on and trust than were families of children with OND (M = 4.80, *p* =.047) and families of children with DLD (M = 4.80, *p* =.047). Families of children with CP were also significantly less satisfied (M = 3.50, *p* =.030) with service provider paying attention to what they have to say than were families of children with OND (M = 4.70, *p* =.030) and families of children with DLD (M = 4.80, *p* =.013). Lastly, families of children with HI/VI were significantly less satisfied with service providers degree of availability to family when needed (M = 3.63, *p* = .035) than were families of children with DLD (M = 4.80, *p* = .035).

With regard to the severity of the child's disability, the study showed statistically significant differences among the three family groups based on severity of disability (mild, moderate, and severe). Both families of children with mild and moderate disability were significantly less satisfied than were families of children with severe disability for the overall scale (F (2, 54) = 4.93, *p* = .011) and both subscales (Child-Focused Subscale: F (2, 54) = 4.09, *p* = .022; Family-Focused Subscale: F (2, 54) = 5.29, *p* = .008). Study results demonstrated that families of children with mild disabilities were significantly less satisfied (M = 3.90, 95% CI [3.42, 4.38]) than were families of children with severe disabilities (M = 4.75, 95% CI [4.61, 4.89]), *p* = .008, for the overall Partnership Scale. Similarly, families of children with moderate disabilities were significantly less satisfied (M = 4.33, 95% CI [4.12, 4.55]) than were families of children with severe disabilities (M = 4.75, 95% CI [4.61, 4.89]), *p* = .005, for the overall Partnership Scale. For the Child-Focused Subscale, families of children with mild disabilities were significantly less satisfied (M = 3.84) than were families of children with severe disabilities (M = 4.68), *p* = .012, and families of children with moderate disabilities were significantly less satisfied (M = 4.25) than were families of children with severe disabilities (M = 4.68), *p* = .012. Lastly, for the Family-Focused Subscale study results demonstrated that families of children with mild disabilities were significantly less satisfied (M = 3.95) than were families of children with severe disabilities (M = 4.81), *p* = .008, and families of children with moderate disabilities were significantly less satisfied (M = 4.41) than were families of children with severe disability (M = 4.81), *p* = .003.

Even though there were no studies that specifically examined satisfaction with partnerships based on type and/or severity of a child's disability in the research reviewed, in general these findings are consistent with the literature in that families of children with severe disability tend to report higher satisfaction ratings (Lucyshyn, Dunlap, & Albin, 2002). However, methodological inconsistencies in the research reviewed by Lucyshyn et al. (2002) reduce confidence in the generalization that families with children who have severe disabilities express more satisfaction.

Research Question 4: *Is the level of satisfaction with partnership similar or different for service providers from different disciplines in EI/ECSE programs in Qatar?*

The study revealed a significant difference across the four service providers discipline groups of Special Educators, Related Services Therapists, Paraprofessionals, and Health and Social Services Providers. Special educators had the highest mean satisfaction rating on the overall partnership scale and the two subscales, while the lowest satisfaction rating was for health and social services providers. Service providers varied across in mean satisfaction ratings across all 18 items on the Partnership Self-Assessment with mean satisfaction ratings ranged from 3.00 to 4.93. The lowest mean satisfaction rating score was for paraprofessionals being least satisfied with being available when parents need them, whereas the highest mean satisfaction rating score was for special educators being most satisfied with their ability to keep children safe at all times when in their care. Other low scores in satisfaction ratings were reported by paraprofessionals being least satisfied with being honest with parents, even when they have bad news (M = 3.18), and helping parents gain skills or information to get what their child needs (M = 3.27). However, paraprofessionals were highly satisfied with their ability to keep children safe at all times when in their care (M = 4.91) and protect the family’s privacy (M = 4.91). Moreover, health and social services providers were significantly less satisfied than were special educators for the overall partnership scale and the two subscales. They were also significantly less satisfied than related services therapists for the overall partnership scale and the family-focused subscale.

These findings related to paraprofessionals and health and social services providers were consistent with previous research studies (Appl, 2006; Bruder & Dunst, 2005; Carter, O'Rourke, Sisco, & Pelsue, 2009; Dickens, Matthews, & Thompson, 2010; Dokken & Ahmann, 2006; Hughesa & Valle-Riestrab, 2008; Law, Hanna, King, Hurley, King, Kertoy, & Rosenbaum, 2003; Moretz, 2010; Raghavendra, Murchland, Bentley,Wake-Dyster, & Lyons, 2007). Even though health care professionals embraced the philosophy of family-centered practices and the importance of partnering with families in the provision of care to children with disabilities, the implementation in everyday practices presented a challenge, specifically for medical and nursing care providers (Dokken & Ahmann, 2006; Moretz, 2010; Raghavendra, Murchland, Bentley,Wake-Dyster, & Lyons, 2007).

Paraprofessionals have evolved into being an important team member and key service delivery provider in EI/ECSE programs. Paraprofessionals provide a wide range of direct services for children with disabilities including those of instruction, making curriculum modifications, and managing children’s challenging behaviors. Recent studies demonstrated that paraprofessionals lack sufficient knowledge and skills needed to assume their roles. There is a solid need for providing additional training and professional development opportunities for paraprofessionals to improve their knowledge and skills towards partnering with families of young children with disabilities (Appl, 2006; Carter, O'Rourke, Sisco, & Pelsue, 2009; Hughesa & Valle-Riestrab, 2008; Walter & Petr, 2006).

Research Question 5: *Is the level of satisfaction with partnership similar or different for families and service providers between a hospital-based setting and a school/community-based setting?*

The study explored similarities and differences in perceptions of families' and service providers concerning their levels of satisfaction with partnerships between a hospital-based setting (HMC) and a school/community-based setting (Shafallah Center). The study findings revealed no significant differences in satisfaction ratings between service providers and families of young children with disabilities in HMC (n = 85) and Shafallah Center (n = 38) on the overall partnership scale (HMC: M = 4.32, SD = .60; Shafallah: M = 4.37, SD = .45; t (121) = -.503, *p* = .616) and both Child-Focused (HMC: M = 4.28, SD = .65; Shafallah: M = 4.37, SD = .54; t (121) = -.761, *p* = .448) and Family-Focused (HMC: M = 4.35, SD = .60; Shafallah: M = 4.37, SD = .46; t (121) = -.168, *p* = .867) subscales. However, findings of the 18 items analyses showed that both families and service providers from Shafallah Center were significantly less satisfied (M = 3.82, t (121) = 3.18, *p* = .002) with their honesty, even when there is bad news, than were respondents from HMC (M = 4.34, SD = .75). Additionally, families and service providers from HMC were significantly less satisfied with service providers using words that families understand (M = 4.38, SD = .85, t (121) = -2.34, *p* = .021) and with service providers protecting families' privacy (M = 4.49, t (121) = -2.68, *p* = .009) than were families and service providers from Shafallah Center (M = 4.66; M = 4.76 respectively). As with previous research studies by Miles (2003), parents of children with disabilities reported that healthcare providers tend to use technical language when they are informing them about their children's progress.

Research Question 6: *What are the factors that promote or hinder successful family-professional partnership from the perspectives of families of children with disabilities, service providers, and program directors in EI/ECSE programs in the State of Qatar?*

An important aspect of this study was to examine factors that impede or facilitate successful family-professional partnership by exploring the experiences of key stakeholders including families of young children with disabilities, service providers, and program directors. Semi-structured interviews were used as the major avenue of gaining a more in-depth description of key stakeholders' experiences. A snowball purposeful sampling scheme was utilized for participants' selection for the qualitative strand. A total of eight interviews were conducted as follows: (a) two participants were families of young children with disabilities (father of a five years old child with Hearing Impairment and Hyperactivity who was receiving EI services at HMC and a mother of a three and a half years old child with ASD who were receiving EIEC services at HMC); (b) two service providers from Hamad Medical Corporation (Pediatric Occupational Therapist and Supervisor Pediatric Occupational Therapist); and (c) four were program directors at both HMC and Shafallah Center (Assistant Director for Rehabilitation Services at HMC, Rehabilitation Coordinator at HMC, Managing Director of Shafallah Center, and Head of Psychological Services at Shafallah Center).

The study revealed eight themes that play a key role in promoting successful family-professional partnership at two levels: interpersonal factors and structural factors.

Out of the eight themes, five themes emerged as interpersonal factors that impede or facilitate partnership efforts between the families of young children with disabilities and service providers. The interpersonal factors were in agreement between both families and service providers: (1) positive communication, (2) demonstrating commitment to child and parent, (3) demonstrating respectful behaviors to families, (4) having knowledge, skills, and competency to meet the individual needs of the child, and (5) demonstrating equality through empowering parents and advocating for child's interests with other service providers. Interpersonal factors were consistent with previous research studies that examined indicators of positive family-professional partnerships (Blue-Banning et al., 2004; Knox et al., 2000; Turnbull et al., 2000; Turnbull & Turnbull, 2001). Blue-Banning et al. (2004) identified a series of behaviors indicative of successful family-professional partnership including: Communication, respect, commitment, trust, and equality.

The structural factors were those aspects of the relationship that affect at the larger context of the agency or system that facilitate the development of partnership efforts. These factors include: (1) administrative vision and leadership, (2) organizational climate, and (3) environmental factors within community or agency. Structural findings were consistent with previous research literature that examined family-professional partnership and factors influencing service integration in EIEC programs (Blue-Banning et al., 2004; Epley, Gotto, Summers, Brotherson, Turnbull, & Friend, 2010; Park & Turnbull, 2003).

Families, service providers, and administrators viewed good communication as the foundation of successful partnerships and described a range of behaviors that they perceived to define good communication. These behaviors include: (a) positive, two-way, and frequent communication, (b) active listening, (c) access to information, and (d) clear communication. The degree of agreement on what constitute good communication between families, service providers, and administrators was astonishing. The differences were merely a matter of importance rather than a disagreement. Like administrators, parents stressed that service providers with good listening skills and willingness to listen to them were important factors to successful partnerships. Like professionals, parents also expressed their need for professionals to communicate in a clear manner and use words that can be understood by families who may not be familiar with medical and technical terms. Moreover, both families and service providers highlighted the lack of access to information and educational materials as a factor that impeded positive communication. Parents also expressed their frustration with the lack of needed access to information about their child's disability. Lastly, the majority of professionals viewed language differences as a major barrier to having quality communication between parents of children with disabilities and service providers. Language barrier was reflective of having many service providers from culturally and linguistically different backgrounds due to the shortage of qualified Arabic-speaking therapists and special educators in Qatar. Professionals at HMC indicated the lack of interpreter services as a major challenge when working with culturally and linguistically diverse families. In an attempt to remediate this issue, service providers stated that they often try to get assistance in interpretation from other colleagues working with them. However, miscommunication difficulties result due to problematic translations of medical and technical terms to families.

Administrators, service providers, and families indicated that the most successful partnerships occurred when both service providers and families have demonstrated commitment. Participants described indicators of commitment as: (a) having a shared responsibility for the child with disabilities, (b) view of work as “more than just a job”, and (c) being accessible to child and parents. Service providers viewed families as the primary source of nurturing for the child and that the ultimate goal of EIEC programs is to assist the parents as the primary caregivers in helping their child develop and learn. In support of this view, both service providers and administrators emphasized the importance of parent education and training to help them acquire the needed skills to care for their child with disability. Service providers described a shared responsibility as having the same goals and expectations for the child. They also stressed the need to increase awareness and understanding of the concept of shared responsibility parents and service providers equally and to educate the parents about their role in EIEC programs. Administrators described committed service providers as those who value their work as “more than just a job” and “more than a paycheck”. Likewise, parents held a similar description of service providers’ commitment to their work using statements such as “going all the way” and “doing more than expected” to meet their child’s needs. Parents described those service providers as being “enthusiastic”, “passionate” about their work, and devoted to achieving positive outcomes for their children with disabilities. Lastly, while administrators described accessibility as having an “open door” policy, parents described service providers’ accessibility as being available during and outside of regular working hours when family need them.

For many participants, respect and demonstrating respectful behaviors were considered essential facilitators of successful partnerships. Most service providers described respect in the sense of being non-judgmental and acceptance of culturally and linguistically diverse families. In fact, both administrators and service providers described this aspect as challenging to establishing positive partnerships in EIECS programs. Like service providers, parents also expressed that professionals' negative attitudes and lack of acceptance of the child were major impediments to establishing positive partnerships.

Service providers' competency to meet the needs of young children with disabilities was key element to successful partnerships between families and service providers. Many service providers described the importance of having a solid knowledge base and advanced clinical skills in their professional field. They also described skilled service providers as those who are "flexible" in terms of being willing to adapt their approaches to meet the child's needs. Service providers viewed competency within the context of achieving positive outcomes for children with disabilities. Further, parents described service providers' skills and competency in their ability to build on the child's strengths.

The study participants perceived having a sense of equality as a characteristic of successful partnerships between service providers and families of young children with disabilities. Service providers described equality in terms of activities and strategies they utilized to empower parents about their rights as well as advocating for child's interests with other service providers. On the other hand, administrators expressed the need for service providers to avoid acting like the expert when working with families. The importance of parent empowerment and advocacy in building collaborative partnerships between families and service providers were consistent with previous literature (Knox et al., 2000; Turnbull et al., 2000; Turnbull & Turnbull, 2001).

Overall, the study participants identified a wide range of structural factors that facilitated or impeded successful partnerships between families and service providers. Administrators, service providers, and families described key features of administrative vision and leadership that influenced successful partnerships. These characteristics include: (a) program practices and policies that support family involvement and family-centeredness, (b) effective leadership of administrators, (c) different philosophies for provision of services for families, (d) provision of professional development opportunities in teamwork and partnerships, (e) parent involvement into agency policies, and (f) flexibility of the program in the provision of different options of early intervention services.

The majority of service providers at HMC identified having policies that supported family involvement and family-centered practices were a key factor that facilitated positive partnerships. They also believed that administrators' understanding of the importance of family involvement and families' role in the EIEC programs was essential to implementation of family-centered practices. Further, service providers described two characteristics of administrators demonstrating effective leadership: (a) having technical skills and experience in provision of EI services for children with disabilities and their families , and (b) making sure that all professionals are fulfilling their roles and responsibilities through skillful training and supervision of staff. Remarkably, both top-level administrators at HMC and Shafallah were honest about the limitation they had in their technical as well as administrative skills in their current position.

Administrators at both HMC and Shafallah Center identified having different philosophies for provision of services for families were a key factor in facilitating positive partnerships. As described by the Managing Director at Shafallah Center, program philosophy was grounded in the belief that ‘parents are partners’ in EIEC programs for their children. This philosophy was evident in the Shafallah Center provision of an explicit program for family support services that encompassed support groups as well as educational opportunities designed specifically for families of children with disabilities. In contrast, the program philosophy at HMC had a strong emphasis on service integration for children with disabilities and their families and implementation of evidence-based practices. Ironically, many service providers perceived that evidence-based practices were inconsistently implemented throughout EIEC programs and that the major challenge affecting delivery of EIEC services was the lack of service integration. Nevertheless, many service providers at Shafallah Center also perceived the lack of evidence-based practice had a negative effect on the delivery of EIEC services and supports to families of young children with disabilities.

Administration at Shafallah Center has identified the lack of professional skills in partnering with families of children with disabilities as an area of need that must be addressed to improve service providers’ skills and knowledge in successful partnerships. They also perceived the lack of parent involvement into the Center policies was an impeding factor to building positive partnerships. Lastly, Administrators emphasized the lack of flexibility in their current programs with regard to provision of different options of EI services was a key factor impeding positive partnerships. Both HMC and Shafallah Center provide home visits services to families on a need basis only. One of the major challenges that administrators faced in developing home-based services was the cultural issues related to the Qatari society acceptance of having female service providers going into the families' homes. Another challenge includes the shortage of specialized professionals.

Participants described indicators of organizational environment that is favorable to positive partnerships: (a) reasonable size of caseloads, (b) having a shared ownership and decreased sensitivity to power and control concerns of others, (c) flexibility in working hours that accommodate family's schedule, (d) availability of service coordination for families, and (e) availability of resources within the agency. Almost all service providers reported that their caseloads were difficult to manage and made it difficult for them to provide quality services for young children with disabilities and their families as well as adequate time devoted to partnership with families. They also reported their increased caseload made it difficult and often almost impossible to spend additional time with families and to engage in advocacy activities.

Administrators identified ownership and sensitivity to power and control concerns of others as a key factor impeding positive partnerships. Even though administrators perceived neutralizing territory issues related to different disciplines was one way to manage issues related to ownership, they did not have the needed knowledge to establish transdisciplinary teams. Further, service providers viewed service coordination an area that is currently lacking in EIEC programs in Qatar. Service providers also viewed lack of flexibility in working hours to accommodate families' schedules as an essential factor that impeded family involvement and positive partnerships. Lastly, almost all participants (administrators, service providers, and families) identified limited resources as crucial factors that impeded successful partnerships. Service providers described limited facility space, shortage of qualified personnel, and lack of Arabic educational materials for parents as the main challenges related to resources.

The last theme reported by both service providers and administrators that impeded positive partnerships was related to environmental factors within the organization and community. Like administrators, service providers described environmental factors in the context of lack of coordination between agencies that provide EIEC services for children with disabilities and their families to the point of being non-existing. Almost all service providers reported the limited service offerings for children with disabilities and their families within the community as a major factor that impeded their ability to have a successful partnership with families.

Research Question 7: *Are EI/ECSE programs effective in terms of achieving family outcomes for families of young children with disabilities receiving services in Qatar?*

With regard to achievement of outcomes, approximately one-third (35%) of participating families reported achievement of outcome 1 (understands child's strengths, abilities, and needs), 40% of families reported achievement of outcome 2 (knowing rights and advocating effectively), whereas approximately half of the families (49%) achieved outcome 3 (help child develop and learn). Only 39% of families indicated achievement of outcome 4 (having support systems), and 45% of families achieved outcome 5 (accessing desired services in the community). Thus the highest achieved outcome was outcome 3 (help child develop and learn) and the lowest achieved outcome was outcome 1 (understands child's strengths, abilities, and needs). With regard to the overall achievement of the five family outcomes, only 39% of families indicated an overall achievement of the five family outcomes. Lastly, concerning families' perceptions of the helpfulness of EI, the study findings revealed that 42% of families reported that EI helped them know their rights, followed by 37% of families reported that early intervention helped them communicate their child's needs, and approximately one third (33%) of families reported that early intervention enhanced their ability to help their child develop and learn.

With regard to the family groups based on child's type of disability, the highest mean score was for families of children with DS (M = 4.83) on outcome 4 relating to family having supports system, whereas the lowest mean score was for families of CP (M = 2.96) on the same outcome. In fact, families of children with CP had the lowest mean scores for outcome 2 (knowing rights and advocating effectively; M = 3.54) and outcome 5 (accessing desired services in the community; M = 3.04). Consistent with study results related to satisfaction with levels of partnerships, families of children with CP had the lowest mean on three out of the five family outcomes. Although these lower outcomes may be explained by the nature of children with CP as a heterogeneous group, mobility issues and limited accessibility within the community may be a limiting factor to accessing desired services in the community.

Despite the high satisfaction ratings on the Partnership Scale, the majority of participating families reported lower outcomes for the five outcomes. This may be a reflection of the complexity of factors interacting within the EI/ECSE programs. Also, taking into account the heterogeneity of participating families, this might be an actual reflection of true differences in the outcomes experienced by families. A recent study of family outcomes reported similar findings where Hispanic families reported lower outcomes compared to non-Hispanic families (Olmsted, et al., 2010). Further, Olmsted and colleagues (2010) reported a significant association between program characteristics and families' reported outcomes. These characteristics include length of time in early intervention, family-centered practices, and families' perceptions of the helpfulness of early intervention services. In fact, family-centered practices were positively related to family outcomes, demonstrating that families who reported higher outcomes were receiving more family-centered services.

Recommendations

Through careful examination of major findings of the study, following are a series of recommendations to address inadequacies in EI/ECSE programs in Qatar. These recommendations are intended to foster family-centered and family-supportive practices, and be more receptive to collaborative partnerships with families of young children with disabilities:

1. *Provision of Professional Development in Family-Centered Approach*

This research demonstrated that administrators had a good understanding of the value of family involvement and family-centered practices in the EIEC programs for their young children with disabilities. However, administrators lacked the ability to utilize evidence-based practices in the implementation of family-centered care. Administrators were less likely to see provision of professional development opportunities in family-centered practices and collaborative teaming as an area of extreme need for professionals working in EI/ECSE programs in Qatar. Recent studies demonstrated that administrators with a full understanding of family-centered practices were more motivated to support provision of professional development in this area (Mandell & Murray, 2009).

Professional development that emphasizes ongoing training, adequate supervision, and continued monitoring are important aspects of a full commitment to family-centered practices and building collaborative partnerships with families of children with disabilities. Thus, one of the recommendations of this study is the provision of a professional development program that is embedded in research-based practices in the areas of family-centered approach, family-supportive practices, family-professional partnerships and collaborative teaming practices. Ongoing professional development will enable professionals to acquire the knowledge and skills necessary to participate in collaborative partnerships with families of young children with disabilities and to foster trans-disciplinary team work within the EI/ECSE service delivery for children with disabilities and their families. Further, given the heterogeneity of families of children with disabilities receiving EI/ECSE service in Qatar, it is critical that professional development opportunities focus on building partnerships with culturally and linguistically diverse families (Hyun, 2007; Osher & Osher, 2002).

