

PUTTING IT TOGETHER

Providing Mental Health Services in Early Intervention

By Susan Burns, Ph.D., Vaughan Stagg, Ph.D., and Bernadette Bennermon, M. Ed.

a CASSP monograph



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PART 1 Beginnings

by Susan Burns, Ph.D., Vaughan Stagg, Ph.D., and Bernadette Bennermon, M. Ed.

We would like to present you with a brief history of our decision to offer inclusive mental health programming in an early childhood setting. Our childcare setting serves children under the age of six years. We were becoming increasingly concerned by the number of children arriving at our center with “challenging behaviors.” Often, these children had been expelled from one or more child care or kindergarten settings because of their behavior. Some children were directly or indirectly exposed to violence, drugs and alcohol, and other conditions that made typical emotional or behavioral development difficult. Every member of our staff was personally and professionally disturbed by what we were seeing. So we, as a program, decided to do something.

We decided to create two specialized programs for children with or at great risk for behavioral or emotional difficulties. These programs operated within the context of a childcare setting for typical children. The first was a Partial Hospital or Day Treatment Program for children with diagnosed behavior problems. The second was a Therapeutic Nursery for children between the ages of 0 and 36 months who were exposed to drugs and alcohol in utero, or whose mothers had significant psychiatric difficulties. What follows is a description of the challenges we faced in starting our programs. Our solutions to those challenges are also presented.

Our Neighborhood

The Matilda Theiss Child Development Center is located in a low income housing community in the city of Pittsburgh. Most of the families using our services are living in poverty and are receiving public assistance. Many families worry about their own and their children's safety in their

neighborhoods, and must deal with the constant presence of drugs and drug dealers.

We provide mental health and early intervention services for families in our neighborhood because, even in their early years, many children have serious emotional or behavioral problems. For these we provide psychiatric treatment. Other children have specific risk factors that indicate a possible future problem. These include parental mental illness and/or drug and alcohol addiction, serious emotional or behavioral problem in an older sibling, extreme neighborhood violence and domestic violence.

Start-Up

Developing an integrated Mental Health Early Intervention Program presents many complex challenges. But however difficult, this undertaking provided a unique opportunity for the agency and its staff to enhance their professional expertise.

With an ever-increasing population of children identified as having special needs, and considered to be at risk for developing such problems, it is unlikely that anyone would question the need for quality early intervention programming. However, the development of an early intervention program in an integrated early childhood education setting is controversial. Apart from the benefits to the affected children, reasons for such a program include the need for typical children to serve as peer models for children with developmental delays or behavior problems, and the need for the typical children to learn tolerance and concern for the well being of others who may be very different from themselves. Although these reasons are supported by research on integrated learning environments,

there are those who maintain that special needs should be addressed only in specialized settings.

Clearly, there are considerations that are unique to the integrated setting. Issues will arise on all levels and within all components: direct care and service, administrative, programmatic, legal, etc. Perhaps the best way to deal with the debates that arise is to remind oneself that controversy encourages creative thinking. It will bring questions to the table before they become problems. Frank exchanges of opinion will assist in the development of a viable program that will serve its clients well. Debate should be embraced and used to your advantage.

Laying the Ground Work

Changes of any kind within an agency inevitably result in various levels of acceptance and resistance of agency staff. Some will be open and receptive to the idea from the beginning. Others will not be able to “see the vision” until it begins to happen; and there are those who, even with evidence that the program is making a measurable difference in children's lives, will not be convinced that it was the best direction to take. These differences of opinion cannot be avoided, and should not be approached from a defensive stance.

Change can be threatening. Proposing to become an early intervention program may raise issues around job security, role and responsibility changes, competency, etc. People may wonder how the demands on them will increase and whether they possess the necessary skills and knowledge to meet those demands. These very real fears may be expressed openly. More likely, however, they will not, and will thus serve as the primary, if hidden, source of resistance. It is essential that these concerns be addressed very early in the process to reduce resistance and increase the likelihood of establishing a cooperative and collective effort. These issues should be the starting point for the initial planning phase.

The Planning Phase

The first step in the initial planning phase should be for program leaders to develop a lucid rationale for becoming an early intervention program. This should then be presented to agency staff along with a well-defined problem-solving strategy. Identify the need and then focus on issues of how and why the agency can and should address the need. Once everyone involved has a clear picture of the direction that the agency will be taking, issues of concern should be addressed.

Rather than attempt to answer all the questions that may arise at once, inform agency staff that they will be involved in every aspect of the development process. Direct involvement of the staff from the planning phase to the evaluation phase helps alleviate many concerns. When staff members know that they will be helping to determine the changes that need to be made, their fears regarding role and responsibility changes will dissipate. Questions about competency will be reduced once the staff is involved in determining what kind of training is needed, who should provide the training, and how that training should be conducted. In essence, what you will be saying to staff is that together, you will be asking all the questions that need to be asked, and answering those questions along the way.

From your initial rationale, agency staff can work together to develop a mission statement: identifying who you are and why you exist. The mission statement should include the program philosophy; your beliefs about how children grow, develop and learn, and what you believe to be the most appropriate approach to promoting that growth and development. Of course, the program philosophy should be supported by sound theory and proven practice in the field. The program philosophy should also include your beliefs concerning the most appropriate approach to serving the family, and involving the family in the child's early learning experiences and treatment program.

Program Goals

Your mission statement will provide the framework for the development of specific program goals and objectives. Your goals will be somewhat general in nature, regarding expected outcomes; while your objectives will break down your goals into observable, measurable performance standards. These standards will later serve as the basis for the evaluation of your program, and its overall effectiveness in achieving treatment outcomes.

Below we list two of our program goals. Under each goal we list objectives that can serve as an indicator that we are meeting our goals.

Goal 1:

To provide each child with positive learning experiences to enhance the whole child, including the areas of physical, social, emotional and intellectual development.

- Objective 1: Each program lists how these areas of development are addressed in the daily schedule.
- Objective 2: Children's progress in each of the developmental areas is assessed every 20 days.
- Objective 3: Learning centers in each unit address a variety of developmental areas and all developmental areas are included.

Goal 2:

To encourage parents to be partners in their children's development and to be advocates for their children.

- Objective 1: All parents participate in a parents group at least once a month.
- Objective 2: All parents meet on a regular basis to receive feedback about their child's development.
- Objective 3: By discharge, parents make the phone calls for services for their child 75 percent of the time.

You should expect that your list of goals and objectives will be revised and expanded as you

continue through the development process. But it is important to begin with some basic goals and objectives in mind. When you have established program goals and objectives that reflect your program philosophy and support your mission statement, you are ready to begin planning the details of the program.

Training

In converting our regular day care to a developmentally integrated or inclusive program, we were faced with significant training issues. In our case, this was particularly so since we intended to keep as many of our employees on staff as was possible. We carried out an inventory of staff strengths and skills and compared these to what was needed to implement the program.

Some training needs initially selected included:

- Overview of diagnostic categories relevant to preschool populations
- Overview of medications
- Clinical charts and note taking
- Treatment planning and teaming
- Management tactics for aggressive children
- Confidentiality
- Building a positive attitude toward difficult children

Since that time, our choices for continuing training have been guided by staff requests and by emerging clinical needs. For example, we have had in-service training on substance abuse and its physical and psychological effects on children in families where this occurs, as is the case with so many of our children. Because HIV infection in children is becoming more prevalent, we have begun training around clinical issues related to HIV infection. We expect to upgrade our knowledge and skills on a continual basis and are committed to ongoing staff education.

Paper Work

In any human service program, paper work can become a burden. This is especially true when you have integrated or inclusive services with multiple funding streams and regulatory agencies. From the outset we attempted to minimize paperwork. However, both regulatory and fiscal good practice require comprehensive record keeping. We have attempted to make paper serve more than one function.

One factor we considered from the beginning is how to build into our paper work the capacity for subsequent evaluation activities. It is much easier to build in the capacity at start-up than to retroactively collect evaluation information from disparate sources.

Managing Information

Soon after starting our program, we developed a management information system (MIS). Our system was built around a commercially available relational database, Paradox. This software is published by Borland International (1990). The cost was reasonable (under \$600) for almost any small clinical program and the software will run on most IBM or compatible PCs. Similar relational database software programs are available and we suggest you review them carefully before selecting one. Our MIS has proved invaluable in managing our program, providing us with timely program level reports, and helping us to adhere to regulatory guidelines.

We created the database to do several tasks. The first was to store basic demographic information about the child and family. This includes such useful information as emergency contacts, pediatrician of record, and insurance coverage.

The second was to store basic clinical information (e.g., diagnosis, other treatment agents, etc.) about the child. Access to this information is limited by a password security system. Having

basic demographic as well as clinical information at our fingertips has come in handy on a number of occasions. As a center, we are subject to a number of regulatory agencies (State Department of Public Welfare, Department of Education, Joint Commission on the Accreditation of Hospital Operations, County Mental Health/Mental Retardation Programs, County Department of Health, etc.). All request basic information about the children and families we serve. Additionally, clinical profiles of the children we have served over time enable us to plan for services and training.

The third task was to create a series of “tickler routines” to remind us of important tasks related to the child or regulatory issues. For example, at the beginning of the month each family worker is told which children need physicals within the time frame recommended by the American Academy of Pediatrics. The “tickler” routines also prompt the family worker to undertake eligibility determinations for our food program one month before they are due. The treatment team is notified which children should be placed on the agenda for treatment plan review so that we stay in compliance with state regulations.

The fourth task relates to bookkeeping, billing, and other fiscal issues. Because we have a very small support staff we found this very necessary. Currently, we use the MIS to track any parent fees, special contractual arrangements for a child, etc. We also use the same system to generate invoices to families and third party payers.

We are also becoming more sophisticated in the use of word processing capabilities of the personal computer. The development of program-specific macros has saved us considerable time. For example, word processing simplified EPSDT applications. We estimate that it takes a minimum of 10 hours of staff time to process one application for this funding stream. Documentation of need for the service consumes a great deal of this time. We have reduced the time needed for this important task by creating templates of the application. Each relevant clinician completes his or her section of the

application on the computer template then circulates a floppy disk to the next clinician involved with the child. The draft is then printed out for an interdisciplinary team meeting, where it is finished and updated.

Ideally, we would like to move to a more paper-free environment. In time, we would like to develop direct entry (by parent or clinician) of intake information, some clinical assessments, individualized treatment plans and individualized treatment plan reviews, family service plans, etc. We would also like to automate much of our follow-up process.

Informing the Community about Our Program

To inform the community about our programs, we developed a brochure outlining our services. This brochure was sent to agencies that served children. We spoke to any group willing to listen about our services. Through word of mouth and through our printed material, we got referrals from various social service agencies, such as child protective services, drug and alcohol treatment centers, psychiatric hospital emergency rooms, day care centers, pediatricians, private practice therapists, school districts, and individual families.

Funding

Funding for any community-based program is a major issue. We are currently faced with rapidly changing federal, state, and local priorities and a nationwide change in the way health care dollars are managed. Funding is particularly a challenge when you attempt to create developmentally integrated, inclusive programs. We serve children and families receiving funds from diverse sources. This is illustrated by the number of funding streams that have to be managed in our center. Our services to children with special needs are funded primarily by Medical Assistance, Early Periodic Screening, Diagnosis and Treatment (EPSDT), and, to a very small extent, private insurance. Many of our ancillary services are funded through the early

intervention stream. Title XX and Title IV fund services to our typical children. Food services to all qualified children are funded by the Pennsylvania Department of Education. Finally, we have several governmental and foundation grants that allow us to provide some specialized services. Keep in mind that we only enroll up to 70 children at any one time.

As our diverse financial scenario illustrates, programs need to be prepared to manage a variety of income streams. It is important to be responsive to the various rules, bookkeeping conventions, and priorities of each funding stream. However, it has been our experience that our diverse portfolio allows us to survive if one funding stream dries up or changes course.

Lessons Learned

As in any new venture one learns many lessons; that certainly has been the case with the implementation of our services. Some of those lessons have been enjoyable; others have made us rethink our approach and goals. The following list outlines some of the lessons we have learned.

- Most importantly, we learned that we could shift a program that served only typical children to one that includes children with emotional or behavioral disorders. This is important because many of our staff were very skeptical about the possibility of doing so.
- Ongoing training is essential for both staff and program leadership. Such training has enhanced our confidence and skills in serving children with special needs.
- We have to be willing to take a close look at our goals as a program and for specific children and change those goals as this becomes necessary. For example, our conception of our parent program involved detailed education (i.e., what is object permanence and how do you as a parent

facilitate its development?) for all parents. However, when Mrs. A. showed up at school one day intoxicated and with a wine bottle in hand we had to reevaluate our demands. Our focus for this family quickly shifted. We told the parent that bottles at the center were not permitted and worked very carefully to help her see the need for her own treatment. It took some time, but eventually she got into treatment and became sober. This had a profound impact on the child we were serving.