2. *Support and Mentoring of Administrative Personnel*

The relationship between administrative roles and the provision of EI/ECSE service delivery and outcomes for young children with disabilities and their families have been recognized in recent research literature (Epley et al., 2010; Mandell & Murray, 2009). Administrative practices have been found to play a key role in influencing collaborative partnerships between professionals and families of young children with disabilities. Mandell & Murray (2009) described administrators who have a comprehensive understanding in the use of family-centered practices in EI/ECSE as those who "view their administrative roles as supportive for both staff members and families, especially in establishing and maintaining a shared vision, which may be pivotal to creating change within educational programs"(p.31). Those administrators tend to emphasize the role of service providers in supporting the role of families as advocates and decision makers in their children's intervention/educational programs. Thus, effective administrators prioritize professional development that emphasizes training of both professionals and families in building collaborative partnerships. These administrators support professionals and families to share responsibility and equality for program outcomes. Conversely, this study demonstrated that administrators of EI/ECSE programs in Qatar do not perceive the importance of serving as a conduit in supporting the strength of partnerships between families and professionals. Administrators in the study described their role as focused on supervising improvement in child functioning. In their view the main role of service providers was to support families' involvement in EIEC programs through provision of traditional parent education. The preferred training for parents consisted of categorically based, professionally developed and delivered content about disabilities. These traditional parent education services did not require personal or individualized activities designed to enhance collaborative partnerships. Administrative parent training characterized as high in convenience and replication of content across similar programs, settings, or groups of parents was perceived as an adequate vehicle for family involvement in EIEC programs. EIEC program administrators in Qatar require assistance in order to reconceptualize and expand their professional roles. Parent training as described severely limits family involvement and ownership in the positive outcomes of EIEC services. Service providers respond to and rely on leadership that is informed through recommended practices based on knowledgeable research. This study has demonstrated that administrators need current information to comprehend the central and critical roles families play in effecting their children's outcomes. Their leadership role includes supporting service providers to deconstruct the centrality and control of knowledge inherent to professional preparation. Collaborative partnerships between professionals and families require role release/shifts in interpersonal perceptions and values. Administrators are responsible for recognition, acknowledgement, and reinforcement of professionals as they expand their skills repertoire. Professional development and supports are recommended for administrators and service providers that include modeling and guided practices, definitions of and criteria for monitoring increases in partnership abilities should be developed through consensual staff development activities.

The study further revealed that administrators working in EI/ECSE programs in Qatar often lack knowledge on implementation of programs that reflect family-centered practices for children with disabilities and their families. Thus, one of the recommendations of this study is to provide support and mentoring of administrative personnel to address the technical deficiency related to EI/ECSE service delivery models. Although opportunities are provided for administrative personnel to improve their skills in management and administrative practices at both settings (HMC and Shafallah Center), there is limited attention and focus to provision of educational opportunities for administrators in EI/ECSE to improve their skills and knowledge in early intervention service delivery models. By establishing a supervisory and mentoring system for administrative personnel, measures can be taken to alleviate these technical deficiencies through ongoing training. One measure can be established through partnerships with Qatar University (Program in Early Childhood and Program in Special Education) and U.S. Universities at the Education City for provision of training courses for administrative personnel.

3. *Establishing Service Integration within EI/ECSE Programs*

A major finding of the study was the conflicting information communicated to families and the lack of service integration for young children with disabilities and their families in EI/ECSE programs in Qatar. Young children with disabilities have complex needs that require the combined expertise of various professionals from different disciplines, a wide range of services and programs, and multiple agencies (Bruder, 2005). This study demonstrated that this is often a source of stress and overwhelmed feelings for parents of children with disabilities due to service fragmentation in EIEC programs in Qatar. Park & Turnbull (2003) defined service integration as “(a) a systemic effort to provide appropriate and harmonized services to young children and their families , and (b) collaborative partnerships between families and professionals, among professionals, and among agencies that are formed in the process of enhancing child and family outcomes” (p. 50). Service integration refers to “those functions and activities that are aimed at the formation of a unified and comprehensive range of services in a geographical area, where the intent is to enhance the effectiveness of the delivery of services. Service integration deals with the organization perspective (the macro level of service delivery)” (King & Meyer, 2006, p.479). Further, the overall goal of service integration is ensure that children with disabilities and their families have a wide range of services that are available and accessible to them across different programs within a single EIEC agency or organization.

To improve efficacy of EI/ECSE programs and to achieve positive outcomes for young children with disabilities and their families, medical, therapeutic, educational, developmental, and social services must be delivered through an integrated transdisciplinary team approach (Carpenter, 2005; Davies, 2007; King, Strachan, Tucker, Duwyn, Desserud, & Shillington, 2009). Unlike other service delivery models (multidisciplinary and interdisciplinary), the transdisciplinary team approach has been documented as a best practice in EI. Models of teamwork in delivering EIEC services have evolved over time. Research literature reviewed described three kinds of teamwork models: multidisciplinary, interdisciplinary and transdisciplinary (Bell, Corfield, Davies & Richardson, 2009; Walls & O’Connor, 2004). Multidisciplinary team approach is a discipline-specific team in which service providers from different disciplines work in parallel with limited interaction or coordination between team members. Service providers in multidisciplinary teams conduct their evaluation, plan, and provide services in isolation. A provider from a single discipline working in isolation puts positive child and family outcomes at risk. Interdisciplinary team approach is the next step in service delivery in which there is information sharing and coordination between team members; however, service providers still conduct separate assessment, planning and implementation of intervention.

Transdisciplinary teamwork approach is the groundwork for development of collaborative partnerships. As a model of service delivery, it requires every member of the EIEC team to release their parental or discipline specific roles. Each member of the team has equal input towards development of the primary goals and desired outcomes for the child and the family. Effective transdisciplinary teams: (a) value and share knowledge, skills, expertise and techniques openly; (b) work on the same set of priorities that have been consensually agreed on; (c) depend on frequent communication between team members; and (d) members share responsibility for implementation of the plan (Bell, Corfield, Davies & Richardson, 2009). The hallmark of transdisciplinary is the blurring of boundaries between disciplines that allows for role release to occur amongst team members. Thus, a major recommendation of this study is to establish a transdisciplinary team approach in EI/ECSE programs as a model of service delivery to provide more integrated family-centered services. Adopting a transdisciplinary team approach will alleviate current inadequacies in EIEC services reducing fragmentation in services and ensuring a smooth continuum of services for children with disabilities and their families. In order to increase the efficacy and efficiency of family members and service providers from each critical discipline require concurrent training to achieve the competencies and attitudes needed for transdisciplinary teaming. Professional development activities should be designed to increase collaborative planning, improve communication skills, and support discipline specific role release.

4. *Establishing Coordination/Collaboration between EI/ECSE Agencies*

Meeting the individual needs of young children with disabilities and their families requires services from different sources and settings, making coordination of these services of a vital importance (King & Meyer, 2006). The ultimate goal of service coordination is to assist families in accessing needed services for their children with disabilities from multiple agencies that provide EI/ECSE services. In other words, service coordinators organize inter-agency collaboration relationships by coordinating with other service providers from different disciplines. They are responsible for communicating options to enable families to navigate the system and obtain needed services for their children with disabilities, monitor delivery of available services, and facilitate development of transition plans. Park & Turnbull (2003) viewed service coordination as a "systematic process for assisting family members in obtaining services and resources they need" (p.49). Considering the complexity of the EIEC systems, it is essential to provide service coordination for families.

Therefore, one of the recommendations for this study is to provide service coordination and train service coordinators for families of young children with disabilities to facilitate their access to needed services. The study revealed that a majority of families experienced difficulties finding the services and supports they needed. Families reported problems accessing desired services with no one available to advocate for them or provide a referral. Families who lack access to existing services or limited resources within the community reported lower satisfaction with their level of partnership. Family-focused coordination that is flexible, personalized, and designed to meet the unique needs of individual families is needed. King & Meyer (2006) described family-focused coordination:

> "emphasizes activities that link clients to services, including developing service linkage plans with clients, linking clients to services and supports, and liaising

> with service providers both within and across agencies in order to determine the availability of services and facilitate access" (p. 486).

Further, the role of service coordinator involves tasks that support families on emotional and practical levels such as providing of information on community resources, or advocacy and educational activities. Service coordinators provide families a central source when they seek advice and facilitate supports to families of young children with disabilities. The service provider responsible for coordination of child and family services should represent the discipline most critical to meeting the child's development needs. Each team member should receive training in transdisciplinary team work and family centered social services.

As part of family-based service coordination, it is imperative to establish a partnership between the HMC and Shafallah Center. They are the two major organizations for the provision of medical, therapeutic, and educational services for children with disabilities and their families. A point to start this partnership is to plan a consortium to establish a network of community members, administrative members, and professional members. The consortium will liaison between the two agencies to develop an inter-agency agreement providing guidelines, targeted outcomes, schedules for planning, training, and implementation of recommended service delivery models. Collaborative service providers have potential to further improve EI/ECSE service delivery. A team of experts could be invited to facilitate the process and to provide workshops in this area. The consortium should serve as a networking and problem-solving opportunity for all key stakeholders in EI/ECSE. The ultimate outcome is an action plan for collaboration between HMC and Shafallah Center with immediate, short-term, and long-term goals and objectives.

5. *Establishing Quality Indicators for EI/ECSE*

The study findings revealed a need for creating a system for accountability in EI/ECSE programs in Qatar as it relates to the quality and outcomes of services for young children with disabilities and their families. Establishing a system of quality indicators for EI/ECSE programs is crucial to making informed decisions about services and programs. Assessment of family outcomes, in addition to child outcomes, can serve as a vital tool in evaluating the efficacy of early intervention programs (Olmsted et al., 2010). Thus, EI/ECSE programs in Qatar can utilize the Family Outcomes Survey (FOS) to evaluate achievement of family outcomes as part of program evaluation. Further, EI/ECSE programs can utilize the Family Outcomes Survey- Revised version (FOS-R) that was available at the end of 2009 for self-assessment. The surveys can be downloaded from the Center of Early Childhood Outcomes website (http://www.fpg.unc.edu/~eco/). The revised version is reduced to two-pages, has been simplified, and utilizes a 5-point rating scale instead of the 7-point rating scale in the original FOS. The FOS-R includes two sections: (a) the first section focuses on the five family outcomes and consists of 24 items; and (b) the second section focuses on the three helpfulness indicators of EI/ECSE programs and consists of 17 items. The FOS-R has been translated to many different languages and is available in Arabic. (See Appendix M for both the English and Arabic versions of the Family Outcomes Survey-Revised).

Implications for future research

The present study contributes to current research literature by providing an insight into two key aspects of EI/ECSE programs in Qatar relating to satisfaction with family-professional partnerships and family outcomes. The study fills in the gap of needed research by exploring key elements in early intervention in other cultures and languages. The study is the first attempt to explore EI/ECSE services in Qatar from the perspectives of key stakeholders including families of young children with disabilities, service providers, and program directors. The study also adds to current literature on family outcomes by examining parents' perceived family outcomes in early intervention programs in Qatar.

Study findings point to a further need for research to explore other factors influencing the success of family-professional partnerships in EI/ECSE programs in Qatar that are serving families within diverse cultural contexts. The study employed an Exploratory Concurrent Triangulation design, which allowed convergent triangulation of both quantitative and qualitative data to provide validity evidence and address the concern related to the cultural specificity of the Partnership Scale. However, future replication of the study is needed to further endorse the findings of this study.

In addition, this study provides information related to differences in reported levels of satisfaction with partnership between families according to the child's type and severity of disability, and differences between service providers according to their discipline. More in-depth research is needed to explore issues relating to factors influencing satisfaction with partnership with larger samples of families of children with Cerebral Palsy. This study finding showed these families had the lowest satisfaction ratings on the Partnership Scale as well as the lowest outcomes. The information and recommendations presented here will enable administrators to make appropriate and informed decisions towards implementing strategies for program improvement.

Study limitations

Some limitations apply to this study. First, the choice of snowball sampling strategy for the qualitative strand has affected the depth of qualitative findings. Even though snowball sampling provides richness of information regarding participants' experiences, the participants may not be a representative sample, specifically the initial nominees. Patton (2002) notes that "the chain of recommended informants would typically diverge initially as many possible sources are recommended, then converge as a few key names get mentioned over and over" (p. 237). Nevertheless, snowball sampling was the most appropriate strategy as it provided participants who were willing to share their lived experiences of partnership in EI/ECSE programs.

Second, the sample size was fairly small. A sample of 127 participants was appropriate for this study as the research literature examining satisfaction with partnership utilized a sample size in the range of 145- 180 participants (Dunst & Dempsey, 2007; Summers et al., 2005a; Summers et al., 2005b; Summers et al., 2007). However, out of the 127 participants only 57 (45%) were families of young children with disabilities, which represented only 10% of the targeted population. Thus, the small sample size for the families and the small sample sizes in the family groups may be considered another limitation to the study. Nevertheless, analyses of families' characteristics showed that the sample was representative of the larger population of children with disabilities and families receiving EIEC services at both HMC and

Shafallah Center. Accordingly, a larger sample of families of young children with disabilities should be employed in future research replications of this study.

Conclusion

The present study is the first to explore the overall perceptions and experiences of key stakeholders in EI/ECSE programs in Qatar that included families of young children with disabilities, service providers, and administrators. The inclusion of key stakeholders from top level administrative management in EI/ECSE (Assistant Director for Rehabilitation Service at HMC and Managing Director of Shafallah Center) provided additional reliability to the results. Moreover, key findings of the study were also supported by previous research literature on administrative policies and practices, as well as service delivery models that influence the success of family-professional partnerships (Appl, 2006; Bailey & Bruder, 2005; Bailey, Scarborough, & Hebbeler, 2003; Blue-Banning et al., 2004; Brotherson et al., 2009; Bruder, 2010; Bruder & Dunst, 2005; Carter et al., 2009; Dickens et al., 2010; Dokken & Ahmann, 2006; Hughesa & Valle-Riestrab, 2008; Law et al., 2003; Moretz, 2010; Park & Turnbull, 2003; Raghavendra et al., 2007; Summers et al., 2007).

In order to effectively meet the complex needs of young children with disabilities and their families, there is a need to understand the context in which early intervention services are delivered by service providers and received by children with disabilities and their families. For partnerships to develop, the family's commitment must be complemented by the availability of a team of professionals who value a family-centered approach and embrace collaborative partnership with families of children with disabilities. Once these supporting factors are available, the process of establishing the partnership and engaging in collaborative relationship can then begin. Even though professionals value the importance of family involvement and family-centered approach, many feel challenged and uncomfortable with the family-centered and collaborative orientation that is necessary to engage with parents in a true partnership. The majority of professionals (mainly health care providers), are educated and trained to be the expert, which makes sharing authority with families of young children with disabilities a challenging process. Family-professional partnerships require a high level commitment and time. The shortage of professionals increases their caseloads. Professionals consider their time is more valuable than a family’s time. Until professionals understand that it is their job to share expertise with the family members who will live with and care for this child long after whatever small service the professional can offer is remembered, the discipline professionals represent is not an issue for families.

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APPENDICES

Appendix A

Family-Professional Partnership Scale (Family Version)

Family-Professional Partnership Scale

Developed by the Beach Center on Disability,
at the University of Kansas,
in partnership with families, service providers
and researchers

SURVEY INSTRUCTIONS

- All the information you give us is confidential. Your name will not be attached to any of the information you give us. It is important that you answer as many questions as you can, but please feel free to skip those questions that make you feel uncomfortable.
- Please circle the best answer that describes your experience. If you change your answer, please use a mark of "X" to indicate the wrong answer and then circle the correct answer.
- If you have any comments, please write them down in the comments section.

Partnership Scale

- This survey is about how you feel about the main person who works with you and your child. We will use what we learn from families to inform policy makers and service providers for children and families.
- There may be many different service providers who work with your child with special needs, such as teachers, social workers, or speech, occupational, physical, or behavior therapists. Think about the service provider who has worked THE MOST with your child over the **last six months.**
- Please tell us what type of service provider you are thinking about. (Check only one)

☐ Special education teacher
☐ Occupational therapist
☐ Speech therapist
☐ Counselor or therapist
☐ Nurse
☐ Behavior therapist
☐ Physical therapist
☐ Social worker
☐ Doctor
☐ Other (please specify)

Service provider Relationships with the Child. **How do you feel about the way your child's service provider (the one who work with him or her the most) works with your child?**	**How satisfied are you that . . .**				
My child's service provider . . .*	Very Unsatisfied	Somewhat Unsatisfied	Feeling Neutral	Somewhat Satisfied	Very Satisfied
1. Helps me gain skills or information to get what my child needs.	1	2	3	4	5
2. Has the skills to help my child succeed.	1	2	3	4	5
3. Provides services that meet the individual needs of my child.	1	2	3	4	5
4. Speaks up for my child's best interests when working with other service providers.	1	2	3	4	5
5. Lets me know about the good things my child does.	1	2	3	4	5
6. Treats my child with dignity.	1	2	3	4	5
7. Builds on my child's strengths	1	2	3	4	5
8. Values my opinion about my child's needs.	1	2	3	4	5
9. Keeps my child safe when my child is in his or her care.	1	2	3	4	5

Family and Service Provider Relationships. **How do you feel about the way your child's primary service provider (the one who works with him or her the most) works with you and your family as a whole?**	**How satisfied are you that . . .**				
My child's service provider . . .	Very Unsatisfied	Somewhat Unsatisfied	Feeling Neutral	Somewhat Satisfied	Very
10. Is available when I need them.	1	2	3	4	5
11. Is honest, even when they have bad news.	1	2	3	4	5
12. Uses words that I understand	1	2	3	4	5
13. Protects my family's privacy.	1	2	3	4	5
14. Shows respect for my family's values and beliefs.	1	2	3	4	5
15. Listens without judging my child or family.	1	2	3	4	5
16. Is a person who I can depend on and trust.	1	2	3	4	5
17. Pays attention to what I have to say.	1	2	3	4	5
18. Is friendly.	1	2	3	4	5

Appendix B

Family-Professional Partnership Self-Assessment (Professional Version)

Family-Professional Partnership
Self-Assessment

Based on the Beach Center
Family-Professional Partnership Survey

The purpose of this self-assessment is to assist professionals to look at their practice and identify possible barriers and facilitators to their ability to have positive family-professional partnerships.

Below are the individual items based on the Family-Professional Partnership Scale that is used with families to assess their satisfaction with their child's and family's services and partnerships with professionals.

For each item, evaluate your current skills and attitudes and give yourself a score between 1 and 5, with 5 being the best. Then, think about and identify what helps you demonstrate the attitude or skill that the item represents. Also identify what hinders (gets in your way) of demonstrating the attitude or skill.

1. I help parents gain the skills or information to be able to get what their child needs (provide training to parents, help parents access information on resources).

Score	**What Helps**	**What Hinders**

2. As a professional, I have the skills to help children succeed (have basic competencies, engage in continuous learning to gain new information and skills, hold high expectations for the child's achievement and provide meaningful opportunities for him or her to succeed).

Score	**What Helps**	**What Hinders**

3. I provide services that meet the individual needs of each child (know how to individualize instructional or treatment techniques to accommodate the child’s strengths and needs).

Score	**What Helps**	**What Hinders**

4. I speak up for children’s best interests when working with other service providers (advocate with other programs or professionals on behalf of a child or family).

Score	**What Helps**	**What Hinders**

5. I let parents know about the good things their children do.

Score	**What Helps**	**What Hinders**

6. I treat children with dignity at all times (value children as persons, shield children from humiliating or embarrassing situations).

Score	**What Helps**	**What Hinders**

7. I build on children’s strengths (use a strengths perspective to set objectives or outcomes).

Score	What Helps	What Hinders

8. I am honest with parents, even when I have bad news (honesty both in terms of children’s needs/disabilities, and in terms of program/resource limitations, do not claim to know something when we don’t).

Score	What Helps	What Hinders

9. I keep children safe at all times when in our care.

Score	What Helps	What Hinders

10. I am available when parents need me (emergency evening or weekend access, dependable availability during posted hours, reliably accessible to families by phone or in person, willing to come to their home).

Score	What Helps	What Hinders

11. I value parents' opinions about children's needs (ask parents their opinions, incorporate parents' points of view in outcomes and instructional or service strategies).

Score	**What Helps**	**What Hinders**

12. I use words that the parent understands (avoid jargon, take time to explain).

Score	**What Helps**	**What Hinders**

13. I protect the family's privacy (maintain confidentiality with other programs, avoid "gossip" about families).

Score	**What Helps**	**What Hinders**

14. I show respect for the family's values and beliefs.

Score	**What Helps**	**What Hinders**

15. I listen without judging the child or family.

Score	What Helps	What Hinders

16. I am dependable (follow through on commitments or promises).

Score	What Helps	What Hinders

17. I pay attention to what parents have to say (listen actively, demonstrate respect for parent's comments, demonstrate belief/respect parent's observations about the child).

Score	What Helps	What Hinders

18. I am friendly to parents (maintain a welcoming and friendly atmosphere).

Score	**What Helps**	**What Hinders**

Appendix C

Family Outcomes Survey

Translated Family Outcomes Survey (Arabic Version)

Family Outcomes Survey

Directions:

- On the following pages, please circle the number that best describes your family right now. If a statement almost describes your family, but not quite, circle the number just below the statement. For example, if the statement under 3 almost describes your family, but not quite, circle the 2.
- You will notice that the responses include the word “we.” This refers to your family. It’s okay if you are answering just for yourself (your own opinion or experience) or as a family with a shared opinion or experiences.

Family Outcomes Survey

Understanding your child’s strengths, abilities, and special needs

1. Your child is growing and learning. How well do you understand your child’s development?

1	2	3	4	5	6	7
We are just beginning to understand our child’s development		We have a basic understanding of our child’s development, but still have a lot to learn		We have a pretty good understanding of our child’s development		We understand our child’s development very well

2. Some children have special health needs, a disability, or are delayed in their development. How much do you know about your child’s special needs? ☐ CHECK HERE IF YOUR CHILD DOES NOT HAVE SPECIAL NEEDS AND GO TO QUESTION 3.

1	2	3	4	5	6	7
Right now we do not know very much		We have learned some things, but still have a lot of unanswered questions		We know a lot, but still need or want to know more		We are confident that we know most of what we need to know right now

3. Professionals who work with you and your child want to know if the things they do are working. Are you able to tell if your child is making progress?

1	2	3	4	5	6	7
Right now we can’t tell if our child is making progress		We sometimes can tell if our child is making progress, but still have a lot to learn		We usually can tell if our child is making progress		We almost always can tell if our child is making progress

Knowing your rights and advocating for your child

4. A variety of programs and services may be available for your child and family. Do you know what is available for your child and family?

1	2	3	4	5	6	7
We are just beginning to learn about the programs and services that are available		We know about some programs and services, but still have a lot to learn		We think we are aware of most available programs and services		We are very aware of the programs and services that are available

5. Parents often meet with professionals to plan services or activities. How comfortable are you participating in these meetings?

1	2	3	4	5	6	7
Right now we are very uncomfortable participating in meetings		We are not very comfortable participating in meetings, but we do it anyway		We are pretty comfortable participating in meetings		We are very comfortable participating in meetings

6. Families of children with special needs have rights, and there are things you can do if you are not satisfied. How well do you know your rights and what to do if you are not satisfied?

☐ CHECK HERE IF YOUR CHILD DOES NOT HAVE SPECIAL NEEDS AND GO TO QUESTION 7

1	2	3	4	5	6	7
We are not sure about our rights or what to do if we are not satisfied		We understand our basic rights but are not sure about all of our options if we are not satisfied		We think we know most of our rights and what to do if we are not satisfied		We are very aware of our rights and know exactly what to do if we are not satisfied

Helping your child develop and learn

7. All parents help their children develop and learn, but sometimes it is hard to know what to do. How would you describe your ability to help your child develop and learn?

1	2	3	4	5	6	7
We need to know a lot more about how to help our child develop and learn		We know the basics of helping our child develop and learn, but still have many questions		We feel pretty sure that we know how to help our child develop and learn		We are very sure that we know how to help our child develop and learn

8. All parents try to help their children learn to behave the way they would like, but sometimes it is hard to know what to do. How would you describe your ability to help your child learn to behave the way you would like?

1	2	3	4	5	6	7
We need to know a lot more about how to help our child behave like we want		We know the basics of helping our child behave, but still have many questions		We feel pretty sure that we know how to help our child behave		We are very sure that we know how to help our child behave

9. Your family has worked with professionals to develop a plan to help your child learn new skills and behaviors. How much are you able to help your child learn or practice these new skills at home or in your community?

1	2	3	4	5	6	7
We have not yet started to help our child learn or practice these skills and behaviors		We have started to help our child learn and practice these skills and behaviors, but it is not a regular thing yet		We often help our child learn and practice these skills and behaviors, but it is not as regular as we would like		We regularly help our child learn and practice these skills and behaviors throughout the day

Having support systems

10. Many people feel that talking with another person helps them deal with problems or celebrate when good things happen. Does your family have someone you trust to listen and talk with you?

1	2	3	4	5	6	7
Right now, we really don’t have anyone we can talk with about the things that are happening in our lives		We can probably find at least one person we could talk with, but are not very satisfied with the situation		We usually have other people that we can talk with about things		There are definitely people in our lives we can talk with whenever we need to

11. Families sometimes must rely on other people for help when they need it, for example to provide a ride, run an errand, or watch their child for a short period of time. Do you have someone you can call on when you need help with things?

1	2	3	4	5	6	7
Right now our family really doesn’t have anyone we can call on when we need help with things		In an emergency we have people we can call on for help, but not for the everyday things		Usually there is someone that we can call on for help when we need it		We almost always have other people we can call on for help when we need it

12. Most families have things they enjoy doing. How much is your family able to do the things you enjoy?

1	2	3	4	5	6	7
Right now it is really difficult to do any of the things we enjoy		We are able to participate in some of the things we enjoy, but not nearly as much as we would like		We are able to participate in many of the activities we enjoy		We are able to participate in almost all of the activities we enjoy

Accessing your community

13. All children need medical care. How would you describe the medical care you have for your child right now?

1	2	3	4	5	6	7
We do not have the medical care we want for our child		We have some medical care, but still have a long way to go before it is what we want		We have good medical care for our child		We have excellent medical care for our child

14. Many families have a need for quality childcare. By this, we do not mean occasional babysitting, but regular childcare, either part-day or full-day. How would you describe the childcare you have for your child right now? ☐CHECK HERE IF YOU HAVE NOT WANTED CHILD CARE, AND GO TO QUESTION 15.

1	2	3	4	5	6	7
We do not have the childcare we want <u>OR</u> because of our child's special needs we have decided not to look for it.		We have some childcare, but still have a long way to go before it is what we want		We have good childcare for our child		We have excellent childcare for our child

15. Many families want their child to play with other children or participate in religious, community, or social activities. How would you describe your child's participation in these activities right now? ☐CHECK HERE IF YOU HAVE NOT WANTED YOUR CHILD TO PARTICIPATE IN SUCH ACTIVITIES AND GO TO QUESTION 16.

1	2	3	4	5	6	7
Right now our child does not participate in activities we want <u>OR</u> because of our child's special needs we have decided not to look for it		Our child participates in some social or community activities, but we have a long way to go before it is what we want		Our child has good participation in social or community activities		Our child has excellent participation in social or community activities

Your feelings about early intervention

16. To what extent has early intervention helped your family <u>know and understand your rights</u>?

1	2	3	4	5	6	7
Early intervention has not helped us know about our family's rights		Early intervention has done a few things to help us know about our rights		Early intervention has provided good help so that we know our family's rights		Early intervention has done an excellent job of helping us know about our family's rights

17. To what extent has early intervention helped your family <u>effectively communicate your child's needs</u>?

1	2	3	4	5	6	7
Early intervention has not helped us effectively communicate our child's needs		Early intervention has done a few things to help us effectively communicate our child's needs		Early intervention has done a good job of helping us effectively communicate our child's needs		Early intervention has done an excellent job of helping us effectively communicate our child's needs

18. To what extent has early intervention helped your family be able to <u>help your child develop and learn</u>?

1	2	3	4	5	6	7
Early intervention has not helped us help our child develop and learn		Early intervention has done a few things so that we can help our child develop and learn		Early intervention has done a good job of helping us help our child develop and learn		Early intervention has done an excellent job of helping us help our child develop and learn

Thank you for completing this survey

استطلاع رأي نتائج الأسر

تعليمات:

- في الصفحات التالية، يرجى وضع دائرة حول رقم الإجابة التي تقدم أفضل وصف لأسرتك في الوقت الحالي .وإذا كان الوصف تقريبياً وليس دقيقاً، ضع الدائرة حول الرقم الأقل من ذلك الموجود فوق الإجابة .على سبيل المثال، إذا كانت الإجابة رقم 3 تقدم وصفاً تقريبياً وليس دقيقاً لأسرتك، ضع الدائرة حول رقم2

- وسوف تلاحظ أن الإجابات تشمل كلمة" نحن " وهذه الكلمة تشير إلى أسرتك. ولا ضرر في أن تكون إجابتك عن نفسك فقط رأيك الخاص أو تجربتك أو كأسرة لها رأى مشترك وتجربة مشتركة.

استطلاع رأي نتائج الأسر

فهم مواطن القوة لدى الطفل، وقدراته واحتياجاته الخاصة.

1. طفلك ينمو ويتعلم .إلى أي مدى تفهم ما يطرأ على الطفل من تطور؟

1	2	3	4	5	6	7
لقد بدأنا لتونا فهم تطور طفلنا.		لدينا فهم أساسي لتطور طفلنا، ولكن مازلنا في حاجة إلى معرفة الكثير بهذا الشأن.		لدينا فهم معقول لتطور طفلنا.		نحن نفهم تماماً تطور طفلنا.

2. بعض الأطفال لديهم احتياجات صحية خاصة، أو إعاقة، أو تأخر في تطورهم .ما مدى معرفتك بالاحتياجات الخاصة لطفلك؟

1	2	3	4	5	6	7
في الوقت الحالي، نحن لا نعرف الكثير.		لقد عرفنا بعض الأشياء، ولكن مازال هناك الكثير من الأسئلة التي تحتاج إلى إجابات.		نحن نعرف الكثير، ولكن مازال لدينا الحاجة أو الرغبة لمعرفة المزيد.		نحن على ثقة من أن لدينا معظم ما نريد معرفته في الوقت الحالي.

3-المتخصصون الذين يعملون معك ومع طفلك يريدون معرفة ما إذا كانت الأشياء التي يفعلونها مجدية .هل تستطيع معرفة ما إذا كان طفلك يحرز تقدماً؟

1	2	3	4	5	6	7
في الوقت الحالي، لا نستطيع معرفة ما إذا كان طفلنا يحرز تقدماً.		أحياناً نستطيع القول بأن طفلنا يحرز تقدماً .ولكنا لا نزال في حاجة إلى معرفة الكثير بهذا الشأن.		عادة ما نستطيع معرفة ما إذا آن طفلنا يحرز تقدماً.		في معظم الأحيان نستطيع معرفة ما إذا كان طفلنا يحرز تقدما.

معرفة حقوقك والدفاع عن طفلك

4-هناك أنواع مختلفة من البرامج والخدمات التي قد تكون متاحة لطفلك ولأسرتك .هل تعرف ما هو متاح لطفلك ولأسرتك؟

1	2	3	4	5	6	7
لقد بدأنا منذ فترة بسيطة التعرف على البرامج والخدمات المتاحة.		نحن نعرف أشياء عن بعض البرامج والخدمات، ولكنا لا نزال في حاجة إلى معرفة الكثير بهذا الشأن.		نعتقد أننا على علم بمعظم البرامج والخدمات المتاحة.		نحن على علم تام بالبرامج والخدمات المتاحة.

5-غالباً ما يلتقي الآباء بالمتخصصين لتخطيط الخدمات والأنشطة .إلى أي مدى تشعر بالارتياح إزاء المشاركة في هذه اللقاءات؟

1	2	3	4	5	6	7
في الوقت الحالي، لا نشعر بأى ارتياح إزاء المشاركة في هذه اللقاءات.		لا نشعر بقدر كبير من الارتياح إزاء المشاركة في هذه اللقاءات.		نشعر بقدر معقول من الارتياح إزاء المشاركة في هذه اللقاءات.		نشعر بقدركبير من الارتياح إزاء المشاركة في هذه اللقاءات.

6-أسر الأطفال ذوى الاعاقات لها حقوق .وهناك أشياء يمكن لهذه الأسر أن تقوم بها إذا لم تشعر بالرضا .إلى أي مدى أنت على علم بحقوقك، وماذا تفعل إذا لم تشعر بالرضا بشأنها؟

1	2	3	4	5	6	7
نحن لسنا متأآدين بشأن حقوقنا، ولا نعرف ماذا نفعل إذا لم نشعر بالرضا بشأنها.		نحن نفهم حقوقنا الأساسية، ولكنا لسنا متأآدين بشأن الخيارات المتاحة لنا إذا لم نشعر بالرضا بشأنها.		نعتقد أننا على علم بمعظم حقوقنا، وبما يجب أن نفعله إذا لم نشعر بالرضا بشأنها.		نحن على علم آامل بحقوقنا، ونعرف بالضبط ماذا نفعل إذا لم نشعر بالرضا بشأنها.

مساعدة طفلك على التطور والتعلم

7- كل الآباء يساعدون أطفالهم على التطور والتعلم .ولكن أحياناً يكون من الصعب معرفة ما يجب القيام به .كيف يمكنك وصف قدرتك على مساعدة طفلك على التطور والتعلم؟

1	2	3	4	5	6	7
نحن ما زلنا في حاجة إلى معرفة الكثير عن كيفية مساعدة طفلنا على التطور والتعلم.		نحن نعرف الأساسيات الخاصة بمساعدة طفلنا على التطور والتعلم. لكن مازال لدينا العديد من الأسئلة بهذا الخصوص.		نحن متأكدون بدرجة معقولة أننا على علم بكيفية مساعدة طفلنا على التطور والتعلم.		نحن متأكدون تماماً أننا على علم بكيفية مساعدة طفلنا على التطور والتعلم.

8-كل الآباء يحاولون مساعدة أطفالهم على تعلم السلوك الذي يرتضونه .ولكن أحياناً يكون من الصعب معرفة ما يجب القيام به .كيف يمكنك وصف قدرتك على مساعدة طفلك على تعلم السلوك الذي ترتضيه؟

1	2	3	4	5	6	7
نحن ما زلنا في حاجة إلى معرفة الكثير عن كيفية مساعدة طفلنا على انتهاج السلوك الذي نرتضيه.		نحن نعرف الأساسيات الخاصة بمساعدة طفلنا على انتهاج السلوك الذي نرتضيه، ولكن مازالت لدينا أسئلة كثيرة بهذا الخصوص.		نحن متأكدون بدرجة معقولة أننا على علم بكيفية مساعدة طفلنا على انتهاج السلوك الذي نرتضيه.		نحن متأكدون تماماً أننا على علم بكيفية مساعدة طفلنا على انتهاج السلوك الذي نرتضيه.

9 -لقد عملت أسرتك مع المتخصصين لتطوير خطة تستهدف مساعدة طفلك على تعلم مهارات وأنماط سلوك جديدة .إلى أي مدى تشعر بالقدرة على مساعدة طفلك على تعلم أو ممارسة هذه المهارات في البيت أو في المنطقة التي يعيش فيها؟

1	2	3	4	5	6	7
لم نبدأ بعد مساعدة طفلنا على تعلم أو ممارسة المهارات أو أنماط السلوك هذه.		لقد بدأنا مساعدة طفلنا على تعلم وممارسة المهارات أو أنماط السلوك هذه، ولكن ذلك لا يتم بانتظام.		نحن غالباً ما نساعد طفلنا على تعلم وممارسة المهارات أو أنماط السلوك هذه .ولكن ذلك لا يتم بالانتظام الذي نتمناه.		نحن نساعد طفلنا بانتظام على تعلم وممارسة هذه المهارات وأنماط السلوك طوال اليوم.

الحصول على وسائل الدعم

10-كثير من الناس يشعرون بأن التحدث إلى شخص آخر يساعدهم على التعامل مع المشكلات أو الاحتفال بالمناسبات السعيدة .هل لدى أسرتك شخص جدير بالثقة يمكنك التحدث والاستماع إليه؟

1	2	3	4	5	6	7
في الوقت الحالي، نحن في الحقيقة ليس لدينا أى شخص يمكن أن نتحدث إليه بخصوص الأشياء التي تحدث في حياتنا.		ربما كان بإمكاننا أن نجد شخصاً واحداً على الأقل يمكننا التحدث إليه، ولكننا لا نشعر برضا كبير إزاء هذا الموقف.		عادة ما يكون لدينا أشخاص آخرون نستطيع التحدث إليهم عن الأوضاع.		بكل تأكيد، هناك أشخاص في حياتنا نستطيع التحدث إليهم كلما احتجنا إلى ذلك.

11-تضطر الأسر أحياناً إلى الاعتماد على أشخاص آخرين عند الحاجة إلى المساعدة، وعلى سبيل المثال عند الحاجة إلى وسيلة مواصلات أو قضاء مصلحة أو الاعتناء بطفل لفترة قصيرة . هل لديك شخص تستطيع اللجوء إليه عندما تحتاج مساعدة آهذه؟

1	2	3	4	5	6	7
في الوقت الحالي، ليس لدى أسرتى في الحقيقة شخص يمكننا اللجوء إليه عند الحاجة إلى المساعدة.		لدينا أشخاص يمكننا اللجوء إليهم طلباً للمساعدة في حالات الطوارئ، ولكن ليس في شئون حياتنا اليومية.		عادة ما يكون هناك شخص نستطيع اللجوء إليه طلباً للمساعدة عندما نحتاجها.		لدينا، بصفة شبه دائمة، أشخاص نستطيع اللجوء إليهم طلباً للمساعدة عندما نحتاجها.

12-معظم الأسر لها أنشطة تستمتع بالقيام بها .إلى أي مدى يمكن اعتبار أسرتك قادرة على ممارسة الأنشطة التي تستمتع بها؟

1	2	3	4	5	6	7
في الوقت الحالي، من الصعب في الحقيقة أن نمارس الأنشطة التي نستمتع بها.		نستطيع المشارآة في ممارسة بعض الأنشطة التي نستمتع بها، ولكن ليس بالقدر الذي نتمناه.		نستطيع المشارآة في ممارسة الكثير من الأنشطة التي نستمتع بها.		نستطيع المشارآة في ممارسة أغلب الأنشطة التي نستمتع بها.

الوصول لمجتمعك

13-جميع الأطفال يحتاجون إلى رعاية طبية .كيف يمكنك وصف الرعاية الطبية التي تحصل عليها لأطفالك في الوقت الحالي؟

1	2	3	4	5	6	7
نحن لا نحصل على الرعاية الطبية التي نريدها لأطفالنا.		نحن نحصل على بعض الرعاية الطبية، ولكن مازال هناك الكثير الذي يجب تحقيقه قبل أن تصبح هذه الرعاية على النحو الذي نريده.		نحن نحصل على رعاية طبية جيدة لأطفالنا.		نحن نحصل على رعاية طبية ممتازة لأطفالنا.

14-كثير من الأسر تحتاج إلى رعاية جيدة لأطفالها .وهذا لا يعنى تواجد جليس للأطفال بين الحين والآخر، وإنما يعنى رعاية منتظمة خلال جزء من اليوم أو خلال اليوم كله .كيف يمكنك وصف الرعاية التي تحصل عليها لأطفالك في الوقت الحالي.

☐ ضع علامة هنا إذا كنت لم تطلب رعاية أطفال، وانتقل إلى السؤال رقم15

1	2	3	4	5	6	7
نحن لا نحصل على الرعاية التي نريدها لطفلنا، أو، بسبب الاحتياجات الخاصة لطفلنا قررنا عدم السعى إلى ذلك.		نحن نحصل على بعض الرعاية لطفلنا، ولكن مازال هناك الكثير الذي يجب تحقيقه قبل أن تصبح هذه الرعاية على النحو الذي نريده.		نحن نحصل على رعاية جيدة لطفلنا.		نحن نحصل على رعاية ممتازة لطفلنا.

15- كثير من الأسر تحب أن يلعب أطفالها مع غيرهم من الأطفال، وأن يشاركوا في الأنشطة الدينية أو المجتمعية أو الاجتماعية .كيف يمكنك وصف مشاركة طفلك في هذه الأنشطة في الوقت الحالي؟☐ ضع علامة هنا إذا كنت لا تريد أن يشارك أطفالك في مثل هذه الأنشطة، وانتقل إلى السؤال رقم16

1	2	3	4	5	6	7
طفلنا لا يشارك في مثل هذه الأنشطة، أو، بسبب الاحتياجات الخاصة لطفلنا قررنا عدم السعى إلى ذلك.		طفلنا يشارك في بعض الأنشطة الاجتماعية أو المجتمعية، ولكن مازال هناك الكثير الذي يجب تحقيقه قبل أن تصبح هذه المشاركة على النحو الذي نريده.		يقوم طفلنا بمشاركة جيدة في الأنشطة الاجتماعية أو المجتمعية.		يقوم طفلنا بمشاركة ممتازة في الأنشطة الاجتماعية أو المجتمعية.