- We have had to learn to truly collaborate with other agencies and respect their work and expertise. We have learned that the needs of many of the families are such that no one agency can “fix” everything. In the process we have had to cede control of the treatment agenda to another agency. For example, we often have parents who are in treatment themselves for substance abuse or mental health issues. As an agency we will often reduce the demands we have of parents at the request of another agency, so that both agencies will not place too much stress on the parent.
- One of the phenomena that we have become aware of is that of “sleeper effects.” That is, we often do not see the impact of our program on a family for some time. It is not unusual for us to feel we have “failed” with a family (i.e., if a family prematurely terminates from the program) only to have them re-engage nine or ten

months later and have a successful experience.

- There were several treatment variables that we did not give enough attention to initially. Those include: a) the role of domestic violence toward mothers and its impact on treatment compliance with reference to the child; b) the role of substance abuse in the lives of many of our parents; c) the relationship between substance abuse and psychiatric problems in parents; d) the relationship between substance abuse and other risk factors for parent and child (i.e., child protective services involvement, prostitution, etc.), and e) how to capitalize on fathers in carrying out treatment. These variables and others led us to alterations in the way we carried out our programming.

In the second part of this monograph we will present the workings of our program, our goals, how we assess the child and family, and the treatment we provide for the child and family.

Reference

Borland International (1990). Paradox 3.5
Borland International: Scotts Valley, CA.

PART 2 The Program

INTRODUCTION

by Susan Burns, Ph. D. and Vaughan Stagg, Ph. D.

This section discusses the day-to-day workings of our center, the Matilda Theiss Therapeutic Nursery and Preschool Program. We begin with our Program goals, then present information on child and family assessment and intervention. Our program goals and beliefs incorporate the best practice in early intervention and in mental health services for young children.

Program Goals

- To provide appropriate, nurturing early intervention to enhance the development of infants, toddlers and preschoolers, thereby preventing or reducing the severity of impairment seen in these young children.
 - To provide each child with positive, stimulating learning experiences to enhance development in the social, physical, emotional and intellectual spheres.
 - To encourage parents to be partners in their children's development and to be advocates for their children.
 - To provide community-based treatment that will prevent psychiatric hospitalization of the child, or reduce the length of time in the hospital.
 - To provide intensive outpatient therapy for families in cases where traditional office visits are not meeting their needs.
- Given a variety of learning activities, children will maintain and broaden their desire to learn.
 - Given a variety of thinking strategies, children will learn to solve social and intellectual problems.
 - Given suitable opportunities for language development, children will develop communication skills and tools for learning and social interaction.
 - Given a variety of materials and toys, children will explore and develop individual creativity.
 - Given a foundation in the curriculum areas, children will develop skills in cognition, language, social studies, math, science, gross and fine motor skills, and an understanding of self.
 - Given a variety of multicultural experiences, children will develop a positive sense of their own culture in our culturally diverse society.
 - Given empowering parent support and coordinated social services, families will be able to develop the skills to meet their children's developmental needs.

Program Beliefs

- Given a variety of activities in which children can succeed, they will develop healthy self concepts and faith in their capabilities.

Therapeutic Nursery and Preschool

The Therapeutic Nursery and Preschool Program provides children and families with individual treatment and developmental programming for problems identified by a multidisciplinary diagnostic and treatment team. The program is staffed by representatives from the disciplines of Psychiatry, Psychology, Early Childhood, Special Education, and Social Work.

Specialists in allied disciplines such as Speech Therapy, Occupational and Physical Therapy and Pediatrics are available as needed.

The program takes place in a developmentally inclusive setting. That is, children are mainstreamed with typical children upon entry into the Program. We maintain a 50/50 ratio of children with special need to typical children in our therapeutic classroom setting. The typical children are from low income families.

Child services at our center include:

1. an individualized treatment program designed to address a child's social-emotional development, language development, self-care and adaptive behavior, and cognitive development;
2. periodic re-evaluation to monitor the child's developmental needs;
3. a nutritionally balanced daily breakfast, lunch, and snack.

The Therapeutic Nursery and Preschool Program is available on weekdays from 7:30 a.m.- 5:30 p.m. Parents are asked to bring their children to the program before 9:00 a.m. and pick them up after 2:30 p.m. Parents are encouraged to have the children at the Program for six hours daily. However, their needs often make it necessary for the children to attend for a longer day. Arrangements are made on an individual basis. Full day services are provided for all of our children in daycare and for many of our children with special needs.

Our program adheres to the principles of the Pennsylvania Child and Adolescent Service System Program (PA CASSP): child-centered, family-focused, community-based, multi-system, culturally competent, and least restrictive/least intrusive. When operating according to these principles, a model day treatment program will have the following characteristics:

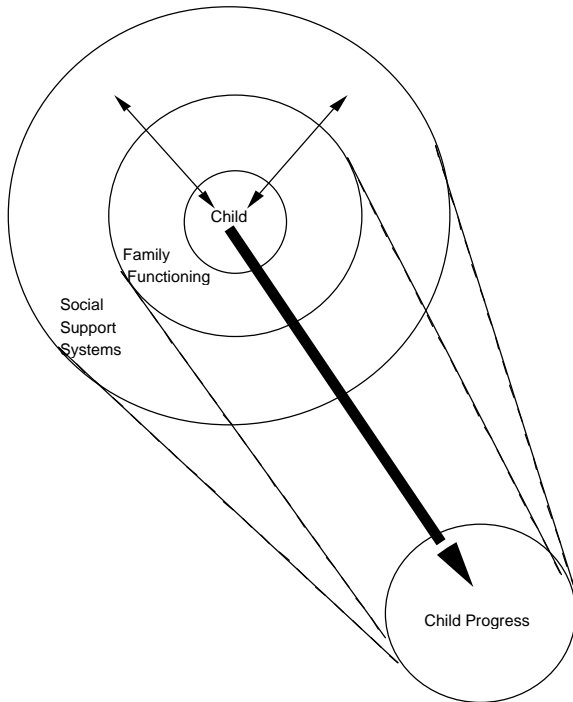
- Children should have access to a continuum of care that provides educational,

psychological, and social services appropriate to their needs.

- Children should be served in the least restrictive environment appropriate to their needs.
- The program should strive to provide as normal an environment for the child as possible.
- The program should provide a rich array of services to children and their families.
- The program should ensure that the special developmental needs of each child are met.
- There should be mechanisms for the monitoring of and feedback on Program effectiveness.
- Residential and Day Treatment Programs/services should be linked with other service systems in the community, so that systems such as health, mental health, child welfare, juvenile justice, etc., are integrated on several different levels including planning, administration, financing, and service delivery.
- Services should be family-oriented, involving families in training, planning, treatment decisions relating to the child, support groups, advocacy efforts and aftercare. However, no child should be denied admission because (a) he or she has no traditional family or (b) the family initially refuses to participate.
- The program should include adequate discharge planning (including permanency planning), aftercare and follow-up services.
- The program and its staff should be advocates for the youth served by the program and teach youth as well as their families skills needed to become their own advocates.

In summary, our program was developed to provide effective intervention for infants, toddlers and preschoolers in need of mental health treatment and prevention services. Our clinical experience indicates that successful family-centered early intervention requires attention to the child and

his/her environment as depicted below. The needs of the child, family and community have to be addressed for effective and long term child progress.



In Part 2, we describe the children we serve, their families, and our therapeutic program. First, Claire Cohen and Nkechinyere Amadi put the child in the context of his or her community and family and address culture and class issues that affect assessment and treatment. The authors present a detailed explanation of the initial psychiatric assessment of the young child. They also discuss

how to provide additional developmental assessments, services from varied professionals who are not a part of our therapeutic nursery and preschool staff, and assessment and monitoring of medication and planning for discharge from the Program.

In the second section of Part 2, Ginny Cowell and Chris Saitz address assessment and treatment issues that are specific to the families. Our various programs are specifically for the child, but with each child comes their family and the context within which they live. Astute and compassionate evaluation, treatment and early intervention are necessary to nurture healthy children. Cowell and Saitz combine their expertise in working with families to provide practical information for parents. Parent workers can provide a variety of services including case management, psychoeducational and parenting skills training and family therapy. Cowell and Saitz discuss how families can identify and build on their own strengths, understand their family functioning and how to incorporate this information into their child's treatment. Direct services and referrals are provided for families.

In the final section of Part 2, we return to specific services for the children we serve. Bernadette Bennamon focuses on the treatment that children receive while in the developmental milieu. She discusses the relationships among the child's assessment and treatment plans and classroom curriculum.

THE CHILD

by Claire Cohen, M.D. and Nkechinere Amadi, M.P.H.

The early intervention programs at Theiss Center provide services for children ages one month to 5 ½ years. Incorporated into the typical day care program are the two programs for children with special needs: the Partial Hospital Program and the Program for At-Risk Kids (a therapeutic nursery). All children referred for admission to the Partial Hospital Program receive a formal psychiatric evaluation from the Center's child psychiatrist to determine appropriateness for admission. The Program for At-Risk Kids (PARK) provides services for children ages 1-36 months who have been exposed to drugs and/or alcohol in utero and whose parents have substance abuse and/or mental illness. While the psychiatrist is part of the team reviewing their histories, the children receive a formal psychiatric evaluation only if the team deems it necessary.

All of our children have numerous risk factors, as we will describe more fully later in this document. Given these risk factors, one must bear in mind that the children in our program also have strengths as evidenced by their resilience.

Of our children with special needs, approximately 25 percent have had previous psychiatric or mental health intervention. The remaining 75 percent have had behavioral, emotional, or developmental problems for which the primary caretaker may or may not have sought help. About 35-40 percent of our 3- to 5-year old children have a confirmed history of exposure to drugs and/or alcohol in utero. Another 10-15 percent are suspected to have had intrauterine substance exposure. There is also a high percentage of children who were born premature. One half (50 percent) of the mothers of children in the Therapeutic Nursery are dually diagnosed.

More than 90 percent of the children served by Matilda Theiss Center are African American. The

rest are biracial or of European descent. Most of the children live in single parent households. Approximately 20 percent of the children in the early intervention programs at Matilda Theiss live in out-of-home placements (i.e., foster placement or institutional placement). (This compares with 1991 U.S. Census Bureau figures of 2.7 percent for all children and 6.5 percent for black children.) All the children we serve are from low income families, with the overwhelming majority living in poverty. The modal income for our families served is under \$5,000 a year.

The socioeconomic status and race/ethnicity of a child have long been shown to be significant factors influencing psychological and cognitive development. Thus, a multicultural perspective is imperative in planning and implementing social services, including early intervention.

The impact of ethnicity and race on the developing child is both positive and negative. Children learn positive values and traditions that are communicated through generations. These values and traditions provide children with a foundation for developing a sense of self and community. The negative impact derives from the historical context of racism and oppression in American society. Much of the negative role of race and ethnicity in children's mental and developmental disability is due to the disproportionate number of minority children living in poverty. Poverty has been strongly correlated with negative outcomes in physical health, mental health, and cognitive development.

Within the last 20 years in the United States, the poverty rate for children has been increasing. According to the 1991 United States census, 21.1 percent of all American children lived in poverty, 16.1 percent of white and 45.6 percent of African American children (52.2 percent under the age of

six). For children under six years of age in particular, the National Center for Children in Poverty reports that in 1996, 23 percent of all children under six years of age lived in families with incomes below the federal poverty line; of these 34 percent were non-Hispanic white, 31 percent were Hispanic, and 29 percent were African American. We can predict that as the living standards of children continue to fall, there will be an increasing need for early intervention programs to counteract the devastating impact of poverty on child development.

Referrals

At our center, common referral sources for psychiatric evaluation include child outpatient clinics of Western Psychiatric Institute and Clinic, shelters for the homeless, the Pittsburgh Public School System, local substance abuse treatment programs for women, pediatricians, and internal referrals from Theiss Center (the pediatric clinic, family medicine clinic, obstetrics clinic, and the regular daycare center).