شعورك إزاء التدخل المبكر

16-إلى أي مدى ساعد التدخل المبكر أسرتك على معرفة وفهم حقوقها؟

1	2	3	4	5	6	7
التدخل المبكر لم يساعدنا على معرفة حقوق أسرتنا.		التدخل المبكر لم يفعل سوى القليل لمساعدتنا بطريقة فعالة على معرفة حقوق أسرتنا.		التدخل المبكر قدم لنا مساعدة جيدة آى نعرف حقوق أسرتنا.		التدخل المبكر قدم لنا مساعدة ممتازة كى نعرف حقوق أسرتنا.

17-إلى أي مدى ساعد التدخل المبكر أسرتك على توصيل احتياجات طفلك بطريقة فعالة؟

1	2	3	4	5	6	7
التدخل المبكر لم يساعدنا بطريقة فعالة على توصيل احتياجات طفلنا.		التدخل المبكر لم يفعل سوى القليل لمساعدتنا بطريقة فعالة على توصيل احتياجات طفلنا.		التدخل المبكر حقق إنجازاً طيباً في مساعدتنا بطريقة فعالة على توصيل احتياجات طفلنا.		التدخل المبكر حقق إنجازاً ممتازاً في مساعدتنا بطريقة فعالة على توصيل احتياجات طفلنا.

18-إلى أي مدى ساعد التدخل المبكر أسرتك على أن تتمكن من مساعدة طفلك على التطور والتعلم؟

1	2	3	4	5	6	7
التدخل المبكر لم يساعدنا في مساعدة طفلنا على التطور والتعلم.		التدخل المبكر لم يفعل سوى القليل ليمكننا من مساعدة طفلنا على التطور والتعلم.		التدخل المبكر حقق إنجازاً طيباً في تمكيننا من مساعدة طفلنا على التطور والتعلم.		التدخل المبكر حقق إنجازاً ممتازاً في تمكيننا من مساعدة طفلنا على التطور والتعلم.

Appendix D

Family Demographic Survey

Family Demographic Survey

University of Oklahoma

The purpose of this survey is to learn more about your child with disability, your family, and services that you and your child receive. All information will be kept completely confidential. None of the information you share will ever be reported individually about you, your child, or your family to the early intervention programs.

Instruction:

- This survey consists of three sections relating to your family, your child with disability, and the services that you and your child receive.
- If you have more than one child with disability, please fill out two forms for section 2 and section 3.
- For each item, please choose the best answer unless otherwise specified.

Section 1: Family Characteristics

1. **What is your relationship to the child with disability?**
    a. Mother
    b. Father
    c. Other (please specify) ________________

2. **What is your nationality?**
    a. Qatari
    b. Non-Qatari (please specify) ________________

3. **What is the child's mother age?**
    a. 20 years old or younger
    b. 21 - 30 years old
    c. 31 - 40 years old
    d. 41 - 50 years old
    e. 51 - 60 years old
    f. Older than 60 years old

4. **What is the child's father age?**
    a. 20 years old or younger
    b. 21 - 30 years old
    c. 31 - 40 years old
    d. 41 - 50 years old
    e. 51 - 60 years old
    f. Older than 60 years old

5. **Does the child's mother work?**
    a. No
    b. Yes (please specify your occupation) ________________

6. Does the child's father work?

   a. No
   b. Yes (please specify your occupation) ___________________

7. What is the child's mother educational level?

   a. Less than high school
   b. High school diploma
   c. Some college courses
   d. 2-year college degree
   e. 4-year college degree (bachelor degree)
   f. Some graduate work
   g. Graduate degree (master degree)
   h. Graduate degree (doctoral degree)

8. What is the child's father educational level?

   a. Less than high school
   b. High school diploma
   c. Some college courses
   d. 2-year college degree
   e. 4-year college degree (bachelor degree)
   f. Some graduate work
   g. Graduate degree (master degree)
   h. Graduate degree (doctoral degree)

9. What is your household monthly income?

   a. Less than $1500
   b. Between $1501 - $1900
   c. More than $1901

10. Where do you live?

a. Doha
b. Al Wakrah
c. Al Rayyan
d. Umm Salal Ali
e. Umm Salal Mohammad
f. Al Khawr
g. Dukhan
h. Al Ru’ays

11. How many children do you have (including the child with disability)?

a. One
b. Two
c. Three
d. Four
e. More than four (please specify) ___________________

12. How many children with disabilities do you have in your family?

a. One
b. More than one (please specify) ___________________

Note:

If you have more than one child with disability, please complete separate forms for section 2 and section 3 for each child.

Section 2: Child Characteristics

13. Does your child with disability live with you at home?

a. Yes
b. No (please specify where does the child live) __________________

14. What is the gender of your child?

a. Male
b. Female

15. How old is your child?

a. Birth to 1 year old
b. 1 – 2 years old
c. 2 – 3 years old
d. 3 – 4 years old
e. 4 - 5 years old
f. Older than 5 years old (please specify) _______________

16. What is your child's disability?

a. Behavioral/emotional disorders (including autism spectrum disorder)
b. Intellectual disability (including Down syndrome)
c. Developmental delay
d. Specific Learning Disability
e. Speech or language impairment
f. Developmental disabilities (i.e. Cerebral palsy, muscular dystrophy)
g. Traumatic brain injury
h. Visual impairment/blindness
i. Hearing impairment/deaf
j. Multiple disability (please specify) ________________
k. Other health impairment (please specify) _____________

17. How old was your child when he was diagnosed?

a. Before birth
b. At birth
c. Less than one month
d. Older than one month (please specify) ____________
e. Don’t know

18. How old was your child when he started receiving early intervention services?

a. At birth or immediately after diagnosis
b. One - two months after diagnosis
c. Two – three months after diagnosis
d. More than three months after diagnosis (please specify) ____________
e. Don’t know

19. Does your child with disability use any medical device/equipment (i.e. oxygen, wheelchair, walker, crutches, orthotics, and hearing aid)?

a. No
b. Yes (please specify) _______________

In the following section, please rate your child ability on a scale of 1 to 6, with 1 indicating normal ability, 2 (suspected) indicating some questions about the child's ability, and 6 indicating extreme or profound lack of ability. In making each rating, think about your child compared to other children the same age.

20. **Think about your child's ability to hear in everyday activities. In the case your child uses a hearing aid, please rate his/her hearing without the use of the hearing aid. Please rate your child's ability to hear separately for each ear.**

    a) **Please rate your child's ability to hear in the left ear:**
        1. My child has normal hearing
        2. My child has a suspected hearing loss
        3. My child has mild hearing loss
        4. My child has moderate hearing loss
        5. My child has severe hearing loss
        6. My child has profound hearing loss

    b) **Please rate your child's ability to hear in the right ear:**
        1. My child has normal hearing
        2. My child has a suspected hearing loss
        3. My child has mild hearing loss
        4. My child has moderate hearing loss
        5. My child has severe hearing loss
        6. My child has profound hearing loss

21. **Think about your child's behavior and social skills. Social skills refer to your child's ability to relate to others in a meaningful way. Your child's behavior refers to inappropriate or unusual behaviors which may include fighting,**

hitting, screaming, rocking, hand flapping, biting self, etc. Please rate your child's behavior and social skills <u>separately</u>.

a) **Please rate your <u>child's social skills</u>.**
    1. My child's social skills are typical and appropriate for his/her age
    2. My child has a suspected disability
    3. My child has mild disability
    4. My child has moderate disability
    5. My child has severe disability
    6. My child has extreme disability

b) **Please rate your <u>child's behavior</u>.**
    1. My child's behaviors are typical and appropriate for age
    2. My child has a suspected inappropriate behaviors
    3. My child has mild inappropriate behaviors
    4. My child has moderate inappropriate behaviors
    5. My child has severe inappropriate behaviors
    6. My child has extreme inappropriate behaviors

22. **Think about your child's intellectual functioning (thinking and reasoning). Think about your child's ability to think and reason, the way your child solves problem and plays with toys and compare this to other children of the same age.**
    1. My child is normal for age
    2. My child has a suspected disability
    3. My child has mild disability
    4. My child has moderate disability
    5. My child has severe disability
    6. My child has profound disability

23. Think about your child's ability to use his or her hands, arms, and legs in daily activities. Please rate your child's ability; a score of 6 (profound disability) means that your child's has no use of a limb. Please make 2 ratings for left and right limbs separately.

a) Please rate your child's ability to use <u>left arm and hand</u>:

1. My child has complete normal use
2. My child has a suspected difficulty
3. My child has mild difficulty
4. My child has moderate difficulty
5. My child has severe difficulty
6. My child has profound difficulty

b) Please rate your child's ability to use <u>left leg</u>:

1. My child has complete normal use
2. My child has a suspected difficulty
3. My child has mild difficulty
4. My child has moderate difficulty
5. My child has severe difficulty
6. My child has profound difficulty

c) Please rate your child's ability to use <u>right arm and hand</u>:

1. My child has complete normal use
2. My child has a suspected difficulty
3. My child has mild difficulty
4. My child has moderate difficulty
5. My child has severe difficulty
6. My child has profound difficulty

d) **Please rate your child's ability to use <u>right leg</u>:**
   1. My child has complete normal use
   2. My child has a suspected difficulty
   3. My child has mild difficulty
   4. My child has moderate difficulty
   5. My child has severe difficulty
   6. My child has profound difficulty

24. **Think about your child's ability to communicate intentionally (understanding and communicating with others). This rating includes attempts to communicate in ways other than talking (signs, gestures, and picture boards). Please make 2 ratings one for your child's ability to understand others and one for communicating with others.**

a) **Please rate your child's ability to <u>understand others</u> compare to other children of the same age.**
   1. My child is normal for age in both verbal and non-verbal (including signs, gestures, or symbol systems)
   2. My child has a suspected disability
   3. My child has mild disability
   4. My child has moderate disability
   5. My child has severe disability
   6. My child has profound disability

b) **Please rate your child's ability to <u>communicate with others</u> compare to other children of the same age.**
   1. My child is normal for age in both verbal and non-verbal (including signs, gestures, or symbol systems)
   2. My child has a suspected disability
   3. My child has mild disability

4. My child has moderate disability
5. My child has severe disability
6. My child has profound disability

25. Think about the child's muscle tone. Normal means that the child's muscles are neither tight nor loose. If the child's muscle tone is not in the normal range, please indicate the degree of tightness or looseness.

1. My child’s muscle tone is normal
2. My child has a suspected tightness and/or looseness in his muscle tone
3. My child has mild tightness and/or looseness in his muscle tone
4. My child has moderate tightness and/or looseness in his muscle tone
5. My child has severe tightness and/or looseness in his muscle tone
6. My child is totally tight and/or totally loose in his muscle tone

26. Think about your child's general health. Normal means the usual health problems & illnesses typical for a child this age. If there is a health problem, please rate your child’s health indicating the degree to which health problems limit his/her activities. Ongoing health problems may include seizures, diabetes, muscular dystrophy, cancer, etc.

1. My child’s general health is good
2. My child has suspected health problems
3. My child has minor ongoing health problems
4. My child has ongoing but medically controlled health problems
5. My child has ongoing poorly controlled health problems
6. My child has extreme health problems with near total restriction of activities

27. Think about the child's vision and ability to see in everyday activities. Please rate both the left & right eye separately. A score of 6 (Profound loss) means that the child has no vision. Rate you child's vision without glasses. If the child uses glasses, indicate this in the comments section of the form.

a) Please rate your child’s ability to hear in the <u>left eye</u>:

1. My child has normal vision

2. My child has suspected vision loss
3. My child has mild vision loss
4. My child has moderate vision loss
5. My child has severe vision loss
6. My child has profound vision loss

b) Please rate your child's ability to hear in the <u>right eye</u>:

1. My child has normal vision
2. My child has suspected vision loss
3. My child has mild vision loss
4. My child has moderate vision loss
5. My child has severe vision loss
6. My child has profound vision loss

28. Think about the form and structure of your child's body. Normal means that there are no differences associated with form, shape, or structure of the body parts. Differences in form include conditions like cleft palate or club foot; differences in structure include conditions like curved spine and arm or leg deformity. Please rate how much these differences interfere with how your child moves, play, or look.

1. My child's shape, body form and structure is normal
2. My child has suspected difference or interference in his shape, body form and structure
3. My child has mild difference or interference in his shape, body form and structure
4. My child has moderate difference or interference in his shape, body form and structure
5. My child has severe difference or interference in his shape, body form and structure
6. My child has profound difference or interference in his shape, body form and structure

Section 3: Service Inventory

29. Does your child currently receive early intervention or therapy services?

a. No
b. Yes

30. Does your child currently receive early intervention or therapy services at home?

a. No
b. Yes (please specify type of services) ________________________

31. Does your child currently go to a center/hospital for early intervention or therapy services?

a. No
b. Yes

32. Does your child receive services from one place or more than place (center or hospital)?

a. One place (please specify name) ____________________
b. More than one place

33. How many different centers/hospitals does your child currently receive early intervention or therapy services?

a. 1
b. 2
c. 3
d. 4

(Please specify all name of center/hospital)

____

____

34. Please check all the services/therapies that you and your child receive?

Medical services	
Nursing services	
Special education	
Occupational therapy	
Physical therapy	
Speech therapy	
Behavior therapy	
Music therapy	
Nutrition/Dietitian	
Family counseling services	
Other (Please specify)	

35. How many days and hours of services/therapies per week do your child receives?

Services/Therapies	**Days per week**	**Hours per week**
Special education		
Occupational therapy		
Physical therapy		
Speech therapy		
Behavior therapy		
Music therapy		

36. Who decided on the kind of services that your child needs and receives?

a. Pediatrician
b. Child’s parents
c. Other professionals (please specify) ___________________

37. Was the decision on the type of services that your child need based on a team meeting?

a. No
b. Yes

38. Which one of these statements best describe your involvement in the decisions about your child services?

a. I am not involved at all or rarely involved
b. I am involved sometimes
c. I am involved most of the times
d. I am always involved

39. How do you feel about your involvement in the decisions about your child services?

a. I want to be more involved
b. I am satisfied with my current involvement
c. I want to be less involved
d. I don’t feel I need to be involved

40. Do you pay for any of the early intervention or therapy services that your child receives?

a. No
b. Yes (please specify type of service) _______________________

41. How would you rate the amount of therapy services that your child receive (occupational therapy, physical therapy, speech therapy)

  a. Less than what my child need
  b. About the right amount that my child need
  c. More than my child need

42. Does your child need more therapy services (occupational therapy, physical therapy, speech therapy)?

  a. No
  b. Yes (please specify which service) ______________________

43. How would you rate the quality of the therapy services that your child receives?

If your child doesn't receive any of these therapies please check "Not Applicable".

Therapy Services	**Excellent**	**Good**	**Fair**	**Poor**	**Not Applicable**
Occupational therapy					
Physical therapy					
Speech therapy					
Behavior therapy					

44. Does your child receive special education services?

  a. No
  b. Yes

45. How would you rate the quality of special education services that your child receives?

   a. Excellent
   b. Good
   c. Fair
   d. Poor
   e. Does not receive special education services

46. Are there any other services that your child need?

   a. No
   b. Yes (please specify which service) _______________________

47. Please use this space if you want to clarify or provide additional information or comments.

Thank You

Appendix E

Service Providers Demographic Survey

Service Providers Demographic Survey

University of Oklahoma

The purpose of this survey is to learn more about you, your work with young children with disabilities and their families, and your work responsibilities. All information will be kept completely confidential. None of the information you share will ever be reported individually about you to your department or organization.

Instruction:

- This survey consists of three sections about you, your clients, and early intervention services you provide to young children with disabilities and their families.
- For each item, please choose the best answer unless otherwise specified.

Section 1: About You

1. **What is your gender?**
    a. Male
    a. Female

2. **What is your nationality?**
    a. Qatari
    b. Non-Qatari (please specify) __________________

3. **What is your age?**
    a. 20 years old or younger
    b. 21 - 30 years old
    c. 31 - 40 years old
    d. 41 - 50 years old
    e. 51 - 60 years old
    f. Older than 60 years old

4. **In what role are you employed at your current job?**
    a. Pediatrician
    b. Special Education Teacher
    c. Occupational Therapist
    d. Physical Therapist
    e. Speech & Language Pathologist
    f. Nurse
    g. Audiologist
    h. Dietitian
    i. Social Worker
    j. Teacher's aid
    k. Other (please specify) __________________

5. **What is your educational level? Please circle the letter next to each kind of degree you have and then write the discipline or subject area of your degree. Please circle <u>all that apply to you</u>.**
    a. Associate Degree (2-3 years); Discipline: ____________________________
    b. Bachelor's Degree; Discipline: ____________________________________
    c. Master's Degree; Discipline: ______________________________________
    d. Doctoral Degree; Discipline: ______________________________________

6. **Did any of your degree or study program involve training in working specifically <u>with young children with disabilities</u> (birth to five years)?**
    a. No
    b. Yes

7. **Did any of your degree or study program involve training in working specifically <u>with families</u> of children with disabilities?**
    a. No
    b. Yes

8. **How many years of experience do you have?**
    a. Less than one year
    b. 1-5 years
    c. 5-10 years
    d. 10-15 years
    e. 15-20 years
    f. More than 20 years (please specify) __________________

9. **Are all of your years of experience in Qatar only?**
    a. Yes
    b. No

10. How many years of experience do you have in Qatar?

   a. Less than one year
   b. 1-5 years
   c. 5-10 years
   d. 10-15 years
   e. 15-20 years
   f. More than 20 years (please specify) __________________
   g. All my years of experience are in Qatar

11. Think about all your professional education and training, please indicate to what extent do you feel adequately prepared to <u>work with young children with disabilities (Birth to 5 years)</u>?

   a. Extremely well prepared
   b. Well prepared
   c. Somewhat prepared
   d. Not at all prepared

12. Think about all your professional education and training, please indicate to what extent do you feel adequately prepared to <u>work with families</u> of young children with disabilities?

   a. Extremely well prepared
   b. Well prepared
   c. Somewhat prepared
   d. Not at all prepared

Section 2: Your Clients

13. **Think of all your current client caseload. How many clients do you see per day?**
    a. Less than 6 clients
    b. Between 6-10 clients
    c. Between 11-15 clients
    d. Between 16-20 clients
    e. More than 20 clients (please specify) ____________________

14. **About how many of these clients are children births to 5 years of age?**
    a. Less than 50%
    b. More than 50%
    c. Almost all
    d. I only work with children birth to 5 years

15. **What is the age range for the children you work with at your work?**
    a. Early intervention (Birth to 5 years) only
    b. School-age (older than 5 years) only
    c. Children of all ages (Birth to 18 years old)

16. **Which of the following are included in your caseload of children that you currently work with?**
    a. Children with all type of disabilities.
    b. Only children with behavioral/emotional disorders only (including autism spectrum disorder)
    c. Only children with intellectual disability (including Down syndrome)
    d. Only children with specific learning disability
    e. Only children with speech or language impairment

f. Only children with developmental disabilities (i.e. Cerebral palsy, muscular dystrophy)
g. Only children with traumatic brain injury
h. Only children with visual impairment/blindness
i. Only children with hearing impairment/deaf
j. Only children with multiple disability

17. When you work with children (birth to 5 years), do you work with mostly children, mostly families, or both children and families?

a. Mostly children
b. Mostly families
c. Both children and their families

Section 3: Early Intervention Services You Provide

This section is about the early intervention and therapy services that you provide <u>directly</u> at your current job.

18. Which of the following early intervention or therapy services do you provide? Please check only one that relate to your job.

1. Medical services	
2. Nursing services	
3. Special education	
4. Occupational therapy	
5. Physical therapy	
6. Speech therapy	
7. Behavior therapy	
8. Music therapy	
9. Nutrition/Dietitian	
10. Family counseling services	
11. Other (Please specify)	

19. What type of center-based or hospital-based early intervention or therapy services do you provide to young children with disabilities (birth to 5 years)?

a. Hospital (inpatients) only
b. Hospital (outpatients) only
c. Hospital (both inpatients and outpatients)
d. Center (early intervention classroom) only
e. Center (both classrooms and outpatients)

20. Do you provide any early intervention or therapy services to young children with disabilities (birth to 5 years) <u>at home</u>?

a. No
b. Yes (please specify type of services) ________________________

21. When working with young children with disabilities (birth to 5 years old), what type of intervention approach do you use?

a. One-to-one only
b. Groups (two or more children) only
c. Both one-to-one and groups

22. Do all children with disabilities (birth to 5 years) in your caseload have team meetings?

a. Hospital inpatients only
b. Hospital outpatients only
c. Both inpatients and outpatients
d. Center classroom only
e. Center outpatients only
f. Both classroom and outpatients

23. Do you attend IEP or rehabilitation team meeting?

a. Never
b. Once or twice
c. Several times
d. Regularly

24. Are families of young children with disabilities involved in the decision relating to the kind of services that their child receives?

a. Yes
b. No

25. **Do you involve families in your assessment process for their children with disabilities?**
    a. No
    b. Yes

26. **Do you involve families in the planning process for setting the intervention and/or treatment plan?**
    a. No
    b. Yes

27. **How do you feel about family and parents involvement in the decisions regarding the intervention strategies for their young children with disabilities?**
    a. I don’t feel there is a need to involve families in these decisions as the professionals are the experts in this area
    b. Family involvement should be limited to carrying out the intervention strategies at home **only**
    c. Families should be involved at all stages including the assessment, identifying priorities and need, setting the intervention goals, and carrying out the program at home

28. **Do you think that early intervention programs should provide services for the families of young children with disabilities such as training and counseling services?**
    a. No
    b. Yes

29. **Please use this space if you want to clarify or provide additional information or comments.**

Thank You

Appendix F

Families Interview Protocol

Interview Protocol

(Families)

Introduction

Thank you for time and willingness to participate. As you know, I am interested in understanding the factors that promote or hinder successful family-professional partnership in Early Intervention and Early Childhood Special Education programs from the perspectives of service providers and families of young children with disabilities.