The most frequent behavioral problems noted are short attention span, hyperactivity, impulsiveness, oppositional behavior, attention seeking behavior, gross motor delay, sleep disturbance, speech delay, self-abusive behavior, severe tantrums and noncompliance. Most of the children meet criteria for one or more of the following DSM-IV diagnoses: Adjustment Disorder with Mixed Disturbance of Emotions and Conduct; Reactive Attachment Disorder; Separation Anxiety Disorder; Parent/Child Problems; Attention Deficit Hyperactivity/Disorder; Mixed Receptive-Expressive Language Disorder; Phonological Disorder; and Developmental Disorder NOS (See also Part 3).

Initial Psychiatric Assessment of the Child

The ambiance of the initial assessment of the child and family is crucial in establishing rapport and a strong therapeutic alliance, especially when one is dealing with populations from diverse cultural groups who have been traditionally underserved. The furniture should be arranged to accommodate a family with room on the floor for children to play, and off limits objects out of the child's reach. Toys should be readily visible and accessible, inviting the child to play. In the case of an infant, a blanket should already be on the floor. We suggest the following toys for evaluating and working with young children: a doll house, dolls, puppets, blocks, a small four-wheel vehicle (car, school bus, or truck), a ball, a mirror, a teething toy, a rattle, a bell, a form box or ball, a toy telephone or telephone receiver, paper with crayon or markers, child safety scissors, nesting cups, tea or dinner set, picture books, and both hard and soft blocks.

Dolls and puppets are especially important when working with preschoolers. It is important to have dolls of all races, a baby doll, a doll family, and anatomically correct dolls. There should be at least one doll with removable clothing other than the anatomically correct dolls. Puppets should include both animal and people puppets. A bunny puppet is helpful in establishing a rapport with extremely shy children. A monster puppet enables children to safely express anger. Concrete positive rewards, such as stickers, and snack foods are necessary tools in establishing a rapport with young children. Children expect something from you when they come to visit.

When working with low-income families, be prepared to provide a small meal and diapers. It is impossible to evaluate a hungry or messy child accurately, and we found that parents will bring children in such states at least once every few months.

The way in which the child and family are greeted sets the tone for the relationship between the program and child and his/her family. It is

important that whoever greets the child and family be courteous and warm. Introduce yourself to the child as well as to the parent.

Some children are reluctant to come to the office, even with their parents. Physicians could introduce themselves as “a talking and playing doctor” who never gives needles or pokes, or undresses the child. Inform the child about the toys in the office. Most reluctant children will come into the office for some kind of candy or snack. Finally, elicit the parent's help in getting the child into the office.

Because many parents come to the interview ashamed about having people see their child “acting bad,” they attempt to control the child by placing many limits on the child's behavior. However, it is important for the clinician to see not only the parent-child interaction, but also the child being him or herself. Thus, when the family enters the office, the child should be given permission to play freely and the parent informed that this will help the clinician to understand their concerns.

Many poor people and people of color are distrustful of the motives and intentions of “the system.” They are especially worried that someone may try to take their children from them if they reveal difficulties in parenting, whether or not abuse is involved. Thus, caretakers may withhold or change information that is given to the clinician. Other common reasons to withhold or distort information include: mistaken ideas about what will motivate the clinician to help, feelings of shame and inadequacy about parenting skills, and the caretaker's perception of being judged by a professional of a different ethnicity and/or class. Because these concerns are seldom made explicit by the client, clinicians must always be aware of these issues and deal with them accordingly. Of course, clinicians must also be aware that their own cultural and class biases can affect their reaction to and understanding of clients and their families.

It is also crucial to be aware of how our culture's bias against male primary caretakers affects both

clinicians and the fathers. It is important to validate a man's role when he comes in as the primary caretaker and give him some positive feedback for taking on such a role in our culture and society. It is also important to explore how this has affected his relationships with family, friends and the larger society.

Because preschool children are normally wary of strange adults, it is not advisable to attempt to interview a child first, even with the parent in the room. Young children need time to be comfortable with a new person. Allow the child to be in the presence of the new person without demands being placed upon him or her. It is also important for the child to see their parent establishing a comfortable relationship with the clinician. During the interview with the parent, the clinician can interact with the child in a casual, friendly way, as opportunities present themselves. Also, the young child is unable to give a coherent history, and interviewing the parent first overcomes this problem.

Explain to the parent what will happen in the interview process. Invite him or her to be a partner in the process by encouraging them to bring up any important information that was not asked about, thus promoting a therapeutic alliance.

Young children normally interact with their parent in some way when they are around them. Because the emphasis is on obtaining information, often you can get a more natural picture of the parent-child relationship during this part of the interview, including how the parent picks up and responds to the child's verbal and nonverbal cues and the ways the dyad expresses affection.

There can be a number of obstacles to a parent giving an accurate history or a clinician getting a history at all. Some of these obstacles are: a parent's intellectual capacity, a parent's own mental health problems or substance abuse problems, fear of loss of child custody, a parent's general distrust of the system, and class and cultural differences in language and in overall perspective. It is important to realize that getting to know a child and family is

an ongoing process over time. If a parent should come to an interview inebriated or under the influence of drugs, the interview should be rescheduled, since one cannot get an accurate history under such circumstances.

While open-ended questions are usually better for obtaining information, if a caretaker is disorganized and has difficulty expressing herself a more structured approach is warranted. Both client and clinician will ultimately benefit in such a situation. Providing more structure initially will often enable the parent to need less structure as the process continues. Sometimes the parent has information that they do not want to divulge in front of the child. In such cases, if possible, you should attempt to try to meet to interview the parent alone.

Many poor parents feel that the system is always putting demands on them and giving little or nothing in return. The interview process can feel this way because the parent is being asked many questions and traditionally given few answers. Poor African Americans sometimes suspect that clinicians are “just trying to get in their business” for ulterior motives. Taking the time to address one of the small, concrete problems a parent may present helps establish trust. Giving practical information helps improve the rapport by making the parent a partner in the process, rather than an object to be acted upon. This increases their hopes that they might get something useful on a regular basis once entering into the program.

Begin the interview by getting information about the family. Here again it is important to recognize that, in this culturally diverse society, there are a variety of living arrangements and family constellations, which are just as “good” and just as “valid” as the traditional nuclear family. For many African-American families, in particular, extended family is more of the norm. Grandparents tend to play a stronger role in well functioning African-American families than in middle class white American families. Do not simply assume that the family constellation is mother and child or mother, father and child. It is also important to get

information about the neighborhood in which the child and family are living, and the family's relationship to the community. One should also ask who made the referral and how the parent feels about the recommendation or the referral to the Program.

There are some important areas of information that are frequently missed in the traditional psychiatric evaluation. For example, it is important always to ask about physical, sexual and emotional abuse without putting the parent on the defensive. Ask the parent if they suspect their child has been abused, rather than asking if they or others in the family have abused the child. You can likewise obtain information about domestic or community violence in the same manner. Many poor women deny domestic abuse when they are directly asked if they are battered or abused by their male partners. They may rationalize that they are not battered women or victims of domestic abuse because they “fought back.” Thus, it is better to inquire if the woman gets into physical fights with her partner rather than ask if she has been abused. Again, it is very important to ask whether the child or any member of the immediate family has ever witnessed or been a victim of any violence in the community or outside their house. At Theiss, initial evaluations have revealed issues of domestic and/or community violence in approximately 15 percent of the cases. However, over time, a higher percentage of cases revealed domestic violence.

Always ask in a matter of fact way about parental drug and alcohol use, keeping in mind that clients commonly minimize their substance use on initial interview. One of the major goals of the Center's child development services is to provide support and guidance for parents with substance abuse. Many agencies refer drug- and alcohol-involved families to Theiss because we are receptive to working with children with parents who abuse drugs and alcohol. Parents of children who have been identified as eligible for the Program for At-Risk Kids (the Therapeutic Nursery) because of prenatal exposure to drugs and/or alcohol are required to attend a weekly parent support group.

Parents often do not realize that what stresses them and other adult members of the family also stresses young children. Make sure to ask about stressors to the family in general, as well as stressors to the child.

Getting a sense of how the parent feels about the child is important in assessing the parent/child relationship. It is helpful to find out how the parent discovered that she was pregnant or his female partner was pregnant and their reaction when they found out. Almost 85 percent of the mothers during the interview indicate that the child was the product of an unplanned pregnancy. However, this is not the same as unwanted.

It is important to determine if a temperamental mismatch between child and caretaker has caused difficulties in the relationship. This can be elicited by asking the parent to describe what the child was like as a baby and as they developed, and their response to the baby's personality. In the process of getting developmental history, it is not uncommon for parents to express worries about whether their child is developing normally. Parents are often reassured if we provide concrete information about normal development at that point. When a child is in foster care or out-of-the-home placement, it is difficult and sometimes impossible to get a developmental history. It is still helpful to get a sense of how the child was doing when they came into the home or placement.

When taking the medical history, it is especially important to ask about head injury, hospitalizations, lead poisoning, exposure to other toxic substances, otitis media, and the use of illicit, prescribed, and over-the-counter drugs during pregnancies. It is important to obtain family history about brothers and sisters, half siblings, and extended family, as well as the immediate caretaker.

Ask the caretaker about the perceived strengths of the child and family. When asking about support systems, include inquiries about both emotional and financial support systems.

Children under a year should be assessed with the parent in the room. Some older children may need their parents to stay in the room. It can be a very positive experience for parents to see what their child can do and can also help in the assessment of the parent-child relationship. Infants and young children who are stressed by the interview can usually be relaxed by gentle stroking, soft singing and quiet talking to them in a high voice. There is good literature on how to do psychiatric and developmental assessments on infants, including material by T.B. Brazelton (1983) and Stanley Greenspan (1992).

Children two years of age and older may be able to tolerate separation from the parent. If they cannot, one should allow the parent to stay in the room. It may be easier for a child to be interviewed alone if the mother leaves something of hers in the office “for the child to take care of until she comes back.” One should expect the child will be reserved for the first five or even ten minutes after the parent has left the room. When the parent leaves, there are two ways to handle separation. One is to begin doing activities with the child while the parent is still in the room and then have the mother announce that she will be going out to take a break but will come right back, leaving a possession of hers in the room. Another method is to quietly sing children's action songs after the parent has left.

To establish rapport with young children, it is best to sit on the floor, move slowly, talk quietly, and give the child plenty of space. Let the child come to you. Respond in kind to appropriate displays of affection. Gently redirect inappropriate interactions. If a child turns his or her back and ignores you, just watch the child and periodically try to gently establish a connection. If a child is having difficulties connecting, singing softly will usually help. If a child cannot get used to being alone with the interviewer within ten to fifteen minutes, the interview should be terminated and the parent brought back in. If the child is severely distressed, one should not even go that long. Some

children find it helpful to go out and see that the parent really is sitting in the waiting room.

It is best to let young children initiate the activities they want and follow their lead. If you are creative, you can find unobtrusive ways to obtain the information you need. For example, if a toddler is building blocks, one can count how many blocks the toddler builds and then say, “You put another one on.”

Assess the toddler's gross and fine motor skills, knowledge of body parts, budding imaginary play skills, ability to follow one-step directions, and social interactions. Toddlers cannot give much information about what is happening at home and have no awareness that they “have problems.”

Three- to five-year-olds are more verbal and can sometimes give information by responding to questions about why they are seeing the clinician. Some children can identify specific problems they are having. It is interesting and informative to hear their perspective and have a conversation with them about this. You can get more verbal information if you intersperse talk with play, during the interview. Children in this age group are often well engaged in imaginative play with the puppets or doll houses by the time the clinician is ready to interview them alone. Rather than stopping this play, watch or join in and gently begin asking questions or suggest doing other activities together. You can elicit more information from three- to five-year-olds by asking indirect rather than direct questions. For example, asking about their Mommy or Daddy fighting may not get much information. Instead ask, “Does this pretend Mommy or Daddy ever fight?” as the child is playing house.

Sometimes the clinician will have to give information that the child is more seriously impaired than the parent realized. Concerns about serious impairment should be handled carefully. Keep in mind that you really cannot tell whether a pre-school child has mild mental retardation. When there are developmental delays, the parent has often already indicated concern about this. Validate the

parent's concern where appropriate, and explain that staff will attempt to determine the severity of any delays as “we get to know the child better.”

Sometimes there is disagreement between a clinician and a parent about the best course of treatment for the child. If the parent insists that the child needs treatment and the clinician disagrees, sometimes the child can be admitted for “observation.” Sometimes the parent turns out to be right. More often it becomes a way for a clinician to point out the issues and interventions that would be more helpful for the child.

Occasionally, information comes out that mandates a Childline report to child protective services. In such cases, maintaining or developing a therapeutic alliance will be difficult, but it is possible. Start by giving the parent positive reinforcement for revealing difficult information about his or her relationship with the child. Be very clear about what one is required to do by law. Invite the parent to participate in calling in the report. Emphasize wanting to continue to work with the parent despite the situation, and how one will intercede to help protect the child and also work towards maintaining or reuniting the family. Meet with parents soon after any action takes place by child welfare authorities.

One four-year-old female was referred to the program by her mother, who was having difficulty managing her child's behavior and was concerned that she may hurt her child physically. During the course of the psychiatric interview, the mother admitted physically abusing the child and leaving marks on the child. The psychiatrist explained to the parent that she was mandated to report the abuse to Child Protective Services. The psychiatrist encouraged the parent to be present while the report was made. The parent agreed to be present. Child Protective Services accepted the report and became involved with the family. The parent and child continued with the program at the Theiss Center.

When Further Assessments are Needed

Each child involved in the Partial Hospital Program or the Program for At-Risk Kids (P.A.R.K.) is monitored in their respective developmental groups. Teachers keep daily notes on children's developmental progress, using the Ages and Stages Questionnaire, a well-validated early intervention screening instrument by Diane Bricker. As it becomes clear that a child is having difficulty in any of the developmental domains (gross motor, fine motor, cognitive skills, social and self skills, and adaptive behavior,) arrangements for further evaluation are made.

Currently, the Center has a part-time speech pathologist. This was essential since 40 percent of the children in our programs have speech impediments. The Pittsburgh Public School system also sends in a speech pathologist for children over the age of 36 months who are eligible. We have brokered an arrangement with Children's Hospital of Pittsburgh and the Department of Communication of the University of Pittsburgh to serve children under the age of 36 months.

The Child Development Unit (CDU) of the Children's Hospital of Pittsburgh does a Developmental Evaluation on each child. There are a number of children who require physical and occupational therapy evaluations and treatment. There is a pediatric clinic on site to which children are referred immediately if necessary. Otherwise, we make referrals to the child's pediatrician or clinic. It is helpful to write a letter for the parent to take with them for the referral.

Collaborating to Provide Integrated Therapy

For many children you can integrate therapeutic interventions directly into the milieu of the early intervention setting. This requires much in-service training with the teachers, developmental therapists, and staff who are working directly with the client. (Please refer to the final section of this part on the Therapeutic Nursery/Preschool.)

To benefit from individual therapy, a child generally needs some basic verbal communicative skills, and some development of imaginative play. The children who spontaneously talk about their issues, or act them out in play, usually would benefit from individual therapy.

The best keys to establishing therapeutic alliance with young children are toys, food, singing songs, sitting on the floor so that you are at their level, being low-keyed and gentle, and returning appropriate affection when given by the child. Many parents are receptive to individual therapy, but clearly want to know what is going on in the sessions. Give the parent a sense of the basic themes of the session. Use this as an opportunity to educate the parent about the child's perspective and needs.

It is often difficult to convey to a young child that you will eventually have to end sessions. It is important to explain why the therapy sessions are coming to an end, over at least two to three sessions. With three- to five-year-olds, use a large calendar to mark off the days to the end of therapy. Children often appreciate some kind of goodbye gift. Make cards and pictures with the child. Taking the child out on an outing can also be appropriate.

Medication

It is very rare for children under three to be on any kind of psychiatric medicine. Over three years of age, a small number of children may benefit from a trial of stimulants to treat severe Attention Deficit Hyperactivity Disorder (ADHD). To determine whether a child of this age could benefit, interview teachers and parents, observe the child in his/her natural setting and ask the teacher to complete a reliable rating scale. Since most rating scales are for children five and above, we generally do our own observations of on and off task behavior and compare them with the norms of the classroom the child is in. If the child is substantially above the norm, then we consider that they possibly may benefit from some medication.

Be sure to engage the support of parents and families before beginning a medication trial for children. It may take several meetings before one can do a medication trial. Emphasize to the caretaker or parent that you want to do a trial first. Often people will accept the idea of a trial with the understanding that everyone will evaluate the results of the trial together to determine whether the child should be put on medicine for the long term.

It is easy to monitor the effects of medication on children in a program setting. Invite the parent in for monthly medication checks and to discuss the child’s progress at home. This gives the parent a chance to be a partner in the monitoring of the medication. Always remember that it is ultimately the parent's decision whether to proceed with medication therapy.

Disposition Planning

When a child's behavior has stabilized both at home and in the program for at least a month, discharge planning should begin. It is important to involve the parent every step of the way on this. Children are discharged to another program such as a regular Head Start or regular daycare. Some children will be leaving the program because they

will be graduating to kindergarten or because a parent is moving, not because their problems have been “cured.” If possible, establish a positive and strong relationship with the new school administration before transition occurs. Assessment for appropriate placement can take place during this time.

Sometimes it is appropriate that a child will be going home with outpatient therapy alone, rather than transferring to another program. It is important to make the referral for outpatient therapy before discharge from the program and have the parent and child meet with the outpatient therapist at least once. We find it helpful for the staff to work on a good-bye book with the child making a transition. The book includes pictures of friends and staff with whom they have grown close in the program at Theiss. The child has a “good-bye party.” Transitions are always presented in a positive light of moving on. The child is always given the option of coming back to visit Theiss shortly after starting the new program to let us know how it is going. If possible, we recommend that the child and their parent visit the new Program. Again, they can come back and let us know how the experience is going for them.

THE FAMILY

by Ginny Cowell, M.Ed. and Christine Saitz, M.S.W.

Our various programs are specifically for the child, but with each child comes a family and the context within which they all live. Astute and compassionate evaluation, treatment and early intervention are necessary to nurture healthy children. In this section we will address assessment and treatment issues that are specific to the families.

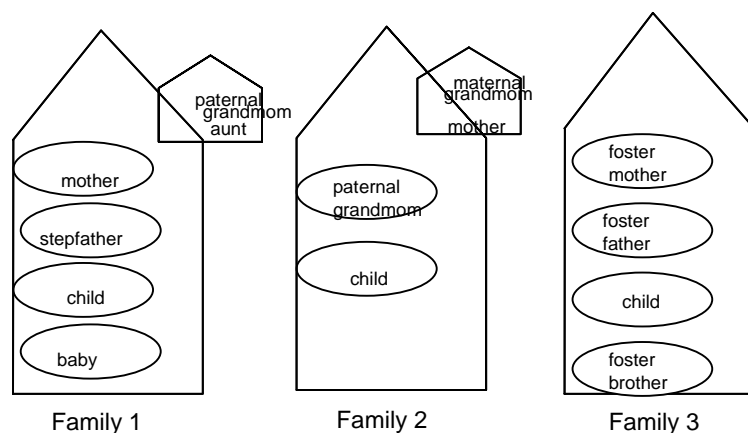
Our center is located in a low-income housing community in the city of Pittsburgh. Most of the families who use the services at the center are living in poverty. As Claire Cohen and Chi Amadi described in the previous section, the families we serve are coping with many stressors. Despite stereotypes to the contrary, our parents are very interested in their children’s development.

Our mission and objectives reflect our goals to serve the children within the context of their families. Respect and non-judgmental attitudes are evident in our work with individuals and families. The intricate constellation of risk factors families face, from living in dangerous neighborhoods to self-medicating for depression with street drugs, certainly weighs heavily on their choices. We meet each child and family where they are with the belief that positive growth and change is possible and work from there. We work intensively with the families by providing case management services, as well as a variety of counseling options to families whose children are enrolled in our programs.

In our therapeutic nursery and preschool programs, the parent worker interacts with children who 1) have mothers who are trying to get away from abusive paramours; 2) have caregivers with drug and alcohol problems; 3) have been exposed to drugs and alcohol in utero; 4) have been sexually, physically, verbally and emotionally abused; 5) have grandparents taking care of them and their mothers, and 6) are part of families who lack the money for adequate food, shelter, clothing, utilities, or entertainment.

To work successfully with families, the parent worker must first define the family unit. Contrary to popular myth, here in the United States, the family composed of the mother, father and siblings living in the same house was the norm only briefly in the 1950s. Parent workers interact with family units that include a variety of household member configurations. The families depicted in the diagram below are examples drawn from our program. Family One's household includes a mother and child, however, three additional households function psychologically in the family. Family Two's household includes a grandmother, mother and child. Family Three's household includes a mother and child; however, an additional household with a grandmother and aunts function psychologically in the family.

Family constellations change over time. Look at the three examples one year later:



Every household constellation has changed. In Family One, the mother who was white, acquired a paramour who was black. He moved in with her and they had a biracial baby. The child's maternal aunt and uncle, their landlords, evicted the family from their home because of racial intolerance. The maternal grandmother died and no one in the mother's family would accept her paramour or the new baby. The stepfather's family became a significant support system for the mother. In Family Two, the mother and the maternal grandmother no longer have the child living in their home. Child Protective Service placed him in foster care with the paternal grandmother. The child in Family Three was initially living alone with his mother. Mother's significant physical and psychiatric impairment forced her to ask the child's paternal grandmother to care for her. The paternal grandmother also had psychiatric illness. Due to grandmother's need for inpatient care, the child was moved to a foster home, where she currently lives.

In this paper we define the family as a unit, changeable over time, that has a composition that significantly affects one constant—the child. There are three guidelines that can promote successful work with families. First, serve children in the context of their own family. Second, define the members in the family, changes in the family and how they affect the child. Finally, identify the

strengths and needs that the family has when facing everyday problems.

Treatment and Paper Work

Once referred to us, each family is assigned to a parent worker. The parent worker is responsible for obtaining complete intake information from families. At the Theiss Center, the intake process involves completing paperwork such as emergency contact forms and consent forms for obtaining medical, psychiatric and educational records. The parent worker assesses the family's social supports and the history of agency involvement. If the child will attend the program, the parent worker provides a copy of the Center guidelines, takes the family on a tour of the agency and introduces the child and family to his or her new developmental therapists.

During the initial contact with the caregiver, the parent worker completes a form with basic information (see below). Two critical pieces of information needed are health insurance and a description of the child's problems. Payment is necessary for services provided. If the child's insurance is not one we can accept, the child will be referred to an appropriate facility. Programs must stay current with the array of insurance/managed care entities in this era of change in health care. The other important piece of information is the family's description of the child's problem behaviors. This

may differ completely from the referring agency’s idea of the problem, and it is important for the psychiatrist to know about these discrepancies in perception.

Each family is assigned to a parent worker when their child begins attending the program. The parent worker is responsible for obtaining complete intake information from families. At the Theiss Center, the intake process involves completing paper work such as emergency contact forms, and consent forms to obtain medical, psychiatric and educational records.

The parent worker assesses the family’s social supports and the history of agency involvement. If the child will attend the program, the parent worker provides a copy of the Center guidelines, takes the family on a tour of the agency, and introduces the child and family to their new developmental therapists.

Below are samples of the Initial Contact Form and the Intake/Family Orientation Checklist.

INITIAL CONTACT FORM	
Referral date Child's name Date of birth	Parent's name Address Telephone Insurance Referred by
Problems	Comments Person taking call

INTAKE/FAMILY ORIENTATION CHECKLIST	
Task	Yes/No
1. Has reason for referral been established?	
2. Has appointment for evaluation been scheduled?	
3. Has basic demographic information been obtained?	
4. Have emergency contacts (including medical) been established?	
5. Has consent to admit been obtained?	
6. Has consent to communicate with other agencies been obtained?	
7. Has family toured the facility?	
8. Have family strengths and needs been assessed?	
9. Has family history of agency involvement been assessed?	
10. Have initial family treatment targets been established?	
11. Has family received printed Center Guidelines?	
12. Has family been oriented to phase in guidelines for the child?	

13. Has family been informed of the Treatment Teams’ role and meeting dates?	
14. Has application for food Program been processed?	
15. Has insurance information been obtained?	
16. Has the family registered the child with the Base Service Unit	

A psychiatrist evaluates all the children referred to the Partial Hospital Program and the Program for At-Risk Kids and determines if a child could benefit from participation. If the psychiatrist recommends that the child be admitted to the program, he/she is either admitted immediately or placed on a waiting list until a space is available.

We are an agency that has taken a significant role in the child's life and we need to keep the avenues of communication open with all other agencies. This eliminates duplication of services and helps to facilitate appropriate programming. Consent for release of information must be signed to communicate with other agencies about the child.