Particularly, I am trying to explore 1) How satisfied are families of children with disabilities and service providers working in early intervention and early childhood special education (EI/ECSE) programs in Qatar with their level of partnership? 2) What are the factors that promote or hinder successful family-professional partnership from the perspectives of families of children with disabilities, service providers, and program directors in Early Intervention and Early Childhood Special Education programs?

If the questions are general and abstract, you may volunteer any detail you wish.

You also have the option of declining to answer – passing on – any of the questions.

Do you have any questions before we start?

Interview Questions

Participant's Background Information Session

1. Tell me about your child with disability (age, gender, type of disability, use of medical device/equipment).
2. How old was your child when he was diagnosed? How old was your child when he was first referred to early intervention services?
3. Does your child currently receive early intervention and therapy services? How long have your child been receiving early intervention services?
4. What type of early intervention services does your child receive? (Frequency and duration of services).

5. Where does your child receive early intervention services (school-based or hospital-based setting)? How did you find out about these programs (referral source)?

Family Involvement/Partnership Session

1. How do you feel about your involvement in the intervention/educational program for your child?
2. How important is it for you to be involved in your child’s intervention/educational program?
3. How were you involved in developing the intervention/educational program for your child?
4. Which service providers are involving you in the intervention/educational process for your child? How are they involving you (assessment, identifying priorities, setting goals, intervention/educational program planning)?
5. How well do you feel you were you were involved in deciding what your child can do (educational/intervention program)?
6. Do you feel that your family’s preferences (type of services, gender of service provider, language spoken) and priorities are respected by the service providers and the program where your child receives service?
7. What has been your experience in working with service providers in early intervention programs?

Barriers and Facilitators of Positive Family-Professional Partnership Session

1. How satisfied are you with the relationship/partnership you have with the service providers working with your child? Are you more or less satisfied with service providers from different disciplines? Which one and why?
2. What type of information are usually communicated or shared with you as a parent of a child with a disability (evaluation, available sources and services in the community, child’s abilities and strengths, child’s disability). How often this information is shared with you?
3. What are the most important qualities or professional behavior/skill you look for in service providers working with your child to make you feel as an equal partner in the decisions relating to your child intervention/educational program?

4. How do you feel about the service providers in terms of meeting the needs of your child?
5. How do you feel about the service providers in terms of meeting your needs as a parent of a child with disability?
6. What things (skills/attitudes) that service providers do that enable you have a good relationship/partnership with them?
7. When service providers develop an intervention/educational program for your child, what kind of information are shared/communicated to you? (e.g. child's disability, child's development, available programs and services, support services, family's rights, community resources)
8. How do service providers support your role as an advocate for your child?
9. How well do service providers working with you and your child respect your cultural background?
10. What is an ideal family-professional partnership look like to you? What elements make up an ideal partnership?
11. Think of examples of successful partnerships between you as a parent of a child with a disability and a service provider that worked with you and your child in the past. Describe one example of a successful partnership you had with a service provider? What factors made this partnership successful?
12. Now think of an example of unsuccessful partnerships between you as a parent of a child with a disability and a service provider that worked with you and your child in the past. Describe one example of unsuccessful partnership you had with a service provider? What factors made this partnership unsuccessful?
13. Based on your experience with early intervention programs in Qatar, what are three things would you like to change to make these programs more responsive to your family's needs and priorities or to promote positive/successful partnerships?
14. Is there anything else you would like to add regarding partnerships between professionals with families? Any final comments you would like to add?

Closing

Now that we are done, do you have any questions you'd like to ask me about this research project? If you want to contact me later, here is my contact information (follow-up contact information sheet will be provided). Also, I may need to contact you later for additional questions or clarification. Can I also have your follow-up contact information?

Appendix G

Service Providers Interview Protocol

Interview Protocol

(Service Providers)

Introduction

Thank you for time and willingness to participate. As you know, I am interested in understanding the factors that promote or hinder successful family-professional partnership in Early Intervention and Early Childhood Special Education programs from the perspectives of service providers and families of young children with disabilities.

Particularly, I am trying to explore 1) How satisfied are families of children with disabilities and service providers working in early intervention and early childhood special education (EI/ECSE) programs in Qatar with their level of partnership? 2) What are the factors that promote or hinder successful family-professional partnership from the perspectives of families of children with disabilities, service providers, and program directors in Early Intervention and Early Childhood Special Education programs?

If the questions are general and abstract, you may volunteer any detail you wish.

You also have the option of declining to answer – passing on – any of the questions.

Do you have any questions before we start?

Interview Questions

Participant's Background Information Session

6. Tell me about your current professional position. How long have you worked (years of experience)? What is your level of education (associate, bachelor, master)?
7. How many years have you work in Qatar?
8. How long have you been working in Early Intervention programs (years of experience in EI programs)?
9. What is your current caseload? How many clients/patients do you have?
10. Describe your classroom/program (e.g. age, ability level, type of disability)

Participant's Commitment to Family Involvement/Partnership Session

8. How do you feel about family involvement in the educational process/treatment program?
9. How do you see the role of families in Early Intervention programs?
10. How are families involved in service delivery in your job (in your program)?
11. What strategies do you use as a professional (OT, PT, SLP, SP ED) to involve families in the educational process/treatment program?
12. How are families involved during the different phases of the educational process including evaluation and setting goals (assessment, setting goals, treatment priorities/planning)?
13. What are your roles and responsibilities about family involvement in your position?
14. How are families involved organizationally in your place of employment (e.g. boards, committees)?
15. What has been your experience in working with families of children with disabilities?

Indicators of Positive Partnerships Session

15. When do you hear the words "family-professional partnership", what first comes to your mind?
16. What does family-professional partnership mean to you?
17. How do you communicate with families and how often? What strategies do you use to facilitate open communications with families about their child's care? Describe some of the strategies you use to communicate with families.
18. What do professionals (early childhood special education teachers) need to know and be able to do to have positive partnerships with families of children with disabilities? Can these skills, knowledge, attitudes be taught?
19. What skills do you have/strategies you used that have helped you in the past in building positive partnerships with families?
20. When developing a care plan, what kind of information you share with parents/families (e.g. child's disability, child's education and development, available programs and services, support services, family's rights, community resources)
21. How do you support families in their role as an advocate for their child?

22. How do you address linguistic and cultural barriers between you and the families you work with? How did you honor a family's diversity?
23. What do you think the most important characteristics of a positive and collaborative partnership with families? What's the ideal family-professional partnership look like to you?

Barriers and Facilitators of Positive Family-Professional Partnership Session

1. What challenges or barriers have you experienced in establishing and/or implementing family-professional partnerships in your job?
2. What opportunities or supports have you experienced in establishing and/or implementing family-professional partnerships in your job?
3. Think of examples of successful partnerships between you as a professional and parents you have worked with in the past. Describe one example of a successful partnership you had with a family/parent? What factors made this partnership successful?
4. Now think of an example of unsuccessful partnerships between you as a professional and parents you have worked with in the past. Describe one example of unsuccessful partnership you had with a family/parent? What factors made this partnership unsuccessful?
5. What policies or procedures are in place related to family-professional partnership at your place of employment?
6. How have your perceptions of family-professional partnership changed over time?
7. Based on your experience with EI programs in Qatar, what are three things would you like to change to make EI programs more responsive to family-professional partnerships (or to promote positive/successful partnerships)?
8. Is there anything else you would like to add regarding partnerships between professionals with families? Any final comments you would like to add?

Closing

Now that we are done, do you have any questions you'd like to ask me about this research project? If you want to contact me later, here is my contact information (follow-up contact information sheet will be provided). Also, I may need to contact you later for additional questions or clarification. Can I also have your follow-up contact information?

Appendix H

Program Directors Interview Protocol

Interview Protocol

(Program Directors)

Introduction

Thank you for time and willingness to participate. As you know, I am interested in understanding the factors that promote or hinder successful family-professional partnership in Early Intervention and Early Childhood Special Education programs from the perspectives of service providers and families of young children with disabilities.

Particularly, I am trying to explore 1) How satisfied are families of children with disabilities and service providers working in early intervention and early childhood special education (EI/ECSE) programs in Qatar with their level of partnership? 2) What are the factors that promote or hinder successful family-professional partnership from the perspectives of families of children with disabilities, service providers, and program directors in Early Intervention and Early Childhood Special Education programs?

If the questions are general and abstract, you may volunteer any detail you wish.

You also have the option of declining to answer – passing on – any of the questions.

Do you have any questions before we start?

Interview Questions

Participant's Background Information Session

11. Tell me about your current professional position and job responsibilities as a program director. How long have you worked in this position? What is your level of education (associate, bachelor, master)?
12. How many years of experience do you have? How many years have you work in Qatar?
13. How long have you been working in Early Intervention (EI) programs in Qatar (years of experience in EI programs)?

Program Information Session

1. Describe your early intervention program. What kinds of early intervention services does your program staff provide directly to children with disabilities and their families?
2. What is the financial status of the agency/organization that operates your program (public agency, private nonprofit organization, private for-profit organization)?
3. What is the nature of the agency/organization that operates your program (community-based, school-based, and hospital-based)?
4. Where does your staff provide early intervention services (classroom, center, child's home, clinic, hospital inpatient/outpatient)? What is the main setting for provision of early intervention services at your program?
5. What kind of curricula (if any) do you utilize in your early intervention program (TEECH, Portage Curriculum, Carolina Curriculum for Infants and Preschoolers, Parents as Teachers, developed own curriculum)?
14. What is the approach or philosophies of your early intervention program (emphasize principles of behavior modification, developmental approach, focus on child's medical diagnosis and therapeutic interventions, family-centered approach)?
15. Approximately how many children (birth to 5 years) are being served through your early intervention program in one year?
16. What kind of personnel/service providers does your program employ to provide early intervention services to children with disabilities and their families?
17. How many full-time staff employed by your program is involved with early intervention services?

Family Involvement/Partnership Session

16. How do you feel about family involvement in the educational process/treatment program?
17. How do you see the role of families in Early Intervention programs?
18. What kind of services does your program provide for families of young children with disabilities?
19. How are families involved in service delivery in your program?
20. What strategies does your program utilize to involve families in the educational process/treatment program?

21. How are families involved during the different phases of the educational process including evaluation and setting goals (assessment, setting goals, treatment priorities/planning)?
22. What are your roles and responsibilities about family involvement in your position?
23. How are families involved organizationally in your program (e.g. boards, committees)?
24. What has been your experience in working with families of children with disabilities?

Indicators of Positive Partnerships Session

24. When do you hear the words “family-professional partnership”, what first comes to your mind?
25. What does family-professional partnership mean to you as a program director?
26. What is your program’s philosophy in terms of facilitating communication with families of young children with disabilities? What strategies does your staff/program use to facilitate open communications with families about their child’s care/education? Describe some of the strategies you use in your program to communicate with families.
27. What kind of skills, knowledge, and attitudes that your staff has that facilitate building positive partnerships with families of young children with disabilities?
28. Does your program provide training for early intervention service providers in strategies to work/partner with families of young children with disabilities? What kind of training is provided? Describe examples of topics covered in these training the frequency of training?
29. How does your program support families in their role as an advocate for their child? What strategies/approaches does your program use to support this role?
30. How does your program address linguistic and cultural diversity of families of young children with disabilities? How does the program honor a family’s diversity?
31. What do you think the most important characteristics of a positive and collaborative partnership with families? What’s the ideal family-professional partnership look like to you?

Barriers and Facilitators of Positive Family-Professional Partnership Session

9. What challenges or barriers have you experienced in establishing and/or implementing family-professional partnerships in your program?
10. What opportunities or supports does your program provide to promote positive partnerships between service providers and families of young children with disabilities?
11. What policies or procedures are in place related to family-professional partnership at your program?
12. How have your perceptions of family-professional partnership changed over time?
13. Based on your experience with EI programs in Qatar, what are three things would you like to change to make EI programs more responsive to family-professional partnerships (or to promote positive/successful partnerships)?
14. Is there anything else you would like to add regarding partnerships between professionals with families? Any final comments you would like to add?

Closing

Now that we are done, do you have any questions you'd like to ask me about this research project? If you want to contact me later, here is my contact information (follow-up contact information sheet will be provided). Also, I may need to contact you later for additional questions or clarification. Can I also have your follow-up contact information?

Appendix I

Informed Consent Forms

Informed Consent Form for Families Interviews

Informed Consent Form for Service Providers Interviews

University of Oklahoma

Institutional Review Board

Informed Consent to Participate in a Research Study

Families Form

Project Title:	Family-Professional Partnership in Early Intervention and Early Childhood Special Education Programs in Qatar
Principal Investigator:	Nawal Al-Hadad
Department:	Educational Psychology

You are being asked to volunteer for this research study. This study is being conducted for a doctoral dissertation in the Department of Educational Psychology at the University of Oklahoma. You were selected as a possible participant because you have a young child with a disability who receives early intervention/early childhood special education services.

Please read this form and ask any questions that you may have before agreeing to take part in this study.

Purpose of the Research Study

The purpose of this study is to understand factors that promote or hinder successful family-professional partnership in Early Intervention and Early Childhood Special Education programs (EI/ECSE) from the perspectives of service providers and families of young children with disabilities.

Specifically, the study aim to explore: How satisfied are families of children with disabilities and service providers working in early intervention and early childhood special education (EI/ECSE) programs in Qatar with their level of partnership?; What are the factors that promote or hinder successful family-professional partnership from the perspectives of families of children with disabilities, service providers, and program directors in EI/ECSE programs in the State of Qatar?, and Are EI/ECSE programs effective in terms of achieving family outcomes for families of young children with disabilities receiving services in Qatar?

Number of Participants

About eight to ten people will take part in this study.

Procedures

If you agree to be in this study, you will be asked to participate in a one-time interview.

Length of Participation

Each participant will participate in a one time 60-90 minutes interview.

This study has the following risks:

There are no foreseeable risks involved in participation in this study beyond those present in routine daily life. However, it is possible that talking about your experience with the early intervention services and programs may bring up sensitive issues that make you feel uncomfortable. You can contact the researcher for local resources if you want to talk to someone other than your family or the researcher. If you feel any question is too personal or sensitive, you can decline to answer without any penalty.

Benefits of being in the study are

Although there are no direct benefits for you as a participant, your participation in this study is very important. The study is valuable in terms of improving early intervention services and future services for young children with disabilities and their families in Qatar.

Confidentiality

In published reports, there will be no information included that will make it possible to identify you without your permission. Research records will be stored securely and only approved researchers will have access to the records.

There are organizations that may inspect and/or copy your research records for quality assurance and data analysis. These organizations include the OU Institutional Review Board.

Compensation

You will not be reimbursed for you time and participation in this study.

Voluntary Nature of the Study

Participation in this study is voluntary. If you withdraw or decline participation, you will not be penalized or lose benefits or services unrelated to the study. If you decide to participate, you may decline to answer any question and may choose to withdraw at any time.

Audio Recording of Study Activities

To assist with accurate recording of participant responses, interviews may be recorded on an audio recording device. You have the right to refuse to allow such recording without penalty. Please select one of the following options.

I consent to audio recording. ___ Yes ___ No.

Contacts and Questions

If you have concerns, questions, or complaints about the research, you can contact the researcher conducting this study, Nawal Al-Hadad, at 974-687-0658 or nawal@ou.edu, or Dr. Kathryn Haring, Ph.D., at (405) 613-0197 or kharing@ou.edu

Contact the researcher if you have questions or if you have experienced a research-related injury.

If you have any questions about your rights as a research participant, concerns, or complaints about the research and wish to talk to someone other than individuals on the research team or if you cannot reach the research team, you may contact the University of Oklahoma – Norman Campus Institutional Review Board (OU-NC IRB) at 405-325-8110 or irb@ou.edu.

You will be given a copy of this information to keep for your records. If you are not given a copy of this consent form, please request one.

Statement of Consent

I have read the above information. I have asked questions and have received satisfactory answers. I consent to participate in the study.

Signature Date

University of Oklahoma

Institutional Review Board

Informed Consent to Participate in a Research Study

Service Providers Form

Project Title:	Family-Professional Partnership in Early Intervention and Early Childhood Special Education Programs in Qatar
Principal Investigator:	Nawal Al-Hadad
Department:	Educational Psychology

You are being asked to volunteer for this research study. This study is being conducted for a doctoral dissertation in the Department of Educational Psychology at the University of Oklahoma. You were selected as a possible participant because you are a direct service provider working with young children with disabilities and their families receiving early intervention/early childhood special education services.

Please read this form and ask any questions that you may have before agreeing to take part in this study.

Purpose of the Research Study

The purpose of this study is to understand factors that promote or hinder successful family-professional partnership in Early Intervention and Early Childhood Special Education programs (EI/ECSE) from the perspectives of service providers and families of young children with disabilities.

Specifically, the study aim to explore: How satisfied are families of children with disabilities and service providers working in early intervention and early childhood special education (EI/ECSE) programs in Qatar with their level of partnership?; What are the factors that promote or hinder successful family-professional partnership from the perspectives of families of children with disabilities, service providers, and program directors in EI/ECSE programs in the State of Qatar?, and Are EI/ECSE programs effective in terms of achieving family outcomes for families of young children with disabilities receiving services in Qatar?

Number of Participants

About eight to ten people will take part in this study.

Procedures

If you agree to be in this study, you will be asked to participate in a one-time interview.

Length of Participation

Each participant will participate in a one time 60-90 minutes interview.

This study has the following risks:

There are no foreseeable risks involved in participation in this study beyond those encountered at your work on a daily basis. However, it is possible that talking about your work experience with the early intervention services and programs may bring up sensitive issues that make you feel uncomfortable. You can contact the researcher for local resources if you want to talk to someone other than your family, colleagues, or the researcher. If you feel any question is too personal or sensitive, you can decline to answer without any penalty.

Benefits of being in the study are

Although there are no direct benefits for you as a participant, your participation in this study is very important. The study is valuable in terms of improving early intervention services and future services for young children with disabilities and their families in Qatar.

Confidentiality

In published reports, there will be no information included that will make it possible to identify you without your permission. Research records will be stored securely and only approved researchers will have access to the records.

There are organizations that may inspect and/or copy your research records for quality assurance and data analysis. These organizations include the OU Institutional Review Board.

Compensation

You will not be reimbursed for you time and participation in this study.

Voluntary Nature of the Study

Participation in this study is voluntary. If you withdraw or decline participation, you will not be penalized or lose benefits or services unrelated to the study. If you decide to participate, you may decline to answer any question and may choose to withdraw at any time.

Audio Recording of Study Activities

To assist with accurate recording of participant responses, interviews may be recorded on an audio recording device. You have the right to refuse to allow such recording without penalty. Please select one of the following options.

I consent to audio recording. ___ Yes ___ No.

Contacts and Questions

If you have concerns, questions, or complaints about the research, you can contact the researcher conducting this study, Nawal Al-Hadad, at 974-687-0658 or nawal@ou.edu, or Dr. Kathryn Haring, Ph.D., at (405) 613-0197 or kharing@ou.edu

Contact the researcher if you have questions or if you have experienced a research-related injury.

If you have any questions about your rights as a research participant, concerns, or complaints about the research and wish to talk to someone other than individuals on the research team or if you cannot reach the research team, you may contact the University of Oklahoma – Norman Campus Institutional Review Board (OU-NC IRB) at 405-325-8110 or irb@ou.edu.

You will be given a copy of this information to keep for your records. If you are not given a copy of this consent form, please request one.

Statement of Consent

I have read the above information. I have asked questions and have received satisfactory answers. I consent to participate in the study.

____

Signature Date

Appendix J

Family-Professional Partnership Scale (Family Version) - Translated Arabic Version

Family-Professional Partnership Self-Assessment (Professional Version) - Translated Arabic Version

استبيان الشراكة بين الأخصائي والأسرة

تم تطويره في مركز بيتش للإعاقة
في جامعة كنساس
بالاشتراك مع الأسر والأخصائيين والباحثين

تعليمات الاستبيان

- سوف تحاط جميع المعلومات التي ستعطى من قبلكم بالسرية التامة. كما أن اسمكم لن يكون ملحق بأي من المعلومات. ومن المهم الإجابة على جميع الأسئلة كما يمكنكم عدم الإجابة على الأسئلة التي تشعرون تجاهها بعدم الراحة.

- في الصفحات التالية، يرجى وضع دائرة حول رقم الإجابة التي تقدم أفضل وصف. إذا أردت تغيير إجابتك يرجى وضع علامة **"X"** على الإجابة الخاطئة، ومن ثم وضع دائرة حول رقم الإجابة الصحيحة.