Family members also complete four forms that describe family functioning. Four out of a series of eight forms developed by Carl Dunst are used to give caseworker's information about the family. The scales used include the Family Support, Support Functions, Family Needs, and Family Resource Scales (see information on scales in resources section). Caregivers may not give complete or accurate information on the family's strengths or needs while meeting with the parent worker. They may be skeptical about freely giving information to someone they don't know and may not initially trust. Due to the personal nature of some of the questions, it can be less threatening for caregivers to complete questionnaires at home. Others find it more comfortable to complete the forms after they are in the program for a couple of weeks.

Treatment Team

A treatment team review is scheduled every 20 days. This is a mandatory review in which the child's identified problems, the child's progress with these problems and information about the child's behavior in the home setting are discussed. Parents

usually do not attend the treatment team meeting. The parent worker obtains information about the child's progress in the home and any other family issues (such as changes in family structure) that may be affecting the child. Following this monthly review, the parent worker meets with the family to ask for and provide feedback regarding the child's progress. Parent workers again discuss the child's progress in the home and any other family issues that may be affecting the child's mood and behavior.

What Children and Their Families Need

Parent workers must be able to assess the various family members’ needs for supportive services as they listen. Adult caregivers need to be emotionally and physically healthy to provide the best care to their children.

Many parents whose children are in the program are coping with an array of personal problems and stressors. Some parents are recovering from drug and alcohol addiction, others have mental health problems or are experiencing social stressors such as domestic violence, marital separation, single parenthood. These problems can make caring for children, particularly children with special needs, extremely difficult. As a result, parent workers need to be acutely aware of these family issues both so they can monitor problems and make referrals as needed.

Families under such stress often need the supportive services of an Intensive Case Manager and/or Resource Coordinator. The criteria for involvement of these supports are families with 1) two or more mental health agencies involved in their care, and 2) a significant need for more intensive services for their child. These services can be obtained through the local community mental health agency. All clients should be registered with

their local community mental health agency to receive other services. These services can include respite care, mobile therapy, therapeutic staff support, or other wraparound services. We would also like to note that the County MH/MR system itself can be most helpful. We have particularly drawn upon their expertise in helping our children make the transition to the public schools.

Although some of our clients are within walking distance, most use public transportation. As a center, we do not provide transportation. However, because we are a medical program, the Medical Assistance Transportation Program will reimburse parents bus fare up to \$40.00 a month. The psychiatrist can also write a letter for Medical Assistance cab service. At the Theiss Center, we have a fund for emergency transportation.

Parents sometimes need support services for themselves as well. Part of our intervention is to keep in touch with the parents and monitor their symptoms and behaviors, and to remain in close contact with the parent's treatment providers. When parents are not receiving treatment for their personal problems, we often work with them to accept treatment recommendations and then make a referral to an appropriate facility. Parent workers walk a fine line in their work. Their role is to encourage the family to obtain needed services while at the same time making it clear that the parents are the decision makers. The parents' opinions are considered most important, except for when there is immediate danger to self or others.

When providing services, remember to give parents what they feel they need at that time. Parent workers need to get a sense of how many services can be provided for a successful outcome. Caseworkers sometimes overload parents with too many services, thus setting them up for treatment failure. Be open with parents and seek their input. Ask them if they feel that they can do what you are asking. Work to build a therapeutic alliance and rapport.

Parents who choose to have more involvement in their child's treatment can attend a number of direct services to families. These include weekly parent support groups, a monthly psychoeducational group for parents that deals with a number of topics, and child-centered parent counseling both in home and on site.

Parent Groups

The Theiss Child Development Center currently offers three weekly parent groups to families. These groups are open to parents of children who live in the community as well as parents whose children are enrolled in any one of the Center's programs. The primary goal of the groups is to provide support and education for parents of young children. Parents discuss both problems and rewards of parenthood and receive support and validation from their peers and the group facilitators. Some of the specific issues addressed include behavior management, discipline, safety, self-help skills and educational placement for children. Each group meets for one hour each week. Babysitting services are provided for the parents who attend the group sessions.

We have observed several common concerns and needs that the parents' groups satisfy. One of these important needs is additional social support. Our families are typically coping with many stressors and tend to be socially isolated. The groups enable parents to form supportive relationships with other individuals dealing with similar problems.

One parent support group has a core group of women who have been working together for almost one year. Most members have an extensive history of drug/alcohol abuse and mental health problems. They are overwhelmed by caring for their children and all initially had a very limited support system. Over the past year, the group members have become close and support each other outside of the group. They call each other on the phone, babysit or run errands for each other, take each other shopping, and share baby clothes and toys. One woman gave another a crib when she had her baby.

Another group consists of four men who are the primary caregivers of their children. The mothers were so incapacitated by drug and alcohol or mental health problems that they either abandoned the child, were unable to care for themselves, or unable to care for the child. All the fathers were inexperienced and expressed concern about their parenting abilities. Through weekly participation in the group, the fathers gained confidence in their abilities as parents by supporting and encouraging each other.

Parents in group often raise questions and concerns about appropriate child development. Parents may overestimate how a child should perform in some areas (e.g., toilet training, understanding that hitting hurts another person) and underestimate how a child should perform in other areas (e.g., verbalizing wants and needs). In the groups, we encourage parents to generate developmentally appropriate expectations of young children.

We address child development through discussion, handouts, videotapes, role plays and other activities. Through these means, parents discover that other children the same age as their children exhibit similar behavior. This allows them to distinguish “normal” behavior from what is atypical for children in a certain age group. Parents also learn that they are not the only ones with children who exhibit atypical behavior. Parents can try interventions at home and share their successes and failures. They have the opportunity to share their exhaustion, their joy about successes and their anger and frustration about their shortcomings. They learn to assess when a situation has reached a critical point when they need immediate help.

Individual Child-Centered Parent Counseling

Individual child-centered parent counseling is a second counseling option available on a voluntary basis. Parents may be referred or encouraged to participate in individual sessions for a several

reasons. Some parents do not feel comfortable in a group setting; others may have too many specific concerns to address in a group. Some parents are not available during the scheduled group times. Therefore we provide individual child-centered parent counseling both on site and in home.

The subject of guilt frequently comes up in the individual child-centered parent counseling sessions. The basis for the guilt is different for each parent. Parents whose children were affected by prenatal drug and alcohol exposure, as well as parents whose children have behavioral/psychiatric problems, often feel guilty and blame themselves for their child's difficulties. Parents who are recovering from serious drug and alcohol problems, feel guilt when they recall the times they were heavy users. Parental guilt often derives from the feeling that they were neglectful of their children during periods of substance abuse.

These feelings of guilt can be overwhelming, affecting the parent-child relationship in a number of negative ways. In our experience, feelings of guilt contribute to the parents' feelings of insecurity and inadequacy. Parents sometimes do not want to set firm limits with their children because they "don't want to be mean." They are excessively vulnerable to the pleas of their children. Because of the effect that parental guilt can have on the parent/child relationship, it is critical to address this feeling during the sessions.

We help parents to gain insight and awareness into the ways in which their symptoms and stress affect their child's mood and behavior. We have frequently observed this correlation with the children at the program. We had an infant whose irritability increased directly with the times that her mother was physically abused by the child's father. However, parents often do not realize that their child, especially an infant, can be affected by parental stress.

Working With Child Protective Services

Through intensive work with parents, parent workers may come to suspect child abuse or neglect. As an agency, we are mandated by law to report any suspected abuse. It is important to back up any allegations with proper documentation. Any marks that a child has on his or her body or any statement that the child makes regarding verbal or physical abuse must be noted.

One of our children in foster care came to the center with marks on his face. The developmental therapist asked how he got those marks; he said that his dad hit him for talking bad and then his eight-year-old brother hit him. The psychiatrist examined the marks and said that they were consistent with a slap from an adult hand. These were not the first marks to appear on the child. Our agency has a committee on child abuse whose task is to keep up with the rules, policies and procedures of the child protective services agency. We called a representative from that committee, who suggested calling the local Child Protective Services office to ask if this should be reported. Before calling Child Protective Services, we contacted the foster father. He said that the child was confused. His brother had hit him because he was playing in water. He also said that the child did say bad words and that he set him down and explained that he was not to do that anymore. We told the foster father that we would have to report the incident. We also contacted the foster parent agency to inform them of the situation, and reported the incident. All of this was carefully documented in the progress notes of the child's chart. An official report was submitted to Child Protective Services by our psychiatrist. As Claire Cohen and Chi Amadi mentioned earlier, there are situations in which clinicians and parents work together to contact child protective services.

We think it is important to work with both biological and foster parents if Child Protective Services feels that it would benefit the child. Some children are removed from their parents temporarily and placed in a foster home. We work with both sets of families to facilitate success. There are times when we are called on to go to court to testify

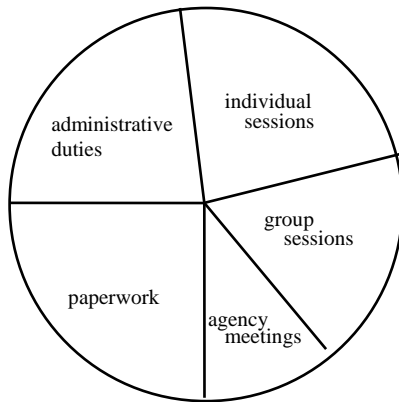
regarding certain issues. Our psychiatrist and the appropriate social worker attend the court session.

Parents and the Center

Through the parent groups and the individual sessions, the parents often form trusting and secure relationships with the parent worker and may disclose deeply personal information. It is important that the parent worker monitor the adult's problems or symptoms and remain in close contact with the parent's treatment providers. When parents are not receiving support for their personal problems, we often work with them to accept treatment recommendations and then facilitate a referral to an appropriate facility. According to our treatment philosophy, parents must be healthy (emotionally and physically) to give their children the best care possible.

Parents need a secure and supportive atmosphere, which nevertheless requires parents to take responsibility for themselves and their children. Parents often become very attached to the program, and when their children are ready to move on, the parents sometimes are not. We have found this to be especially true when the child is going on to kindergarten. Parents wish they could stay with us for another year. We work extensively with these parents on referrals to other agencies or placement in another school program, so that families can move smoothly into necessary continuing intervention.

In summary, the Theiss Partial Hospital Program and Therapeutic Nursery require intensive family and agency participation. As caseworkers, we need to be able to manage time efficiently to work with all aspects of the family/child network, as depicted below. Although there is variation among parent workers and across different times of the year, we think the figure below fairly represents the amount of time that we spend on each of the activities.



The child is the focus of the work and the family is the client. Know what external forces are at work on the child, and keep focused on helping the family achieve its goals. Identify and use family strengths, know the family's limitations and get them involved with only those agencies that can successfully help them. Provide resources for parents, but don't encourage dependency on you or the center. The goals are for the family to be independent, empowered, and able to function without the services of the program. We strive to help parents become advocates for their own children, because if they don't speak for them, who will?

THE THERAPEUTIC NURSERY AND PRESCHOOL

By Bernadette Bennermon, M.Ed.

In this final section of Part 2, we return again to specific services for the children that we serve, focusing on the treatment children receive while in the developmental milieu. We discuss the relationships among the child's assessment and treatment plans and classroom curriculum.

An effective learning environment includes distinct but interrelated components including the physical environment, curriculum, group compositions, staffing, staff and child interaction, equipment and materials. There are general considerations that will apply to these areas, regardless of the age group. For instance, when planning the physical environment, you will want to pay close attention to key factors such as aesthetics, health, safety and functional elements.

There are several resources that can assist in setting up a high quality learning environment. Those resources include *The Infant and Toddler and Early Childhood Rating Scales* and *The National Association for the Education of Young Children's Manual of Developmentally Appropriate Practice in Early Childhood Programs Serving Children From Birth Through Age 8* (both are described in the resources section). Each of these resources provides specific guidelines for establishing and maintaining quality standards. Along with general considerations, there will be specific suggestions for various age groups.

Infant Room

When setting up a learning environment for infants, remember that the most important developmental task for the infant from birth to 18 months is developing a sense of trust. As you structure the environment, ask what will assist in promoting this.

First and foremost, a low staff to child ratio, (maximum 1:4) will assure that nurturing caregivers are readily available to respond to each infant's needs, which is a key factor in the development of trust. It is also essential that the environment provide stability and consistency (i.e., staff and furniture arrangement) that the infant can come to depend on. This is a critical factor that may be absent in the lives of children with mental health issues. Procedures, equipment and materials should be designed to help make a child feel safe and secure. Materials should fit each child's level of emerging abilities, so that the child can build confidence and trust in his or her own abilities to make things happen through active exploration of the learning environment.

Under typical circumstances, the well designed, well equipped learning environment and the supportive adults within that environment will promote healthy growth and development through the natural process of exploration, practice and mastery. However, for the child with mental health issues, developmental delays, etc., it is not enough simply to be placed in a stimulating learning environment. Additional guidance, direction and support are typically required, and must be planned in a systematic manner.

Choosing the appropriate curriculum for an early intervention is an important decision. We recommend an assessment-based program (e.g., the “Partners for Learning” curriculum (Sparling et al, 1991) that helps to identify a child's specific needs and then provide learning experiences to address those needs in an individualized manner. In addition, it is useful to choose a curriculum that includes a parent component. Parents then learn how to enhance their children's early learning experiences, and parents and caregivers can work

together to promote optimal growth and development.

Toddler Room

This stage of development is often referred to as the “Me and Mine” stage. As toddlers become absorbed in various aspects of self awareness, they behave as if the entire world revolves around them. During this period, it is important for the environment to include duplicates of many materials to accommodate the egocentric toddler, who will not only resist the idea of sharing, but may also claim ownership of everything in sight.

As toddlers begin to struggle with the task of gaining independence, while at the same time maintaining a supportive connection to the adult, they will do much testing of their abilities. Safety thus becomes a major issue as both mobility and curiosity increase. The learning environment will need to provide many opportunities for self exploration, safe physical challenges and activities that toddlers can do successfully for themselves. The “Small Wonder” Program (Level 2) is an example of a curriculum that provides a wide variety of activities and learning experiences for toddlers on three different levels: 18 to 24 months, 24 to 30 months, and 30 to 36 months. Curriculum activities focus on 9 different developmental domains, including:

- Balance and Motion Skills
- Body Awareness
- Cognitive Skills
- Finger and Hand Skills
- Language Development
- Listening Skills
- Socialization Skills
- Self Help Skills
- Visual Skills

The intervention package was also developed with parents in mind. It provides information for parents to use to enhance development, assess

developmental progress and promote a closer, more enjoyable parent and child relationship.

Since toddlers have developed a degree of independence and the ability to engage in self management in some areas, it is possible to increase the staff to child ratio from the 1:4 infant ratio to a 1:5 toddler ratio. Again, quality care hinges on the caregivers' ability to provide individual care and attention, which is best achieved through low staff to child ratios.

Preschool Room

As toddlers move in to the preschool years, they develop a sense of competence and their self identity solidifies. Once they have developed a sound sense of self, preschoolers will begin to explore the identities of others. They develop the ability to engage in symbolic thinking, and play takes on a whole new meaning. The environment for the child in this stage of development requires equipment, props and materials for dramatic play. Preschoolers are aware of the importance of learning and will actively seek to acquire new skills and knowledge.

The learning environment should support the child's desire to be independent. This is accomplished in part by arranging the room so that everything has a specific place that is clearly labeled (both picture and word labels), and children can select their own materials and replace them when finished without adult assistance. The environment should allow children to make activity choices from a variety of options. This can be accomplished through the establishment of learning centers built around specific areas of interest, i.e., Art Center, Block Center, Cognitive Center, Discovery Center, Dramatic Play Center and Language Arts Center. There are many good resources, such as the Scholastic Series, “Learning Through Play”, that can assist in arranging, equipping and maintaining learning centers that encourage children's interests, and provide opportunities for children to initiate their own learning experiences. (See Resources.)

The preschool curriculum must have the consistency that children require, but also the flexibility to adapt to the specific needs of the children. The Highscope Curriculum Manual, “Young Children in Action,” provides a framework for establishing a consistent and balanced daily routine, and developing a curriculum that focuses on the “key experiences” essential for optimal learning in the preschool years. (See Resources.)

Along with the general curriculum, the curriculum in an early intervention program must address the unique issues that will arise as a result of the diverse population being served. Many curriculum components will be easily adapted and individualized to address “special needs.” However, problems will be encountered that will not have been considered or included in the original curriculum framework. In the early intervention setting, it will frequently be necessary to address mental health issues. Units developed to address these issues may become permanent components of the curriculum, or may be added temporarily to deal with specific concerns as they arise.

For example, if it is confirmed or suspected that a child is witnessing domestic violence in the home environment, the teacher may develop a unit focusing on fears and how to cope with them. Within a unit on fears or “scary things,” children would be given the opportunity to share their fears, both real and imagined. During this period of sharing, teachers would focus on clarifying misconceptions, giving age-appropriate information and noting if there were specific issues that might need to be further explored or addressed on an individual level. Then through various activities involving stories, puppet play, songs, discussions, etc., children would learn, among other things, that there are frightening things that happen that they cannot control (e.g., thunder and lightning, Mommy and Daddy fighting,) but there are things they can do to make themselves feel better in these frightening situations. Thus, without being singled out, children who witness domestic violence in the home setting learn coping strategies and things they

can actively do to protect themselves and help alleviate the stress. They learn that they can remove themselves from the situation, go to a safe place, such as their bedroom, engage in calming self talk and relaxation techniques, turn on the radio and listen to music, look at a book or get under the covers and cuddle a favorite doll or stuffed animal. A special unit planned for the whole class in this manner will be far more beneficial to the child's mental health and overall development than any pre-packaged lesson on the topic in general.

An emerging curriculum approach is one in which children's problems, concerns, issues and interests drive the curriculum. New components are always unfolding to address ever-changing needs. This is essential to early intervention programming. Developing a curriculum that not only incorporates learning experiences to address developmental needs, but also builds components around children's interests, can result in big rewards. What could be more gratifying to a child than to see his or her very own ideas materialize into fun, meaningful activities for the entire classroom?

Developing a Comprehensive Intervention Plan

The formal assessment, as discussed in the previous section, is the first step in the process of developing a comprehensive intervention plan. Once the assessment is complete, and it is determined that a child meets the criteria for enrollment in the early intervention program, the informal assessment phase begins. The importance of the informal assessment conducted in the classroom setting should never be underestimated. Information obtained through informal assessment often determines the success or failure of the intervention plan.

Target behaviors and concerns are identified during the formal assessment process. It then becomes the responsibility of the classroom teacher to observe the child closely to determine if there are specific patterns to the target behaviors, what the motivating factors appear to be, what response is

typically elicited by the behaviors, and what “pay off” or reward the child appears to be getting for continuing to engage in the target behaviors. There should be very specific observation guidelines in

place so that information can be gathered in a consistent, reliable manner. See the observation guidelines’ sample form below.

PROGRAM NAME	
Child:	Date:
Classroom:	Time:
Target Behavior(s):	Observer:
<p>1. When does the behavior occur?</p> <ul style="list-style-type: none"> • Throughout the day • During specific activities • Only in specific situations • Etc. <p>2. What usually happens before the behavior occurs?</p> <ul style="list-style-type: none"> • Child becomes angry/frustrated • Child is redirected or limits are set • Child is provoked in some way • Etc. <p>3. At whom is the behavior usually directed?</p> <ul style="list-style-type: none"> • Adults • Peers • Children with specific characteristics (e.g., small, passive, male/female) • Etc. <p>4. How does the child carry out the behavior?</p> <ul style="list-style-type: none"> • Are there cues/signals? • Are there patterns? • Are there predictable steps/levels? • Etc. <p>5. What happens when this behavior occurs?</p> <ul style="list-style-type: none"> • How do peers respond? 	

<ul style="list-style-type: none">• How do adults respond?• Are activities disrupted?• Etc. <p>6. How does the child respond to consequences?</p> <ul style="list-style-type: none">• Child cries• Child withdraws• Child becomes aggressive• Etc.	
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These key questions create an observation format that allows the teacher to examine the problem and all the surrounding issues very carefully. Many resources exist that can assist in helping staff to develop their observation skills, and record their observations efficiently.

Resource guides will also provide information about various methods of collecting, recording and compiling information. For instance, you might decide to graph observation data collected on a target behavior—before, during and after intervention—so that you will have an actual "picture" of progress and a visual representation of the effects of intervention. When developing observation guidelines and formats, keep in mind that this information will be vital to both the intervention monitoring and evaluation processes.

Identifying Intervention Targets

Typically, target behaviors, though problematic, are merely symptoms of the real problems. The ultimate goal of observation will be to determine the underlying issues that are causing the target behaviors, so that those underlying issues can be addressed. Often, when underlying issues are successfully identified and addressed, the symptomatic target behaviors will stop by themselves. On the other hand, if underlying issues are not uncovered, target behaviors will continue to occur, possibly escalate, or stop only to resurface or evolve in to new target behaviors.

In situations where problem behaviors are not present, but developmental concerns exist, observation can again be a valuable tool. A formal assessment can determine that developmental delays exist, and influencing factors may be identified as background information is obtained. However, formal assessment alone may not provide enough information to make a clear determination of the factors contributing to developmental lags.

Once the child enters the learning environment, the informal assessment can result in additional information that may be useful in the treatment process. If a child enters the learning environment with developmental delays in specific areas, but then begins to develop quickly, simply through exploration and interaction in the environment, it can often be concluded that deprivation is a major influencing factor. When teachers observe specific abnormalities in a child's emotional state, or reaction to people, sounds, etc. in the environment, they may point to problems that exist in the home setting, or in the relationship between the parent and child. There is no substitute for keen observation skills when planning intervention. These skills are essential to the process of monitoring and evaluating intervention.

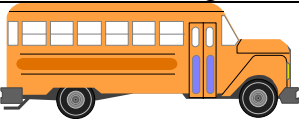


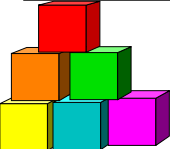
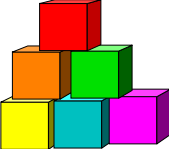


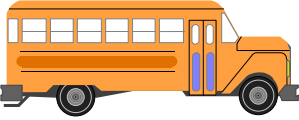
Developing intervention strategies requires that you make use of information from a variety of sources including formal assessment, informal assessment, observation and parent reporting. The

key to effective intervention is individualization. That is, the plan should be tailored to address specific issues, building in parent involvement, and incorporating child and family strengths. Use the child's interests as activators and operate on a level that corresponds with the child's developmental level.

The Treatment Plan

A written record of your intervention program in the form of a treatment plan is essential. The

treatment plan should include target behaviors and/or target areas of development, long term goals and short term objectives. Short term objectives break your long term goals down into smaller steps, and intervention plans to address the target areas should include specific strategies and techniques to be implemented. Two sample treatment plans, one addressing attachment issues and the second addressing compliance training, are presented below.

<p>ATTACHMENT ISSUES TREATMENT PLAN NO 1: Helping Children Separate From Parent When Coming to School Goal: To provide assurance that parent is going to pick child up from school or from school bus Materials: Pictures of coming to school and going home from school - examples below</p>		
<p>Mom putting child on bus</p> 	<p>OR</p>	<p>Mom leaving child at class</p> 
<p>Child on bus</p> 		<p>Child in class</p> 
<p>Child in class</p> 		<p>Mom picking child up from class</p> 
<p>Child on bus</p> 		
<p>Mom getting child off bus</p> 		

Procedures:

Step 1 - Introduce sequence of pictures - place on child’s cubby

Step 2 - Each day go over pictures when child comes to school until child can describe the sequence of pictures to you (do this for approximately 2 weeks) - Emphasize that child’s parent will be there for the child after school

Step 3 - Child goes over pictures to teacher (approximately 1 month)

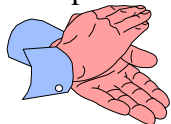
Step 4 - After minimum of 1 month in steps 2 & 3, leave on cubby for child to see and go over by self

COMPLIANCE TRAINING TREATMENT PLAN

Goal: To decrease non-compliance

Specific steps of procedure are outlined below.

1. Whenever _____ is observed engaging in prosocial behaviors (e.g., cooperative interaction with peers/adults), he or she should be reinforced with praise and attention.



2. Whenever _____ fails to comply with staff requests, staff should:

Use additional verbal prompt (e.g., “I have already asked you once to stand up and walk with the group. Please come with me now”).

If the child fails to comply with the additional verbal prompt, say nothing more. Use the physical prompt that completes the first step of the request (e.g., lift the child to his or her feet and gesture him or her to proceed with the group. Make no comments to the child).

If the child fails to comply with the physical prompt, manually guide the child through the completion of your request (e.g., continual physical prompting until the child has rejoined the group). Make no comments to the child. If the child becomes aggressive, has a tantrum or becomes otherwise disruptive in response to the manual guidance procedure, implement a brief time out period (30-60 seconds.) Once the child has met the criterion for release from time-out, require him or her to perform as originally directed. Begin step 2 a second time.