- إذا لديك أي تعليق أو إضافات يرجى كتابتها في الصفحة الخاصة بالتعليقات.

استبيان الشراكة

- الهدف من هذا الاستبيان التعرف على شعوركم تجاه/حول الشخص الرئيسي الذي يعمل معك ومع طفلك. وسوف نستخدم ما نتعلمه من الأسر لإعلام صناع القرار ومقدمي الخدمات للأطفال وأسرهم.

- قد يكون هناك الكثير من مقدمي الخدمات المختلفة يعملون مع طفلك من ذوي الاحتياجات الخاصة، مثل المدرسين والأخصائيين الاجتماعيين أو أخصائيي العلاج الطبيعي والعلاج الوظيفي وعلاج النطق واللغة أو أخصائيي تعديل السلوك أو الأطباء. فكر في الأخصائي الذي تعامل مع طفلك الأكثر طوال فترة **الستة أشهر الماضية**.

- أرجو تحديد الأخصائي الذي تفكر فيه عند تعبئة هذا الاستبيان **(يرجى اختيار شخص واحد فقط)**.

☐ أخصائي (مدرس) التربية الخاصة

☐ أخصائي العلاج الوظيفي

☐ أخصائي علاج النطق واللغة

☐ أخصائي العلاج النفسي

☐ أخصائي التمريض

☐ أخصائي تعديل السلوك

☐ أخصائي العلاج الطبيعي

☐ أخصائي الخدمة الاجتماعية

☐ الطبيب

☐ آخرين (يرجى الذكر) __________

استبيان الشراكة بين الأخصائي والأسرة

ما مدى شعورك بالرضى عن الأخصائي الذي يعمل مع طفلك ...	غير راضي *تماما*	غير راضي	محايد	راضي	راضي جدا
يساعدك على اكتساب المهارات أو المعلومات التي تلبي احتياجات طفلك	**1**	**2**	**3**	**4**	**5**
لديه/يملك المهارات لمساعدة طفلك على النجاح	**1**	**2**	**3**	**4**	**5**
يقدم الخدمات التي تلبي الاحتياجات الفردية لطفلك	**1**	**2**	**3**	**4**	**5**
يتحدث ويقوم بالدفاع عن مصالح طفلك مع الاخصائيين الآخرين الذين يقومون بتقديم خدمات أخرى لطفلك	**1**	**2**	**3**	**4**	**5**
يقوم بإعلامك عن قدرات طفلك والأشياء الإيجابية التي يقوم بها طفلك	**1**	**2**	**3**	**4**	**5**
يكون الأخصائي متواجد عندما تكون بحاجة إليه	**1**	**2**	**3**	**4**	**5**
يتعامل مع طفلك بكل احترام وتقدير (بكرامة)	**1**	**2**	**3**	**4**	**5**
يضيف على النقاط الايجابية لدى طفلك	**1**	**2**	**3**	**4**	**5**

ما مدى شعورك بالرضى عن الأخصائي الذي يعمل مع طفلك ...	غير راضي *تماما*	غير راضي	محايد	راضي	راضي جدا
يقدر / يثمن رأيك حول احتياجات طفلك	**1**	**2**	**3**	**4**	**5**
يتعامل معك بصدق حتى ولو كانت هناك أخبار سيئة	**1**	**2**	**3**	**4**	**5**
يهتم بسلامة طفلك عندما يكون في رعايته (يكون طفلك آمنا عندما يكون في رعايته)	**1**	**2**	**3**	**4**	**5**
يستخدم كلمات تستطيعون فهمها	**1**	**2**	**3**	**4**	**5**
يحافظ على خصوصية أسرتك	**1**	**2**	**3**	**4**	**5**
يحترم قيم وعادات أسرتك	**1**	**2**	**3**	**4**	**5**
يصغي إليك بدون حكم على أسرتك أو طفلك	**1**	**2**	**3**	**4**	**5**
الأخصائي شخص يمكنك الاعتماد عليه والثقة به	**1**	**2**	**3**	**4**	**5**
يهتم بالأمور التي تقولها	**1**	**2**	**3**	**4**	**5**
شخص لطيف وصديق	**1**	**2**	**3**	**4**	**5**

الشراكة الأسرية والمهنية

التقييم الذاتي

مبني على مقياس مركز بيتش للشراكة الأسرية والمهنية

الهدف من هذا التقييم الذاتي هو مساعدة الأخصائيين للنظر في ممارساتهم وتحديد العوائق والتسهيلات التي تساعد على بناء شراكة أسرية مهنية ايجابية.

فيما يلي البنود الفردية المبنية على مقياس الشراكة الأسرية والمهنية الذي يستخدم مع الأسر من أجل تقييم مدى رضاهم عن الخدمات المقدمة لهم ولطفلهم من ذوي الإعاقة والشراكة مع المهنيين.

يرجى تقييم مهاراتك بالنسبة لكل بند من البنود ، وإعطاء نفسك درجة تتراوح بين 1 و 5 حيث يمثل الرقم 5 الأفضل. بعد ذلك ، أرجو التفكير في تحديد ما يساعدك على تحسين المهارة لكل من البنود التالية. أيضا تحديد ما يعوق (يقف في طريقك) لإظهار هذه المهارة.

1. أقوم بمساعدة أولياء الأمور على اكتساب المهارات والمعلومات التي تلبي احتياجات الطفل (توفير التدريب للأهل ، ومساعدة الوالدين في الحصول على المعلومات عن الموارد المتاحة).

الدرجة	**ما يساعد**	**ما يعيق**

2. كأخصائي لدي أو أملك المهارات التي تساعد الطفل على النجاح (اتمتع بقدر كبير من الكفاءة ، الكفاءات الأساسية ، والمشاركة في التعلم المستمر لاكتساب مهارات ومعلومات جديدة ، أتوقع الكثير من الأطفال الذين أعمل معهم ، وتوفير الفرص الهادفة لنجاح الطفل).

الدرجة	**ما يساعد**	**ما يعيق**

3. أقدم الخدمات التي تلبي الاحتياجات الفردية للطفل (كيفية وضع البرامج الفردية أو التقنيات العلاجية لاستيعاب نقاط القوة واحتياجات الطفل).

الدرجة	**ما يساعد**	**ما يعيق**

4. أتعامل مع الطفل بكل إحترام وتقدير في جميع الأوقات (أحترم الطفل كشخص له كرامته)

الدرجة	**ما يساعد**	**ما يعيق**

5. اتحدث وأقوم بالدفاع عن مصالح الطفل مع مقدمي الخدمات الآخرين (مع البرامج أو المهنيين نيابة عن عائلة الطفل).

الدرجة	**ما يساعد**	**ما يعيق**

6. أقوم بإعلام الوالدين عن قدرات الطفل والأشياء الايجابية التي بقوم بها الطفل.

الدرجة	**ما يساعد**	**ما يعيق**

7. اعتمد على نقاط القوة لدى الطفل (اتتبى منهج النقاط الايجابية لتحقيق الأهداف والنتائج).

الدرجة	**ما يساعد**	**ما يعيق**

8. اتعامل بصدق مع الوالدين حتى لو كان لدي أنباء سيئة (الصدق فيما يتعلق باحتياجات الطفل أو إعاقته، محدودية البرامج/الموارد، عدم إدعاء معرفة الأشياء).

الدرجة	**ما يساعد**	**ما يعيق**

9. أحافظ على سلامة الطفل في كل الأقات التي يكون فيها في رعايتي.

الدرجة	**ما يساعد**	**ما يعيق**

10. أكون متواجد عندما يحتاجني والدي الطفل (في حالات الطوارئ أو عطلة نهاية الأسبوع أو الفترات المسائية، يعتمد على تواجدي خلال ساعات الدوام، يثق الأسر بالوصول إلي عن طريق الهاتف أو شخصيا، على استعداد للقيام بزيارات منزلية).

الدرجة	ما يساعد	ما يعيق

11. أقيم وأثمن آراء الوالدين حول احتياجات طفلهم (أطلب من أولياء الأمور رأيهم، إدخال وجهة نظر أولياء الأمور ضمن النتائج والاستراتيجيات التربوية والخدمات).

الدرجة	ما يساعد	ما يعيق

12. استخدم كلمات يستطيع الوالدين فهمها (الإبتعاد عن استخدام المصطلحات، إعطاء الوقت لشرح الأشياء).

الدرجة	ما يساعد	ما يعيق

13. احافظ على حماية خصوصية الأسر (الحفاظ على السرية مع البرامج الأخرى، تجنب "القيل والقال" عن الأسر).

الدرجة	**ما يساعد**	**ما يعيق**

14. احترم قيم وعادات الأسر.

الدرجة	**ما يساعد**	**ما يعيق**

15. أصغي بدون حكم على الأسرة أو الطفل.

الدرجة	**ما يساعد**	**ما يعيق**

16. يمكن الاعتماد علي (متابعة الوعود أو العهود).

الدرجة	**ما يساعد**	**ما يعيق**

17. أهتم بالأمور التي يقولها الوالدين (أصغي بإهتمام، احترم معتقدات الوالدين وأظهر الاحترام لملاحظات الوالدين عن طفلهم).

الدرجة	**ما يساعد**	**ما يعيق**

18. انا بمثابة صديق للوالدين (الحفاظ على الترحيب والأجواء الودية).

الدرجة	**ما يساعد**	**ما يعيق**

Appendix K

Translated Family Demographic Survey (Arabic Version)

Translated Service Providers Demographic Survey (Arabic Version)

المسح الديموغرافي للأسر

جامعة اوكلاهوما

الغرض من هذا الاستبيان هو معرفة المزيد عن عائلتك، طفلك من ذوي الإعاقة، وخدمات التدخل المبكر والتربية الخاصة في مرحلة الطفولة المبكرة التي تقدم لطفلك. جميع المعلومات التي سوف تدلي بها تتصف بالسرية التامة.ولن يتم الإطلاع عليها من قبل المركز أو الجهة التي تقوم بتقديم الخدمات لطفلك.

التعليمات:

- يتضمن هذا الاستبيان ثلاثة أقسام عن عائلتك، طفلك من ذوي الإعاقة ، وخدمات التدخل المبكر التي تقدم لطفلك وعائلتك.
- يرجى اختيار أفضل إجابة لكل بند من البنود ما لم يتم تحديد خلاف ذلك.

القسـم الأول: خصائص الأسـرة

1. **ما هي علاقتك بالطفل ذو الإعاقة؟**

أ. أم الطفل

ب. أب الطفل

ج. غير ذلك (يرجى الذكر) ____________________

2. **ما هي جنسيتك؟**

أ. قطري

ب. غير قطري (يرجى الذكر) ____________________

3. **ما هو عمر والدة الطفل؟**

أ. 20 سنة أو أقل

ب. 21 – 30 سنة

ج. 31 – 40 سنة

د. 41 – 50 سنة

هـ. 51 – 60 سنة

و. أكبر من 60 سنة

4. **ما هو عمر والد الطفل؟**

أ. 20 سنة أو أقل

ب. 21 – 30 سنة

ج. 31 – 40 سنة

د. 41 – 50 سنة

هـ. 51 – 60 سنة

و. أكبر من 60 سنة

5. **هل تعمل والدة الطفل؟**
أ. لا
ب. نعم (يرجى تحديد المهنة) ____________________

6. **هل يعمل والد الطفل؟**
أ. لا
ب. نعم (يرجى تحديد المهنة) ____________________

7. **ما هو المستوى التعليمي لوالدة الطفل ؟**
أ. أقل من الثانوية العامة
ب. شهادة الثانوية العامة
ج. بعض الكورسات في الكلية
د. دبلوم سنتين
هـ. شهادة جامعية (درجة البكالوريوس)
و. دبلوم عالي
ز. درجة الماجستير
ح. درجة الدكتوراه

8. **ما هو المستوى التعليمي لوالد الطفل ؟**
أ. أقل من الثانوية العامة
ب. شهادة الثانوية العامة
ج. بعض الكورسات في الكلية
د. دبلوم سنتين
هـ. شهادة جامعية (درجة البكالوريوس)
و. دبلوم عالي
ز. درجة الماجستير
ح. درجة الدكتوراه

9. **ما هو دخل الأسرة؟**

أ. أقل من خمسة آلاف ريال قطري (5000 ريال قطري)

ب. بين خمسة – عشرة آلاف ريال قطري (5000 -- 7000 ريال قطري)

ج. اكثر من عشرة آلاف ريال قطري (7000 ريال قطري)

10. **في أي مدينة تسكن ؟**

أ. الدوحة

ب. الوكرة

ج. الريان

د. أم صلال علي

هـ. أم صلال محمد

و. الخور

ز. دخان

ح. الرويس

11, ما عدد أبنائك (بما فيهم الطفل ذو الإعاقة)؟

أ. واحد

ب. اثنين

ج. ثلاثة

د. أربع

هـ. أكثر من أربعة (يرجى التحديد) ____________________

12. ما عدد أبنائك من ذوي الإعاقة؟

أ. واحد

ب. أكثر من واحد (يرجى التحديد) ____________________

ملاحظة:

إذا كان لديك أكثر من طفل من ذوي الإعاقة، يرجى ملء استبيان منفصل لكل من القسمين 2 و 3 عن كل طفل.

القسم الثاني: خصائص الطفل

1. **هل طفلك ذو الإعاقة يعيش معك في البيت؟**

أ. نعم

ب. لا (يرجى تحديد أين يعيش الطفل) ____________________

2. ما هو جنس طفلك؟

أ. ذكر

ب. أنثى

3. **كم عمر طفلك؟**

أ. أقل من سنة

ب. 1 – 2 سنة

ج. 2 – 3 سنوات

د. 3 – 4 سنوات

هـ. 4 – 5 سنوات

و. أكثر من 5 سنوات (يرجى التحديد) ________________

4. **ما هي نوع الإعاقة التي لدى طفلك؟**

أ. الاضطرابات النمائية (بما فيها طيف التوحد)
ب. الإعاقة الذهنية (متلازمة داون)
ج. تأخر في النمو
د. صعوبات التعلم
ه. اضطرابات النطق و الكلام
و. إعاقة جسدية أو حركية (مثل الشلل الدماغي ، والضمور العضلي)
ز. إصابات الدماغ
ح. إعاقة بصرية
ط. إعاقة سمعية / الصم
ي. إعاقة متعددة (يرجى التحديد) ________________
ك. إضطرابات صحية أخرى (يرجى تحديدها) ______________
ل. غير متأكدين أو لا نعرف

5. **كم كان عمر طفلك عندما تم تشخيصه؟**

أ. تم تشخيص الإعاقة قبل الولادة
ب. عند الولادة
ج. أقل من شهر واحد
د. أكثر من شهر واحد (يرجى التحديد) ______________
ه. لا أعرف

6. **كم كان يبلغ طفلك من العمر عندما بدأ في تلقي خدمات التدخل المبكر؟**

أ. بعد الولادة أو مباشرة بعد التشخيص

ب. ما بين 1 – 2 شهر من التشخيص

ج. ما بين 2 – 3 أشهر من التشخيص

د. أكثر من ثلاثة أشهر بعد التشخيص (يرجى التحديد) ______________

7. هل يستخدم طفلك ذو الإعاقة أي أجهزة أو معدات طبية (مثل الأكسجين ، والكرسي المتحرك ، المعينات السمعية، أجهزة التقويم، العكازات)؟

أ. لا

ب. نعم (يرجى التحديد) ________________

<u>في الجزء التالي ، يرجى تقديرقدرات طفلك على مقياس من 1 إلى 6 ، حيث يدل 1 على القدرات العادية ، و يدل 2 على بعض التساؤلات أو الشك في قدرات الطفل ، ويشير 6 إلى الضعف الشديد في قدرات الطفل. عن تحديدك أو تقديرك لقدرات طفلك يرجى التفكير في طفلك بالمقارنة مع الأطفال الآخرين في نفس السن أو العمر.</u>

فكر في القدرات السمعية لدى طفلك في الأنشطة اليومية. في حالة استخدام طفلك للمعينات السمعية التي تساعد على السمع ، يرجى تحديد قدرات طفلك السمعية دون استخدام المعينات السمعية. يرجى تقييم قدرة طفلك على السمع منفصلة لكل أذن.

أ) يرجى تحديد قدرات طفلك السمعية في الأذن اليسرى :

1. طفلي فاقد للسمع
2. طفلي يشتبه في وجود إعاقة سمعية لديه
3. طفلي لديه إعاقة سمعية بسيطة
4. طفلي لديه إعاقة سمعية متوسطة
5. طفلي لديه إعاقة سمعية شديدة
6. طفلي لديه إعاقة سمعية شديدة جدا أو عميقة

ب) يرجى تحديد قدرات طفلك السمعية في الأذن اليمنى :

1. طفلي فاقد للسمع
2. طفلي يشتبه في وجود إعاقة سمعية لديه
3. طفلي لديه إعاقة سمعية بسيطة
4. طفلي لديه إعاقة سمعية متوسطة
5. طفلي لديه إعاقة سمعية شديدة
6. طفلي لديه إعاقة سمعية شديدة جدا أو عميقة

2. **فكر في سلوك طفلك ، والمهارات الاجتماعية. المهارات الاجتماعية تشير إلى قدرة طفلك على التعامل مع الآخرين بطريقة هادفة أو معبرة. سلوك الطفل يقصد بها السلوكيات السلبية أو الغير مناسبة أو الغير عادية والتي قد تشمل العراك ، الضرب والصراخ ، الحركات النمطية مثل الاهتزاز ، حركات الأيدي المتكررة ، عض النفس. يرجى تحديد قدرات طفلك فيما يتعلق بالسلوكيات والمهارات الاجتماعية ، وبشكل منفصل.**

أ) يرجى تحديد قدرات طفلك فيما يتعلق بالمهارات الاجتماعية.

1. مهارات طفلي الاجتماعية مناسبة لعمره
2. طفلي يشتبه بوجود إعاقة في مهاراته الاجتماعية
3. طفلي لديه إعاقة بسيطة في مهاراته الاجتماعية
4. طفلي لديه إعاقة متوسطة في مهاراته الاجتماعية
5. طفلي لديه إعاقة شديدة في مهاراته الاجتماعية
6. طفلي لديه إعاقة شديدة جدا أو حادة في مهاراته الاجتماعية

ب) يرجى اختيار الرقم المناسب لسلوكيات طفلك.

1. سلوكيات طفلي طبيعية ومناسبة لعمره

2. طفلي يشتبه في وجود سلوكيات غير مناسبة لديه

3. طفلي لديه إعاقة بسيطة فيما يتعلق بوجود السلوكيات السلبية

4. طفلي لديه إعاقة متوسطة فيما يتعلق بوجود السلوكيات السلبية

5. طفلي لديه إعاقة شديدة فيما يتعلق بوجود السلوكيات السلبية

6. طفلي لديه إعاقة شديدة جدا أو حادة فيما يتعلق بوجود السلوكيات السلبية

3. **فكر في مهارات وقدرات طفلك العقلية (التفكير والتحليل). فكر في قدرة طفلك على التفكير والحكم ، والطريقة التي يحل بها المشكلة وقدرته على الاستنتاج والطريقة التي يلعب فيها بألعابه ومن ثم قارن أداء طفلك مع غيره من الأطفال الذين في نفس سنه.**

1. طفلي طبيعي بالنسبة لسنه
2. طفلي يشتبه في وجود إعاقة في قدراته العقلية
3. طفلي لديه إعاقة بسيطة في قدراته العقلية
4. طفلي لديه إعاقة متوسطة في قدراته العقلية
5. طفلي لديه إعاقة شديدة في قدراته العقلية
6. طفلي لديه إعاقة شديدة جدا أو حادة في قدراته العقلية

4. **فكر في قدرات طفلك على تحريك أطرافه وقدرته على استخدام يديه ، وذراعيه ، وقدميه في الأنشطة اليومية. يرجى تصنيف قدرات طفلك على تحريك الأطراف اليمين واليسار على حدة.**

أ) يرجى تصنيف قدرة طفلك على استخدام ذراعه ويده اليسرى واليد

1. طفلي يستخدم يده وذراعه اليسرى بطريقة عادية
2. طفلي يشتبه في وجود صعوبة في استخدام يده وذراعه اليسرى
3. طفلي لديه صعوبة بسيطة في استخدام يده وذراعه اليسرى
4. طفلي لديه صعوبة متوسطة في استخدام يده وذراعه اليسرى

5. طفلي لديه صعوبة شديدة في استخدام يده وذراعه اليسرى
6. طفلي لديه صعوبة شديدة جدا في استخدام يده وذراعه اليسرى

ب) يرجى تصنيف قدرة طفلك على استعمال الساق اليسرى :

1. طفلي يستخدم ساقه اليسرى بطريقة عادية
2. طفلي يشتبه في وجود صعوبة في استعمال ساقه اليسرى
3. طفلي لديه صعوبة بسيطة في استعمال ساقه اليسرى
4. طفلي لديه صعوبة متوسطة في استعمال ساقه اليسرى
5. طفلي لديه صعوبة شديدة في استعمال ساقه اليسرى
6. طفلي لديه صعوبة شديدة جدا في استعمال ساقه اليسرى

ج) يرجى تصنيف قدرة طفلك على استخدام ذراعه ويده اليمين

1. طفلي يستخدم يده وذراعه اليمين بطريقة عادية
2. طفلي يشتبه في وجود صعوبة في استخدام يده وذراعه اليمين
3. طفلي لديه صعوبة بسيطة في استخدام يده وذراعه اليمين
4. طفلي لديه صعوبة متوسطة في استخدام يده وذراعه اليمين
5. طفلي لديه صعوبة شديدة في استخدام يده وذراعه اليمين
6. طفلي لديه صعوبة شديدة جدا في استخدام يده وذراعه اليمين

د) يرجى تصنيف قدرة طفلك على استعمال الساق اليمنى :

1. طفلي يستخدم ساقه اليمنى بطريقة عادية
2. طفلي يشتبه في وجود صعوبة في استعمال ساقه اليمنى
3. طفلي لديه صعوبة بسيطة في استعمال ساقه اليمنى
4. طفلي لديه صعوبة متوسطة في استعمال ساقه اليمنى
5. طفلي لديه صعوبة شديدة في استعمال ساقه اليمنى
6. طفلي لديه صعوبة شديدة جدا في استعمال ساقه اليمنى

5. **فكر في قدرة طفلك على التواصل والتفاهم مع الآخرين. ويشمل محاولات التواصل بطرق أخرى غير الكلام (لغة الإشارة، علامات الإيماءات ، واستخدام الصور). يرجى تصنيف كل من قدرة طفلك على فهم الآخرين وقدرت طفلك على التواصل مع الآخرين كل على حدة.**

أ) يرجى تصنيف قدرة طفلك على فهم الآخرين مقارنة مع الأطفال الآخرين من نفس العمر.