Besides the initial plan, it is helpful to maintain an ongoing record of revisions, extensions, progress and goal and objective achievements. This can be done in the form of daily or weekly progress notes, depending on the intensity of the child’s treatment plan. Both the treatment plan and the progress notes will provide the basis for treatment reviews, which should occur on a regular basis.

The treatment review provides the opportunity for multidisciplinary team members to come

together to develop initial treatment plans, share information regarding children’s progress and determine if consultation with other specialists (e.g., a speech therapist or physical therapist) is needed. The review process is a vehicle for monitoring progress and evaluating intervention effectiveness as well.

The monitoring and evaluation issues are addressed in Part 3 of this document.

References

Brazelton, T.B. (1983). Assessment techniques for enhancing infant development. In J. Call, E. Galenson, & R. Tyson (Eds.), *Frontiers of Infant Psychiatry*. New York: Basic Books.

Greenspan, S.I. (1992). *Infancy And Early Childhood: The Practice of Clinical Assessment and Intervention with Emotional and Developmental Challenges*. Madison, CT: International Universities Press.

May, E. T. (1995). *Barren in the Promised Land: Childless Americans and the Pursuit of Happiness*. New York, NY: Basic Books.

Sparling, J., Lewis, I., Ramey, C. T., Wasik, B. H., Bryant, D. M., and LaVange, L. M. (1991). Partners: A curriculum to help premature, low birthweight infants get off to a good start. *Topics in Early Childhood Special Education*, 11, 36-55.

PART 3

Quality Improvement and Evaluation

by Vaughan Stagg, Ph. D., Susan Burns, Ph. D., and Bernadette Bennermon, M. Ed.

In this part of our monograph we describe how we monitor the implementation of our program, how we identify aspects of the program that need improvement, and how we evaluate the effectiveness of our program.

One of the buzz phrases of the 1990s is Continuous Quality Improvement (CQI). Quality improvement activities are now required by many certification agencies (i.e., JCAHO), and are undoubtedly required by insurance companies or managed care corporations. CQI helps programs improve the services they deliver. Our CQI activities primarily address two different areas. The first is monitoring and evaluating the intervention and the second is evaluating child progress. We are also currently evaluating collaborative efforts among ourselves and other agencies serving families.

Monitoring and Evaluating Intervention

An intervention program, no matter how well developed on paper, must be properly implemented to assure maximum effectiveness. The only way to assure that intervention is occurring as planned is to observe the plan being put into action. Observation should begin very early on in the intervention process, so that any misinterpretations of the plan can be immediately corrected. Once the steps of the plan are being executed properly, ongoing observation should be continued to obtain information about the effectiveness of the plan.

Observation should be conducted by both the person implementing the intervention and someone not involved in direct implementation. This dual monitoring is done for two reasons. First, dual monitoring allows you to do reliability checks to determine if observers are seeing the same things,

and identifying and recording them in the same manner. Information collected must be accurate or it is of no use. Also, observers should be cautioned about interpreting information obtained through observation alone, without significant supporting evidence. Observers should simply record specific behaviors, without making on-the-spot judgments regarding those behaviors.

The second reason to have a dual monitoring system is because the person involved in the implementation of the plan is observing the situation from a position of personal involvement, while an outside observer may see things in a more objective fashion. The outside observer should spend time focusing on adult behaviors in the therapeutic environment, i.e., quality of adult and child interactions, consistency in adult responses to children's behavior, ability of the adult to identify and address the child's needs. All these things can have a positive or negative effect on the intervention program. Their significance should not be overlooked.

Information gathered during observation can be recorded in an informal manner, i.e., daily and weekly narrative summaries, or in a more structured format with specific components or identified target areas being addressed. Structured forms of observation can also assist in the measurement of changes in a child's behavior. The information collected will be vital to the evaluation of both specific intervention plans, and the entire early intervention program as well.

Unlike other processes, where the evaluation phase comes at the end, in an intervention program the evaluation process is ongoing. Regular multi-disciplinary team meetings provide a forum for evaluating the intervention program, reviewing all

data, observation information, assessment results, parent reports, etc. to evaluate the effectiveness of intervention, and determine whether revision is necessary.

The cyclical process of planning, implementing, evaluating, revising and returning to the planning stage keeps the program in a constant state of development as new strategies are created to address new problems encountered. This allows the team to develop a better understanding of the population being served and their unique needs.

Continuous development will mean frequent change. However, becoming an early intervention program in an integrated setting is itself the biggest challenge. Change becomes a constant, and the staff will become well equipped through their experiences to handle change gracefully.

Evaluating Outcomes

Evaluation of outcomes of intervention is important to determining what is effective in any program. Also, third party payers increasingly demand such information. As mentioned earlier, we attempted to build in evaluation from the inception of the program. An integrated program provides a distinct advantage for evaluation, because it has an intact contrast group of typical children to use as a comparison.

As a program, we decided to look at three outcomes for our children. The first outcome is child symptoms. We have chosen a nationally standardized behavior rating scale, the Child Behavior Checklist (see resources). The checklist is administered at intake and at discharge to all children 24 months or older. We also attempt to follow up with the same measure 12+ months post discharge. This tool is considered one of the best of its kind and provides useful comparisons of normal children and children who have been referred to clinics for behavior problems.

The second outcome is child placement. We have located a restrictiveness of placement scale (institutionalization = most restrictive; regular

education = least restrictive) to measure this, providing a real-world indicator of the effectiveness of our interventions.

The third outcome is parental satisfaction. We measure this at discharge and follow-up (12+months). Consumer satisfaction with intervention programs gauges our impact and helps guide program modifications.

We have studied two components of our programs and our findings are summarized below. In the first study, we describe the children and families in our program for children with emotional disturbances and present the effects of their intervention. More detailed information about the first study was previously presented by Burns and Stagg in 1993. In the second study, we examined the developmental outcomes for our infants and toddlers in the therapeutic nursery program. Expanded versions of this study were presented at the National Head Start Research Conference (Burns & Stagg, 1996) and published in *Infants and Young Children* (Burns, Stagg, Saitz, and Amadi, 1996).

Effective Early Intervention for Young Children with Serious Emotional Problems in an Inclusive Setting.

This section describes the children and families in our program for children with emotional disturbances, their course of intervention, and outcomes of the intervention. Early education integrated with mental health treatment constituted the core of the intervention. The program took place in an inclusive setting. That is, children were mainstreamed with typical children upon entry and throughout the program. We had four specific aims when we undertook this study. The details of the program are described in Part 2 of this monograph.

The goals of the first study were to:

- Describe the children served.
- Describe the course of the children's intervention.
- Ascertain whether the intervention was successful.
- Describe any differences between infants, toddlers and preschoolers.

Methods

Participants

Eighty-six children between the ages of six weeks and 64 months were admitted to the program during the first three years of operation. Ten of the children were infants (up to 17 months), 20 were toddlers (18 to 35 months) and 56 were preschoolers (36 to 64 months.) Sixty-seven percent of our children were African-American, 24 percent were Caucasian, and 8 percent were biracial. Seventy percent of the children were males and 30 percent were females. Yearly income ranged from \$3,432 to \$76,000, with a mean yearly income of \$9,195. The vast majority of the children came from poor families.

Measures

We used the Child Behavior Checklist (CBCL). The CBCL is a nationally standardized behavior rating form. The informant is the parent or caretaker. The problem behavior section of the CBCL requires parents to rate statements indicative of problems on a three point scale: 0 = not true, 1 = somewhat or sometimes true, and 2 = very true or often true. The CBCL generates indices of the overall problem behavior with subscales for internalizing problem behavior (overly withdrawn, depressed, shy, etc.) and externalizing problem behavior (overly aggressive, active, non-compliant, etc).

We assessed aspects of the families' social support system with four measures developed and

validated by Dunst and colleagues (Dunst, Trivette, & Deal, 1988, Dunst and Trivette, 1985, 1987). The measures we employed were: 1) The *Family Resource Scale*. This scale is designed to assess the adequacy of a family's different resources. Thirty one items are contained in the scale and they are rated on a five point scale from 1-not at all adequate to 5-almost always adequate. Resources such as food, housing, money, child care, medical care etc. are rated. 2) The *Support Functions Scale*. This scale rates parents' needs for different types of assistance. Items are rated on a 5 point scale (1 = never need this kind of support to 5 = often need this kind of support). 3) The *Family Needs Scale* is designed to measure a family's need for nine categories of needs (financial, shelter/food, child care, transportation, communication, child education, etc.). Each of the 41 items is rated on a five point scale (1 = almost never needed to 5 = almost always a need). 4) The *Family Support Scale* assesses the perception of the helpfulness of sources of support to parents rearing a young child. Items are rated on a five point scale (1= not at all helpful to 5 = extremely helpful).

The Scale to Assess the Restrictiveness of Educational Setting (SARES) (Epstein & Quinn, 1996) was selected as one of our follow-up measures. SARES was designed to provide data to index program outcomes and student progress. This 18-item rating scale was developed by surveying a national panel of experts and a representative group of supervisors (n=200) involved in monitoring children and youth with emotional and behavioral disorders in the State of Illinois. Placements are ranked on a 10-point scale from most restrictive (i.e., correctional facility, psychiatric hospital-based instruction) to least restrictive (i.e., regular classroom, regular classroom with consultation services).

Procedure

We reviewed the medical charts of all children who entered our program since its beginning in January 1990 through December 1992. Data collection continued until December 1993 when the

last child who entered in December 1992 completed the program. Follow-up data have been collected via telephone interviews and mailings from October 1994 until the present. Before collecting data, we assigned each child a number and recorded the collected data by child number. Initial data were obtained by initial review of each child's medical chart. Data retrieval, entry and coding were checked by a second person. CBCL and family support measures were collected upon child entry into the program. Data missing from medical records was obtained from additional records kept by social workers in the center's management information system.

Results

Background Information

Diagnoses. The DSM-III R diagnoses of the children served are displayed in the table that follows. The major diagnosis is listed.

Diagnostic Category	Percent in Category
Reactive Attachment Disorder	10 %
Anxiety Disorder	5 %
Disruptive Behavior Disorder	35 %
Attention Deficit Hyperactivity Disorder	6 %
Adjustment Disorders	41 %
Adjustment Disorder that included Hyperactivity	2 %
Organic Disorders	1 %
Diagnosis Deferred	1 %

The diagnoses were provided following an evaluation by a Child Psychiatrist and validated by Child Behavior Checklists on children 24 months or older. Mean CBCL scores for overall problem behaviors, internalizing behaviors and externalizing behaviors were significantly higher than scores of a national sample of children. The CBCL results indicate that as a group our children fell at or beyond the 90th percentile in terms of problematic behaviors in comparison to children their own age

and gender, which indicate that they are quite troubled children. Fifty percent of our children had V codes indicating serious parent-child problems.

Other conditions. We also collected information regarding other medical conditions. The following table illustrates the percentage of children who had positive histories for the listed conditions. Please note that a single child could have more than one of the conditions.

When Condition Began	Condition	Percent with Condition
Present at Birth	Prematurity	19 %
	Drug and Alcohol Exposure	33 % (with another 9 % highly suspected)
	Sensory Impairment	13 %
Onset after Birth	Failure to Thrive	8 %
	Eating Problems	23 %
	Otitis Media	46 %
	Cognitive Delays	62%

Living circumstances. Seventy percent of the children lived with a biological parent, 17 percent were in a foster living arrangement, 13 percent were living with a relative, and 2 percent were adopted. Sixty-seven percent of the children lived in single parent homes.

Family support. We list resources identified by at least 40 percent of families as **very helpful or adequate**. Family support from professional helpers (45 percent) was the only source of support identified as very helpful.

Families indicated types of assistance **needed** often or quite often as 1) someone to get services for their child (43 percent), 2) someone to depend on (42 percent), 3) someone who accepts their child regardless of how she or he acts (47 percent) and 4) someone to care for their child in emergencies or

when they must go out (51 percent). Specific needs in rank order were:

Need	Percent with Need
Money to save	57 %
Financial [having money to buy necessities and pay bills]	55 %
Having money to buy things for self	54 %
Time to be by self	53 %
Paying for special needs for child	51 %
Time for travel or vacation	51 %
Budgeting money	50 %
Money for travel or vacation	51 %
Information that would let them explore educational options for their child	50 %
Time to be with close friends	47 %
Money for family entertainment	44 %
Emotional support in the form of finding someone to talk to about my child	42 %
Time to get in touch with people they need to talk to	41 %
Time to complete chores, repairs, home improvements	40 %

Description of treatment and outcome

The types of treatment received and relationship between the types of treatment and success of placement were examined. Types of treatments include developmental/behavioral therapy (100 percent), family therapy, child-centered parent counseling (27 percent), physical, occupational, speech therapy (16 percent), and psychopharmacological treatment (14 percent).