1. قدرات طفلي في المستوى الطبيعي في فهم الآخرين سواء اللفظي وغير اللفظي (بما فيها العلامات ، والإيماءات ، أو نظام الرموز)
2. يشتبه في وجود إعاقة في قدرات طفلي على فهم الآخرين
3. طفلي لديه إعاقة بسيطة في قدراته على فهم الآخرين
4. طفلي لديه إعاقة متوسطة في قدراته على فهم الآخرين
5. طفلي لديه إعاقة شديدة في قدراته على فهم الآخرين
6. طفلي لديه إعاقة شديدة جدا في قدراته على فهم الآخرين

ب) يرجى تصنيف قدرة طفلك على التواصل مع الآخرين مقارنة مع الأطفال الآخرين من نفس العمر.

1. قدرات طفلي في المستوى الطبيعي في التواصل مع الآخرين سواء اللفظي وغير اللفظي (بما فيها العلامات ، والإيماءات ، أو نظام الرموز)
2. يشتبه في وجود إعاقة في قدرات طفلي في التواصل مع الآخرين
3. طفلي لديه إعاقة بسيطة في قدراته في التواصل مع الآخرين
4. طفلي لديه إعاقة متوسطة في قدراته في التواصل مع الآخرين
5. طفلي لديه إعاقة شديدة في قدراته في التواصل مع الآخرين
6. طفلي لديه إعاقة شديدة جدا في قدراته في التواصل مع الآخرين

4. فكر في توتر العضلات لدى طفك. توتر العضلات الطبيعي يعني عدم تيبس أو إرتخاء في العضلات. إذا كان توتر العضلات عند طفلك ليس في المستوى الطبيعي، يرجى تحديد مدى التيبس أو الإرتخاء لدى طفلك.

1. توتر العضلات لدى طفلي طبيعي
2. يشتبه في وجود تيبس أو إرتخاء في توتر العضلات لدى طفلي
3. طفلي لديه تيبس أو إرتخاء بسيط في توتر العضلات
4. طفلي لديه تيبس أو إرتخاء متوسط في توتر العضلات
5. طفلي لديه تيبس أو إرتخاء شديد في توتر العضلات
6. طفلي لديه تيبس أو إرتخاء تام في توتر العضلات

5. فكر في الصحة العامة لطفلك. المقصود بالصحة العامة هي الأمراض والمشاكل الصحية الطبيعية والمعتادة للطفل في هذه السن. اذا كانت هناك مشاكل صحية أخرى، يرجى تصنيف حالة طفلك الصحية بمدى تأثير المشاكل الصحية على قيام طفلك بالأنشطة اليومية. وتشمل هذه المشاكل الصحية التشنجات ، والسكري ، والضمور العضلي ، والسرطان ، الخ.

1. الصحة العامة لطفلي جيدة
2. يشتبه في وجود مشاكل صحية لدى طفلي
3. يعاني طفلي من مشاكل صحية بسيطة
4. يعاني طفلي من مشاكل صحية ولكنها مسيطر عليها من الناحية الطبية
5. يعاني طفلي من مشاكل صحية مستمرة
6. يعاني طفلي من مشاكل صحية بالغة تقيد أو تحد من قيامه بالأنشطة اليومية

6. فكر في قدرة طفلك على الرؤية والإبصار في مختلف الأنشطة اليومية. الإعاقة الشديدة جدا تعني أن طفلك لا يبصر. يرجى تحديد قدرة الطفل على الؤية بدون استخدام النظارات. إذا كان الطفل يستخدم نظارات ، ذلك في الجزء الخاص بالتعليقات. يرجى تحديد قدرة طفلك على الرؤية في كل من لعين اليسار واليمنى على حدة.

أ) يرجى تحديد قدرات طفلك البصرية في العين اليسرى :

1. طفلي يستطيع الؤية بصورة طبيعية
2. طفلي يشتبه في وجود إعاقة بصرية لديه
3. طفلي لديه إعاقة بصرية بسيطة
4. طفلي لديه إعاقة بصرية متوسطة
5. طفلي لديه إعاقة بصرية شديدة
6. طفلي لديه إعاقة بصرية شديدة جدا أو عميقة

ب) يرجى تحديد قدرات طفلك البصرية في العين اليمنى :

1. طفلي يستطيع الؤية بصورة طبيعية
2. طفلي يشتبه في وجود إعاقة بصرية لديه
3. طفلي لديه إعاقة بصرية بسيطة
4. طفلي لديه إعاقة بصرية متوسطة
5. طفلي لديه إعاقة بصرية شديدة
6. طفلي لديه إعاقة بصرية شديدة جدا أو عميقة

7. فكر في شكل وهيئة جسم طفلك. الطبيعي يعني أنه لا توجد اختلافات مرتبطة بالشكل ، والهيئة أو أجزاء الجسم. وتشمل الاختلافات حالات الشق الحلقي أو تشوه القدم ، أو الاختلافات في هيكل الجسم مثل تقوس العمود الفقري أو تشوهات الذراع او الساق. يرجى تقييم مدى تأثير هذه الاختلافات تتعارض حركة طفلك وقدرته على اللعب.

1. شكل وهيئة جسم طفلي طبيعية
2. يشتبه في وجود فروقات أو اختلافات في جسم وهيئة طفلي
3. لدى طفلي فروقات أو اختلافات بسيطة في شكل وهيئة الجسم
4. لدى طفلي فروقات أو اختلافات متوسطة في شكل وهيئة الجسم
5. لدى طفلي فروقات أو اختلافات شديدة في شكل وهيئة الجسم
6. لدى طفلي فروقات أو اختلافات شديدة جدا في شكل وهيئة الجسم

القسم الثالث : حصر الخدمات

1. **هل يتلقى طفلك حاليا خدمات علاجية أو خدمات التدخل المبكر ؟**

أ. لا

ب. نعم

2. **هل يتلقى طفلك حاليا أي خدمات علاجية أو خدمات التدخل المبكر في المنزل؟**

أ. لا

ب. نعم (يرجى تحديد نوع الخدمات) ____________________________

3. **هل يذهب طفلك حاليا إلى مركز / مستشفى لتلقي الخدمات العلاجية أو خدمات التدخل المبكر؟**

أ. لا

ب. نعم

4. **هل يحصل طفلك على الخدمات من مكان واحد أو أكثر من مكان (مستشفى أو مركز)؟**

أ. مكان واحد (يرجى تحديد الاسم) _______________________

ب. أكثر من مكان واحد

5. **كم عدد المراكز / المستشفيات التي يتلقى فيها طفلك حاليا الخدمات العلاجية أو خدمات التدخل المبكر ؟**

أ. 1

ب. 2

ج. 3

د. أكثر من 3

(يرجى ذكر اسم كل مركز/ مستشفى)

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6. يرجى تحديد جميع الخدمات التي يتلقاها طفلك؟

الخدمات الطبية	
خدمات التمريض	
خدمات التربية الخاصة	
العلاج الوظيفي	
العلاج الطبيعي	
علاج النطق والكلام	
العلاج السلوكي	
العلاج بالموسيقى	
خدمات التغذية	
خدمات استشارية للأسرة	
أخرى (الرجاء التحديد)	

7. **كم عدد الساعات والأيام التي يتلقى فيها طفلك الخدمات العلاجية والتأهيلية في كل أسبوع؟**

الخدمات العلاجية والتأهيلية	**عدد الساعات أسبوعيا**	**عدد الأيام أسبوعيا**
التربية الخاصة		
العلاج الوظيفي		
العلاج الطبيعي		
علاج النطق والكلام		
العلاج السلوكي		
العلاج بالموسيقى		

8. **من الشخص الذي قرر أو قام بتحديد نوع الخدمات التي يحتاج إليها أو يحصل عليها طفلك ؟**

أ. طبيب الأطفال

ب. والدي الطفل

ج. غيرهم من المهنيين (يرجى التحديد) ____________________

9. **هل كان القرار المتعلق بنوع الخدمات التي يحتاج لها طفلك بناء على اجتماع فريق المهنيين؟**

أ. لا

ب. نعم

10. **أي واحد من الخيارا التالية تمثل أفضل وصف لمشاركتكم في القرارات المتخذة بشأن الخدمات المقدمة لطفلك؟**

أ. لا علاقة لي على الإطلاق أو نادرا ما أشارك

ب. أشارك في بعض الأحيان

ج. أشارك في معظم الأحيان أو غالبا ما أشارك

د. أشارك دائما

11. كيف تشعر حول المشاركة في اتخاذ القرارات بشأن الخدمات المقدمة أو التي يحصل عليها طفلك؟

أ. أريد أن أكون أكثر مشاركة

ب. أنا راض عن مشاركتي الحالية

ج. اريد ان اكون اقل مشاركة

د. لا أشعر أنني بحاجة إلى أن أشارك

12. هل تدفع لأي من خدمات التدخل المبكر والعلاج أو الخدمات العلاجية التي يحصل عليها طفلك؟

أ. لا

ب. نعم (يرجى تحديد نوع الخدمة) ________________________

13. كيف تقيم كمية الخدمات التأهيلية (العلاج الوظيفي والعلاج الطبيعي وعلاج النطق) التي تحصل طفلك؟

أ. أقل مما يحتاجه طفلي

ب. مناسبة لإحتياجات طفلي

14. هل طفلك بحاجة إلى المزيد من الخدمات التأهيلية (العلاج الوظيفي والعلاج الطبيعي وعلاج النطق)؟

أ. لا

ب. نعم (المرجو تحديد الخدمة التي يحتاجها طفلك) ________________________

15. كيف تقيم نوعية الخدمات التأهيلية التي يحصل طفلك؟

إذا كان طفلك لا يحصل على أي من هذه الخدمات يرجى اختيار "لا ينطبق".

الخدمات التأهيلية	**ممتازة**	**جيدة**	**مقبولة**	**ضعيفة**	**لا ينطبق**
العلاج الوظيفي					
العلاج الوظيفي					
علاج النطق والكلام					
العلاج السلوكي					

16. هل يحصل طفلك على خدمات التربية الخاصة؟

أ. لا

ب. نعم

17. كيف تقيم نوعية خدمات التربية الخاصة التي يحصل عليها طفلك؟

أ. ممتازة

ب. جيدة

ج. مقبولة

د. ضعيفة

هـ. لا يحصل طفلي على خدمات التربية الخاصة

18. هل هناك أية خدمات أخرى يحتاجها طفلك؟

أ. لا

ب. نعم (يرجى تحديد الخدمات) ________________________

17. الرجاء استخدام هذا الجزء إذا كنت ترغب في توضيح أو تقديم معلومات إضافية أو تعليقات.

شكرا لك

المسح الديموغرافي لمقدمي الخدمات

جامعة اوكلاهوما

الغرض من هذا الاستبيان هو معرفة المزيد عن عنك، وعملك مع الأطفال من ذوي الإعاقة، ومهام عملك. جميع المعلومات التي سوف تدلي بها تتصف بالسرية التامة. ولن يتم الإطلاع عليها من قبل المركز أو الجهة التي تعمل بها.

التعليمات:

- يتضمن هذا الاستبيان ثلاثة أقسام عنك، الأطفال من ذوي الإعاقة الذين عمل معهم ، وخدمات التدخل المبكر التي تقدمها
- يرجى اختيار أفضل إجابة لكل بند من البنود ما لم يتم تحديد خلاف ذلك.

القسم الأول: معلومات عنك

1. ما هو جنسك؟

أ. ذكر
أ. أنثى

2. ما هي جنسيتك؟

أ. قطري
ب. غير قطري (يرجى الذكر) ________________

3. ما هو عمرك؟

أ. 20 سنة أو أقل
ب. 21 - 30 سنة
ج. 31 - 40 سنة
د. 41 - 50 سنة
هـ. 51-60 سنة
و. أكثر من 60 سنة

4. ما هي وظيفتك الحالية؟

أ. طبيب أطفال
ب. أخصائب التربية الخاصة
ج. أخصائي علاج وظيفي
د. أخصائي علاج طبيعي
هـ. أخصائي علاج النطق والكلام
و. ممرض/ ممرضة

ز. أخصائي السمعيات
ح. أخصائي تغذية
ط. أخصائي اجتماعي
ي. مساعد مدرس
ك. أخرى (يرجى الذكر) ________________

5. ما هو المستوى التعليمي الخاص بك؟ الرجاء وضع دائرة حول كل من الدرجات العلمية الحاصل عليها ومن ثم تحديد مجال الدراسة أو التخصص. يرجى اختيار جميع الدرجات العلمية الحاصل عليها.

أ. دبلوم (2-3 سنوات) ؛ التخصص : ________________________________
ب. درجة البكالوريوس ؛ التخصص : ________________________________
ج. درجة الماجستير ؛ التخصص : ________________________________
د. درجة الدكتوراه ؛ التخصص : ________________________________

6. هل اشتمل برنامج دراستك أو الدرجات العلمية التي حصلت عليها على أي تدريب على وجه التحديد في العمل مع الأطفال من ذوي الإعاقة (من الولادة وحتى خمس سنوات)؟

أ. لا
ب. نعم

7. هل اشتمل برنامج دراستك أو الدرجات العلمية التي حصلت عليها على أي تدريب وتحديدا العمل مع أسر الأطفال من ذوي الإعاقات ؟

أ. لا
ب. نعم

8. كم عدد سنوات الخبرة التي لديك؟

أ. أقل من سنة واحدة

ب. 1-5 سنوات

ج. 5-10 سنوات

د. 10-15 سنة

هـ. 15- 20 سنة

و. أكثر من 20 سنة (يرجى التحديد) ____________________

9. هل جميع سنوات الخبرة التي لديك في قطر؟

أ. نعم

ب. لا

10. كم عدد سنوات الخبرة التي لديك في قطر؟

أ. أقل من سنة واحدة

ب. 1-5 سنوات

ج. 5-10 سنوات

د. 10-15 سنة

هـ. 15- 20 سنة

و. أكثر من 20 سنة (يرجى التحديد) ____________________

ز. جميع سنوات الخبرة التي لدي في قطر

11. فكر في جميع فرص التدريب والتعليم المستمر التي مررت بها ، يرجى تقييم إلى أي مدى تشعر أنها كانت لإعدادك للعمل مع الأطفال من ذوي الإعاقة (من الولادة وحتى خمس سنوات)؟

أ. أعدتني بشكل ممتاز

ب. أعدتني بشكل جيد

ج. أعدتني إلى حد ما

د. لم تعدني على الاطلاق

12. فكر في جميع فرص التدريب والتعليم المستمر التي مررت بها ، يرجى تقييم إلى أي مدى تشعر أنها كانت لإعدادك للعمل مع أسر الأطفال من ذوي الإعاقة؟

أ. أعدتني بشكل ممتاز

ب. أعدتني بشكل جيد

ج. أعدتني إلى حد ما

د. لم تعدني على الاطلاق

القسم الثاني: معلومات عن عملك

13. كم عدد الأشخاص من ذوي الإعاقات الذين تعمل معهم يوميا؟

أ. أقل من 6

ب. ما بين 6-10

ج. ما بين 11-15

د. ما بين 16-20

e. اكثر من 20 (يرجى التحديد) ______________

14. من الأشخاص ذوي الإعاقات التي تعمل معهم يوميا، كم يبلغ تقريبا نسبة الأطفال من ذوي الإعاقة الذين هم من سن الولادة إلى 5 سنوات من العمر؟

أ. أقل من 50 ٪

ب. أكثر من 50 ٪

ج. تقريبا جميع الذين أعمل معهم هم من الأطفال

د. أعمل فقط مع الأطفال من ذوي الإعاقة الذين هم من سن الولادة إلى 5 سنوات من العمر

15. ما هي الفئة العمرية للأطفال الذين تعمل معهم؟

أ. التدخل المبكر (الولادة إلى 5 سنوات) فقط

ب. في سن المدرسة (أكبر من 5 سنوات) فقط

ج. الأطفال من جميع الفئات العمرية (الولادة إلى 18 سنة)

16. من هم الأطفال الذين تعمل معهم حاليا؟

أ. الأطفال من جميع أنواع الإعاقات

ب. فقط الأطفال الذين لديهم اضطرابات سلوكية / اضطرابات عاطفية ونمائية (بما فيها طيف التوحد)

ج. فقط الأطفال الذين يعانون من الإعاقة الذهنية (متلازمة داون)
د. فقط الأطفال الذين يعانون من صعوبات التعلم
هـ. فقط الأطفال الذين لديهم اضطرابات في النطق أو الكلام
و. فقط الأطفال ذوي العاهات الخالذين لديهم إعاقات جسدية أو حركية (مثل الشلل الدماغي ، والضمور العضلي)
ز. فقط الأطفال الذين يعانون من إصابات الدماغ
ح. فقط الأطفال الذين لديهم إعاقة بصرية
ط. فقط الأطفال الذين لديهم إعاقة سمعية / الصم
ي. فقط الأطفال الذين لديهم إعاقات متعددة

17. عندم تعمل مع الأطفال (الولادة وحتى 5 سنوات) ، هل تعمل غالبا مع الاطفال فقط، أو تعمل مع الأسر ، أو الأطفال والأسر على حد سواء؟

أ. أعمل في غالبا مع الاطفال
ب. أعمل في غالبا مع الأسر
ج. أعمل مع كل من الأطفال وأسرهم

القسم الثالث: خدمات التدخل المبكر

هذا القسم عن التدخل المبكر والعلاج والخدمات التي تقدمها مباشرة في وظيفتك الحالية.

18. من الأمور التالية التي تدخل المبكر والعلاج والخدمات ، أو هل تقدم؟ يرجى مراجعة واحدة فقط والتي تتصل في عملك.

1. الخدمات الطبية	
2. خدمات التمريض	
3. التربية الخاصة	
4. العلاج الوظيفي	
5. العلاج الطبيعي	
6. علاج النطق والكلام	
7. العلاج السلوكي	
8. العلاج بالموسيقى	
9. التغذية	
10. خدمات استشارية للأسرة	
11. أخرى (الرجاء التحديد)	

19. أين تقوم بتقديم خدمات التدخل المبكر والخدمات التأهيلية أو العلاجية للأطفال من ذوي الإعاقة الذين هم في الفئة العمرية من الولادة وحتى 5 سنوات؟

أ. المستشفى (المرضى الداخليين) فقط

ب. المستشفى (العيادات الخارجية) فقط

ج. المستشفى (العيادات الخارجية والمرضى الداخليين على حد سواء)

د. المركز (صفوف التدخل المبكر) فقط

هـ. المركز (كل من الفصول الدراسية والعيادات الخارجية)

20. هل تقوم بتقديم خدمات التدخل المبكر تقديم أو الخدمات التأهيلية للأطفال من ذوي الإعاقة الذين هم في الفئة العمرية من الولادة وحتى 5 سنوات <u>في المنزل</u>؟

أ. لا

ب. نعم (يرجى تحديد نوع الخدمات) ___________________________

21. عند العمل مع الأطفال من ذوي الإعاقة الذين هم في الفئة العمرية من الولادة وحتى 5 سنوات ، ما نوع التدخل أو التدريب العلاجي الذي تستخدمه؟

أ. التدريب الفردي (واحد مقابل واحد) فقط

ب. التدريب الجماعي (طفلين أو أكثر) فقط

ج. كل من التدريب الفردي والجماعي على حد سواء

22. هل يتم عمل اجتماع لفريق التأهيل أو فريق الخطة التربوية لجميع الأطفال من ذوي الإعاقة الذين هم في الفئة العمرية من الولادة وحتى 5 سنوات الذين تعمل معهم؟

أ. المرضى الداخليين بالمستشفى فقط

ب. حالات العيادات الخارجية بالمستشفى فقط

ج. المرضى الداخليين والعيادات الخارجية على حد سواء

د. صفوف التدخل المبكر بالمركز فقط

هـ. العيادات الخارجية بالمركز فقط

و. كل من الفصول الدراسية والعيادات الخارجية بالمركز

ز. غير ذلك (يرجى التحديد) ______________________

23. هل تحضر اجتماعات فريق التأهيل أو فريق الخطة التربوية؟

أ. أبدا

ب. مرة أو مرتين

ج. عدة مرات

د. بانتظام

24. هل يتم إشراك أسر الأطفال من ذوي الإعاقة في اتخاذ القرار بشأن نوع الخدمات التي يتلقاها الطفل؟

أ. نعم

ب. لا

25. هل تقوم بإشراك الأسر في عملية تقييم الأطفال من ذوي الإعاقة؟

أ. لا

ب. نعم

26. هل تقوم بإشراك الأسر في عملية التخطيط وتحديد الخطة العلاجية أو التأهيلية أو التربوية ؟

أ. لا

ب. نعم

27. ما هو شعورك حيال مشاركة الوالدين والأسرة في اتخاذ القرارات المتعلقة بالخطط العلاجية أو التأهيلية أو التربوية لأطفالهم من ذوي الإعاقة؟

أ. لا أشعر أن هناك حاجة إلى إشراك الأسر في هذه القرارات حيث أن المهنيين هم الخبراء والمتخصصين في هذا المجال

ب. مشاركة الأسرة ينبغي أن تقتصر على تنفيذ البرامج العلاجية والتربوية في المنزل فقط

ج. ينبغي إشراك الأسر في جميع المراحل المتعلقة البرامج العلاجية والتأهيلية والتربوية بما في ذلك التقييم وتحديد الأولويات وتحديد أهداف البرامج، ومنابعة تنفيذ البرامج في المنزل

28. هل تعتقد أن برامج التدخل المبكر ينبغي أن تقدم خدمات لأسر الأطفال من ذوي الإعاقة مثل التدريب والخدمات الاستشارية؟

أ. لا

ب. نعم

29. الرجاء استخدام هذا الجزء إذا كنت ترغب في توضيح أو تقديم معلومات إضافية أو تعليقات.

شكرا لك

Appendix L

Information Sheet for Families Survey

Information Sheet for Service Providers Survey

INFORMATION SHEET FOR CONSENT

TO PARTICIPATE IN A RESEARCH STUDY

FAMILIES SURVEY

My name is Nawal Al-Hadad, and I am a doctoral student in the Department of Educational Psychology at the University of the Oklahoma. I am requesting that you volunteer to participate in a research study titled “Family-Professional Partnership and Family Outcomes in Early Intervention and Early Childhood Special Education Programs in Qatar”. You were selected as a possible participant because you have a young child with a disability who receives early intervention/early childhood special education services. Please read this information sheet and contact me to ask any questions that you may have before agreeing to take part in this study.

Purpose of the Research Study: The purpose of this study is to understand factors that promote or hinder successful family-professional partnership in Early Intervention and Early Childhood Special Education programs (EI/ECSE) from the perspectives of service providers and families of young children with disabilities.

Specifically, the study aim to explore: How satisfied are families of children with disabilities and service providers working in early intervention and early childhood special education (EI/ECSE) programs in Qatar with their level of partnership?; What are the factors that promote or hinder successful family-professional partnership from the perspectives of families of children with disabilities, service providers, and program directors in EI/ECSE programs in the State of Qatar?, and Are EI/ECSE programs effective in terms of achieving family outcomes for families of young children with disabilities receiving services in Qatar?

Procedures: If you agree to be in this study, you will be asked to do the following things:

- Complete the *Family-Professional Partnership Scale*. This scale will ask you to rate your satisfaction with the quality of partnership you have with the service provider working with your child.

- Complete the *Family Outcomes Survey*. This survey will ask you to rate your feelings and perceptions of services that your family received from your early intervention program.

- Complete a *Family Demographic Survey*. The demographic survey will ask you basic descriptive information about you, your family, your child with disability, and the services you and your child receive through early intervention programs.

Risks and Benefits of Being in the Study: There are no foreseeable risks involved in participation in this study beyond those present in routine daily life. However, it is possible that talking about your experience with the early intervention services and programs may bring up sensitive issues that make you feel uncomfortable. You can contact the researcher for local resources if you want to talk to someone other than your family or the researcher. If you feel any question is too personal or sensitive, you can decline to answer without any penalty.

Although there are no direct benefits for you as a participant, your participation in this study is very important. The study is valuable in terms of improving early intervention services and future services for young children with disabilities and their families in Qatar.

Compensation: You will not be compensated for your time and participation in this study.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether or not to participate will not result in penalty or loss of benefits to which you are otherwise entitled. If you decide to participate, you are free not to answer any question or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Length of Participation: Each measure will require 10-15 minutes to complete making your total length of participation 30-45 minutes.

Confidentiality: The records of this study will be kept private and your supervisor will not have access to your responses. In published reports, there will be no information included that will make it possible to identify you as a research participant. Research records will be stored securely. All survey materials will be stored in a locked file cabinet with the principal investigators and will be disposed properly after completion of the study. Only approved researchers will have access to the records.

Contacts and Questions: If you have concerns or complaints about the research, you can contact the researcher conducting this study, Nawal Al-Hadad, at 974-687-0658 or nawal@ou.edu, or Dr. Kathryn Haring, Ph.D., at (405) 613-0197 or kharing@ou.edu

In the event of a research-related injury, contact the researchers. You are encouraged to contact the researchers if you have any questions. If you have any questions, concerns, or complaints about the research and wish to talk to someone other than the individuals on the research team, or if you cannot reach the research team, you may contact the University of Oklahoma – Norman Campus Institutional Review Board (OU-NC IRB) at (405) 325-8110 or irb@ou.edu.

Please keep this information sheet for your records. By completing and returning this questionnaire, I am agreeing to participate in this study.

INFORMATION SHEET FOR CONSENT

TO PARTICIPATE IN A RESEARCH STUDY

SERVICE PROVIDERS SURVEY

My name is Nawal Al-Hadad, and I am a doctoral student in the Department of Educational Psychology at the University of the Oklahoma. I am requesting that you volunteer to participate in a research study titled “Family-Professional Partnership and Family Outcomes in Early Intervention and Early Childhood Special Education Programs in Qatar”. You were selected as a possible participant because you are a direct service provider working with young children with disabilities and their families receiving early intervention/early childhood special education services.

Please read this information sheet and contact me to ask any questions that you may have before agreeing to take part in this study.

Purpose of the Research Study: The purpose of this study is to understand factors that promote or hinder successful family-professional partnership in Early Intervention and Early Childhood Special Education programs (EI/ECSE) from the perspectives of service providers and families of young children with disabilities.

Specifically, the study aim to explore: How satisfied are families of children with disabilities and service providers working in early intervention and early childhood special education (EI/ECSE) programs in Qatar with their level of partnership?; What are the factors that promote or hinder successful family-professional partnership from the perspectives of families of children with disabilities, service providers, and program directors in EI/ECSE programs in the State of Qatar?, and Are EI/ECSE programs effective in terms of achieving family outcomes for families of young children with disabilities receiving services in Qatar?

Procedures: If you agree to be in this study, you will be asked to do the following things:

- Complete the *Family-Professional Partnership Scale*. This scale will ask you to rate your skills as it relate to the quality of partnership you have with families of young children with disabilities.

- Complete a *Service Provider Demographic Survey*. The demographic survey will ask you basic information about you, the clients you work with at your early intervention programs, and the services you provide to young children with disabilities and their families.

Risks and Benefits of Being in the Study: There are no foreseeable risks involved in participation in this study beyond those present in routine daily life. However, it is possible that talking about your experience with the early intervention services and programs may bring up sensitive issues that make you feel uncomfortable. You can contact the researcher for local resources if you want to talk to someone other than your family or the researcher. If you feel any question is too personal or sensitive, you can decline to answer without any penalty.

Although there are no direct benefits for you as a participant, your participation in this study is very important. The study is valuable in terms of improving early intervention services and future services for young children with disabilities and their families in Qatar.

Compensation: You will not be compensated for your time and participation in this study.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether or not to participate will not result in penalty or loss of benefits to which you are otherwise entitled. If you decide to participate, you are free not to answer any question or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Length of Participation: Each measure will require 15 minutes to complete making your total length of participation 30 minutes.

Confidentiality: The records of this study will be kept private and your supervisor will not have access to your responses. In published reports, there will be no information included that will make it possible to identify you as a research participant. Research records will be stored securely. All survey materials will be stored in a locked file cabinet with the principal investigators and will be disposed properly after completion of the study. Only approved researchers will have access to the records.

Contacts and Questions: If you have concerns or complaints about the research, you can contact the researcher conducting this study, Nawal Al-Hadad, at 974-687-0658 or nawal@ou.edu, or Dr. Kathryn Haring, Ph.D., at (405) 613-0197 or kharing@ou.edu

In the event of a research-related injury, contact the researchers. You are encouraged to contact the researchers if you have any questions. If you have any questions, concerns, or complaints about the research and wish to talk to someone other than the individuals on the research team, or if you cannot reach the research team, you may contact the University of Oklahoma – Norman Campus Institutional Review Board (OU-NC IRB) at (405) 325-8110 or irb@ou.edu.

Please keep this information sheet for your records. By completing and returning this questionnaire, I am agreeing to participate in this study.

Appendix M

Family Outcomes Survey- Revised

Family Outcomes Survey-Revised (Arabic Version)

FAMILY OUTCOMES SURVEY (Revised Version)

Section A: Family Outcomes

Instructions: Section A of the Family Outcomes Survey focuses on the ways in which you support your child's needs. For each statement below, please select which option best describes your family right now: not at all, a little, somewhat, almost, or completely.		Not at all	A little	Somewhat	Almost	Completely
Outcome 1: Understanding your child's strengths, needs, and abilities						
1.	We know the next steps for our child's growth and learning.	○	○	○	○	○
2.	We understand our child's strengths and abilities.	○	○	○	○	○
3.	We understand our child's delays and/or needs.	○	○	○	○	○
4.	We are able to tell when our child is making progress.	○	○	○	○	○
Outcome 2: Knowing your rights and advocating for your child						
5.	We are able to find and use the services and programs available to us.	○	○	○	○	○
6.	We know our rights related to our child's special needs.	○	○	○	○	○
7.	We know who to contact and what to do when we have questions or concerns.	○	○	○	○	○
8.	We know what options are available when our child leaves the program.	○	○	○	○	○
9.	We are comfortable asking for services & supports that our child and family need.	○	○	○	○	○
Outcome 3: Helping your child develop and learn						
10.	We are able to help our child get along with others.	○	○	○	○	○
11.	We are able to help our child learn new skills.	○	○	○	○	○
12.	We are able to help our child take care of his/her needs.	○	○	○	○	○
13.	We are able to work on our child's goals during everyday routines.	○	○	○	○	○
Outcome 4: Having support systems						
14.	We are comfortable talking to family and friends about our child's needs.	○	○	○	○	○
15.	We have friends or family members who listen and care.	○	○	○	○	○
16.	We are able to talk with other families who have a child with similar needs.	○	○	○	○	○
17.	We have friends or family members we can rely on when we need help.	○	○	○	○	○
18.	I am able to take care of my own needs and do things I enjoy.	○	○	○	○	○
Outcome 5: Accessing the community						
19.	Our child participates in social, recreational, or religious activities that we want.	○	○	○	○	○
20.	We are able to do things we enjoy together as a family.	○	○	○	○	○
21.	Our medical and dental needs are met.	○	○	○	○	○
22.	Our child care needs are met.	○	○	○	○	○
23.	Our transportation needs are met.	○	○	○	○	○
24.	Our food, clothing, and housing needs are met.	○	○	○	○	○

Section B: Helpfulness of Early Intervention

Instructions: Section B of the Family Outcomes Survey focuses on the helpfulness of early intervention. For each question below, please select how helpful early intervention has been to you and your family over the past year: Not at all helpful, a little helpful, somewhat helpful, very helpful, or extremely helpful.		**Not at all helpful**	**A little helpful**	**Somewhat helpful**	**Very helpful**	**Extremely helpful**
Knowing your rights						
How helpful has early intervention been in…						
1.	giving you useful information about services and supports for you and your child?	○	○	○	○	○
2.	giving you useful information about your rights related to your child's special needs?	○	○	○	○	○
3.	giving you useful information about who to contact when you have questions or concerns?	○	○	○	○	○
4.	giving you useful information about available options when your child leaves the program?	○	○	○	○	○
5.	explaining your rights in ways that are easy for you to understand?	○	○	○	○	○
Communicating your child's needs						
How helpful has early intervention been in…						
6.	giving you useful information about your child's delays or needs?	○	○	○	○	○
7.	listening to you and respecting your choices?	○	○	○	○	○
8.	connecting you with other services or people who can help your child and family?	○	○	○	○	○
9.	talking with you about your child and family's strengths and needs?	○	○	○	○	○
10.	talking with you about what you think is important for your child and family?	○	○	○	○	○
11.	developing a good relationship with you and your family?	○	○	○	○	○
Helping your child develop and learn						
How helpful has early intervention been in…						
12.	giving you useful information about how to help your child get along with others?	○	○	○	○	○
13.	giving you useful information about how to help your child learn new skills?	○	○	○	○	○
14.	giving you useful information about how to help your child take care of his/her needs?	○	○	○	○	○
15.	identifying things you do that help your child learn and grow?	○	○	○	○	○
16.	sharing ideas on how to include your child in daily activities?	○	○	○	○	○
17.	working with you to know when your child is making progress?	○	○	○	○	○

استطلاع رأي بشأن نتائج الأسرة

القسم أ: نتائج الأسرة

رقم التعريف التعليمي للطفل (MARSS): __ __ __ __ __ __ __ _ __ __ __ __ __

تعليمات: يركز القسم "أ" من استطلاع رأي بشأن نتائج الأسرة على الطرق التي تدعم من خلالها احتياجات طفلك. بالنسبة لكل بيان فيما يلي، يرجى تحديد أفضل خيار يصف حق أسرتك الآن: لا على الإطلاق، أو قليلاً، أو إلى حدٍ ما، أو تقريباً، أو تماماً.

		لا على الإطلاق	قليلاً	إلى حدٍ ما	تقريباً	تماماً
النتيجة 1:	**فهم نقاط القوة واحتياجات وقدرات طفلك**					
.1	نحن نعرف الخطوات التالية فيما يتعلق بنمو وتعلم طفلنا.	○	○	○	○	○
.2	نحن نفهم نقاط القوة والقدرات عند طفلنا.	○	○	○	○	○
.3	نحن نفهم مواطن التأخر و/أو الاحتياجات عند طفلنا.	○	○	○	○	○
.4	نحن نستطيع أن نعرف متى يقوم طفلنا بإحراز تقدم.	○	○	○	○	○
النتيجة 2:	**معرفة حقوقك ومساندة طفلك**					
.5	نحن نستطيع البحث عن البرامج والخدمات المتاحة لنا واستخدامها.	○	○	○	○	○
.6	نحن نعرف حقوقنا المتعلقة بالاحتياجات الخاصة لطفلنا.	○	○	○	○	○
.7	نحن نعرف الجهات التي يجب الاتصال بها، وما ينبغي علينا القيام به، عندما تكون لدينا أسئلة أو مشكلات.	○	○	○	○	○
.8	نحن نعرف الخيارات المتاحة عند ترك طفلنا للبرامج.	○	○	○	○	○
.9	نحن نشعر بالارتياح عندما نستفسر عن الخدمات وأوجه الدعم التي يحتاج إليها طفلنا وأسرتنا.	○	○	○	○	○
النتيجة 3:	**مساعدة طفلك على النمو والتعلم**					
.10	نستطيع أن نساعد طفلنا على التعامل مع الآخرين.	○	○	○	○	○
.11	نستطيع أن نساعد طفلنا على تعلم مهارات جديدة.	○	○	○	○	○
.12	نستطيع أن نساعد طفلنا على الاعتناء باحتياجاته.	○	○	○	○	○
.13	نستطيع أن نعمل على تحقيق أهداف طفلنا من خلال الأعمال الروتينية كل يوم.	○	○	○	○	○
النتيجة 4:	**توفر أنظمة الدعم**					
.14	نحن نشعر بالارتياح عند التحدث إلى الأسرة والأصدقاء عن احتياجات طفلنا.	○	○	○	○	○
.15	لدينا أصدقاء وأفراد أسرة يستمعون ويعتنون.	○	○	○	○	○
.16	نستطيع التحدث مع العائلات الأخرى الذين لديهم طفل له احتياجات مماثلة.	○	○	○	○	○
.17	لدينا أصدقاء وأفراد أسرة يمكننا الاعتماد عليهم عندما نحتاج إلى المساعدة.	○	○	○	○	○
.18	أستطيع الاعتناء باحتياجاتي والقيام بالأشياء التي أستمتع بها.	○	○	○	○	○
النتيجة 5:	**الاندماج مع المجتمع**					
.19	طفلنا يشارك في الأنشطة الاجتماعية أو الترفيهية أو الدينية التي نريدها.	○	○	○	○	○
.20	نستطيع القيام بالأشياء التي نستمتع بها معاً كأسرة.	○	○	○	○	○
.21	يتم تلبية احتياجاتنا الخاصة بالطب وطب الأسنان.	○	○	○	○	○
.22	يتم تلبية احتياجات الرعاية الخاصة بطفلنا.	○	○	○	○	○
.23	يتم تلبية احتياجات الانتقال الخاصة بنا.	○	○	○	○	○
.24	يتم تلبية احتياجاتنا من الطعام والملابس والمسكن.	○	○	○	○	○

القسم ب: مزايا التدخل المبكر

تعليمات: يركز القسم "ب" من استطلاع رأي بشأن نتائج الأسرة على فوائد التدخل المبكر. بالنسبة لكل سؤال من الأسئلة التالية يرجى تحديد مدى الفوائد التي حققها التدخل المبكر بالنسبة لك وأسرتك خلال العام الماضي: غير مفيد بالمرة، أو مفيد قليلاً، أو مفيد إلى حدٍ ما، أو مفيد جداً، أو مفيد للغاية.	غير مفيد بالمرة	مفيد قليلاً	مفيد إلى حد ما	مفيد جداً	مفيد للغاية
معرفة حقوقك					
إلى أي مدى كان التدخل المبكر مفيداً في ...					
1. إعطائك معلومات مفيدة عن الخدمات وأوجه الدعم التي تخصك أنت وطفلك؟	○	○	○	○	○
2. إعطائك معلومات مفيدة عن حقوقك المتعلقة باحتياجات طفلك الخاصة؟	○	○	○	○	○
3. إعطائك معلومات مفيدة عن الجهات التي يمكنك الاتصال بها عندما تكون لديك أسئلة أو مشكلات؟	○	○	○	○	○
4. إعطائك معلومات مفيدة عن الخيارات المتاحة عند ترك طفلك للبرنامج؟	○	○	○	○	○
5. توضيح حقوقك بطرق يسهل عليك فهمها؟	○	○	○	○	○
توصيل احتياجات طفلك					
إلى أي مدى كان التدخل المبكر مفيداً في ...					
6. إعطائك معلومات مفيدة عن أوجه تأخر طفلك أو احتياجاته؟	○	○	○	○	○
7. الاستماع إليك واحترام اختياراتك؟	○	○	○	○	○
8. توصيلك بالخدمات الأخرى أو الأفراد الآخرين الذين يمكنهم مساعدة طفلك وأسرتك؟	○	○	○	○	○
9. التحدث معك عن مواطن القوة لدى طفلك واحتياجاته؟	○	○	○	○	○
10. التحدث معك عما ترى أنه مهم لطفلك وأسرتك؟	○	○	○	○	○
11. تطوير علاقة جيدة معك ومع أسرتك؟	○	○	○	○	○
مساعدة طفلك على النمو والتعلم					
إلى أي مدى كان التدخل المبكر مفيداً في ...					
12. إعطائك معلومات مفيدة عن كيفية مساعدة طفلك على التعامل مع الآخرين؟	○	○	○	○	○
13. إعطائك معلومات مفيدة عن كيفية مساعدة طفلك في تعلم مهارات جديدة؟	○	○	○	○	○
14. إعطائك معلومات مفيدة عن كيفية مساعدة طفلك في الاعتناء باحتياجاته؟	○	○	○	○	○
15. تحديد الأشياء التي تفعلها لمساعدة طفلك في التعلم والنمو؟	○	○	○	○	○
16. مشاركة الأفكار الخاصة بكيفية إشراك طفلك في الأنشطة اليومية؟	○	○	○	○	○
17. العمل معك لمعرفة متى يقوم طفلك بإحراز تقدم؟	○	○	○	○	○