Immediate outcome. The average (mean) length of stay of the children served was six and three fourths months (SD = 4.19 months). Their overall attendance was 70 percent of available hours. We generated an index of erratic attendance by calculating the average number of monthly bouts of

non-consecutive absences for each child (M = 2.30).

Successful termination was defined as a planned, orderly transition to a placement site determined by the child's treatment team. Based on information contained in our charts, 58 percent of the children had a successful termination. Parental non-compliance (53 percent) and transportation difficulties (16 percent) accounted for most of reasons for non-successful terminations.

Several treatment factors were associated with successful outcome. There were statistically significant differences between the successful and non-successful terminators in terms of the following factors:

- Children with successful outcomes were in intervention for longer periods of time (8 months vs. 5 months)
- Children with successful outcomes had higher rates of attendance (78 percent vs. 58 percent)
- Children with successful outcomes were more likely to receive ancillary services (speech, occupational or physical therapy) (26 percent vs. 3 percent)

Children with successful treatment were discharged to both special education (42 percent) and typical education or child care day settings (26 percent). Two percent were hospitalized. The rest went home full time (30 percent). Most children who were not successful in the program returned home full time. Children who returned to the Center for further treatment were unsuccessful in their previous stint in our program.

Start-up. As a new program we were interested in our rates of success over time. Our data indicated that we had significantly more successful terminations in Year Two and Year Three of our program, than in our start up year. This suggests that as a program we learned from our experience and got better at serving our families.

Follow-up. We are in the midst of our follow up using the CBCL and the SARES scales. This aspect of program evaluation has proven to be somewhat difficult as many of our families have had frequent moves, telephone changes, and changes in living arrangements. We feel that this information is critical to our ability to assess our long-term impact on children.

Age differences

We analyzed our data to examine age differences in order to better understand our children, families and treatment conditions for varying developmental levels. Our three age groups were infants (up to and including 17 months), toddlers (18 to 35 months), and preschoolers (36 to 64 months).

Area of Difference	Infants	Toddlers	Pre-schoolers
Diagnosis	All cases of reactive attachment disorders	Numerous children identified with adjustment disorders	Almost all of the cases of externalizing behavior
Other Conditions	Most children who were premature or had failure to thrive	Few children with history of prematurity or failure to thrive	Few children with history of prematurity or failure to thrive
Attendance	More absences	Fewer absences	Fewer absences

Length of stay was related to age and successful termination in the following manner.

We found that children in our program enter with significant emotional/behavioral problems and have numerous risk factors that have been documented as hazardous to development. Our indicators are that about 27 percent of our children's families were not able to meet minimum requirements for their children to complete the program successfully, even though intensive social

support services were obtained for the families. We found that the frequency of attendance and the provision of auxiliary services such as physical, occupational, and speech therapy were associated with successful outcome.

A Model Therapeutic Nursery for Substance Exposed Infants and Toddlers.

The Therapeutic Nursery Program targets children between the ages of six weeks and 36 months who have been exposed to alcohol or other drugs in utero. Most of the parents have a comorbid psychiatric disorder. The Therapeutic Nursery program is described in Part 2 of this monograph. An expanded version of the findings outlined below was presented at the National Head Start Research Conference by Burns and Stagg in June of 1996.

Description of Children and Families Served

This chart summarizes the demographic and relevant characteristics of the families and children served. Statistical comparisons of both typical and substance exposed children indicated that no differences existed between the two groups for any variable listed.

Child and Family Characteristics

Birth Weight	Mean = 5.5 lbs
Premature	46 percent
Gender	59 percent female 41 percent male
Ethnic Status	89 percent African American 7 percent European American 4 percent Biracial
Annual Income	Mean = \$8,967
Living Circumstances	65 percent birth mother 15 percent foster care 12 percent birth father

8 percent both parents
 Other Health Concerns 50 percent hospitalized
 62 percent chronic otitis media

- Parental Attendance at Parent Education Services 67 percent consistent, 33 percent erratic
- Other Child Services
 - 75 percent Physical Therapy
 - 25 percent Physical and Speech Therapy

Program Evaluation

We compared substance-exposed and typical children's developmental progress in four domains: cognitive, motor, social and language development. The outcome index we report here is rate of developmental progress. Twenty-seven infants are described in this report. Fifteen have been exposed to illicit substances and alcohol in utero. Both typical and substance-exposed children are receiving early intervention. They enter early intervention from 2 to 18 months of age, depending on space available in the program. The following table highlights important program variables.

Important Program Variables

All Children: Mean Entry Age = 9 months

- Developmentally Appropriate Program with Developmentally Inclusive Services

Therapeutic Nursery Children Only

- Percent of Parents Receiving Drug & Alcohol and Mental Health Treatment = 50 percent

Measures

Child entry level of development is assessed using the *Partners for Learning Assessment Instrument*. This instrument is based on the goals of the intervention protocol. Accompanying the assessment is the *Cumulative Record of Assessment Activities Experiences*. Teachers keep track of activities achieved by each child as they progress through the intervention package. These forms are monitored for accuracy. We use the cumulative record as an index of the children's progress. Percentage of activities mastered for a given time frame for each child was the indicator of progress. Similar rate of progress indices have been used in the field of Early Childhood Special Education to evaluate child progress and program impact (Bagnato & Neisworth, 199 ; Wolery, 199).

Results

We summarize our findings in the table below.

Means and significant differences between typical (T) and substance exposed (SE) children by developmental domain and age:

Age Group	12 Months		18 Months		24 months	
	T	SE	T	SE	T	SE
Developmental Domain						
Cognitive	.74	.56*	.78	.69**	.82	.63**
Social	.84	.62	.92	.90	.80	.71
Motor	1.19	.90**	1.00	.96	.93	.83
Language	.43	.32	.58	.46*	.60	.45*

* p<.05, ** p<.01

Our measurement of children's progress in the curriculum at 12 months indicated that typical and substance-exposed children progressed at different rates. Substance-exposed children progressed more slowly through the curriculum than typical children in cognitive, motor and language domains. Our measurement of children's progress in the curriculum at 18 and 24 months indicated that substance-exposed and typical children progressed at the same rates in the social and motor domains,

but that typical children progressed more rapidly in the cognitive and language domains.

In the table below, we summarize progress at 24 months for three groups of children: typical children, substance- exposed children who entered the program before they were 12 months old, and substance exposed children who entered the program above the age of 12 months.

Means and significant differences between typical (T) children, substance exposed children who entered intervention before they were 12 months old (SE<12), and substance exposed children who entered intervention after they were 12 months old (SE>12) by developmental domain

Developmental Domain	TvsSE<12		TvsSE>12		SE<12vsSE>12	
Cognitive	.82	.70*	.82	.53*	.70	.53*
Social	.80	.79	.80	.57*	.79	.57*
Motor	.93	.91	.93	.70*	.91	.70*
Language	.60	.55	.60	.28*	.55	.28*

* p<.05, ** p<.01

The findings above suggest that children who have been exposed to substances who enter intervention before 12 months of age make more progress than those who enter intervention after 12 months of age. The results indicate that substance-exposed children who enter intervention before 12 months of age are more likely to resemble a non-exposed cohort. These data also indicate that without early intervention, substance exposed children do not make progress.

Summary

In summary, the intervention program appears to change the rate of development of children exposed to substances. This is clear in the areas of social and motor development. Additionally, we feel confident that similar trends will emerge for the language domain as more children are added to our data.

Using Evaluation Data for CQI

In selecting our targets for our own CQI initiative, we were guided in part by our own evaluation data. Our initial evaluation (Burns, Stagg, & Marsh, 1994) indicated that the best predictor for success in our program was attendance more than 70 percent of the time. This factor was far more predictive of success than others such as diagnosis, symptom severity, income, family structure, etc.

As we looked more closely at reasons for erratic attendance or frequent absences, transportation difficulties emerged as one of the primary reasons for poor attendance. We set about as a team to look at ways to improve transportation for our families. While we did not arrive at one solution, we were able to identify at least three options (Medical Assistance-assisted transportation, special arrangements with local school districts, and the use of public transportation coupons). We now work

with the families at intake to arrange for stable transportation. Attendance rates in the subsequent two years have improved, as has our success rate. Our ultimate goal is to have our own vehicle and driver, but for the time being, our children's attendance has improved.

References

Burns, M. S., Stagg, V., Saitz, C., & Amadi, N. (1996). Intervention for infants and toddlers exposed to methadone *in utero*: Three case studies. *Infants & Young Children, 9*, 75-88.

Burns, M.S. & Stagg, V. (1996). Mental health services in developmental intervention for infants and families affected by alcohol and other drugs. Head Start National Research Conference.

Burns, M. S., Stagg, V., and Marsh, J. (1993). Effective early intervention for children with serious emotional problems. American Psychological Association.

Dunst, C. J.; Trivette, C. M., and Deal, (1988). Family Resources, Personal Well-Being, and Early

Intervention. *Journal of Special Education, 22*, 108-116.

Dunst, C. J.; and Trivette, C. M., (1985). A Guide to Measures of Social Support and Family Behaviors. Monograph Number 1. North Carolina Univ., Chapel Hill. Technical Assistance Development System.

Dunst, C. J., Trivette, C. M., (1987). Enabling and Empowering Families: Conceptual and Intervention Issues. *School Psychology Review, 16*, 443-456.

Epstein, M. H. and Quinn,-Kevin-P. (1996). A Case Study Approach to Analyzing the Relationship between Children and Services in a System of Care. *Journal-of-Emotional-and-Behavioral-Disorders; 4*, 21-29.

Bagnato & Neisworth, 199 ; Wolery, 199 references are missing

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RESOURCES

Achenbach, T. M. (1979). The Child Behavior Profile: An empirically based system for assessing children's behavioral problems and competencies. *International Journal of Mental Health*, 7, 24-42.

Achenbach, T. M., Edelbrock, C. S., & Howell, C. T. (1987). Empirically based assessment of the behavior/emotional problems of 2- and 3-year-old children. *Journal of Abnormal Child Psychology*, 15, 629-650.

The Child Behavior Profile/Checklist rating scale is considered one of the best of its kind currently available. There is a version for children between the ages of 2 and 4 years and one for children 4 years and older. It provides national comparisons by age and gender. It also provides comparisons to clinic referred children. Another advantage is that a computerized scoring system is available for PC's.

Bailey, R. & Burton, E. (1989). *The Dynamic Infant: Activities to Enhance Infant and Toddler Development*. St. Paul, MN: Toys & Things Press.

The Black Community Crusade for Children (1993). *Progress and Peril: Black Children in America*. Washington, DC: Children's Defense Fund

Boyd-Franklin, N. (1989). *Black Families in Therapy: A Multisystems Approach*. New York, NY: Guilford press.

Brazelton, T. B. (1973). *Neonatal Behavioral Assessment Scale*. Philadelphia: J. B. Lippincott.

Borland International (1990). Paradox 3.5. Scotts Valley, CA: Borland International.

This relational database is widely used and quite flexible. The manual will outline capabilities for you. You may find it helpful in setting up a Management Information system for your program. The cost is reasonable and it can be installed on your PC.

Bredenkamp, S. and Copple, C. (Ed.). (1997). *Developmentally appropriate practice in early childhood programs*. Washington, DC: National Association for the Education of Young Children

Bricker, D., Squires, J. and Mounts, L. (1995). Ages and Stages Questionnaires. Baltimore, MD: Paul Brooks.

This parent completed developmental questionnaire offers a low cost strategy for identifying young children with developmental delays. The instrument possesses adequate technical characteristics and is user friendly. It covers the preschool age 0 through 4 years.

Castle, K. (1983). The Infant & Toddler Handbook: Invitations for Optimum Early Development. Atlanta, GA: Humanics Limited.

This is a very practical guide for those who care for infants and toddlers in home or group settings. In addition to activities that facilitate development in a variety of domains, this handbook contains hints for arranging the environment (indoor and outdoor), safety tips, and suggestions for handling basic care routines. Included in the handbook is a list of resources and materials that are useful for any program (i.e., books, records, publication material, magazines, etc.).

Derman-Sparks, L & A. B. C. Task Force (1989). Anti-Bias Curriculum Tools for Empowering Young Children. Washington, DC: National Association for the Education of Young Children.

Gibbs, J. T., Huang, L. M., and Associated. (1989). Children of Color: Psychological Interventions with Minority Youth. San Francisco, Calif: Jossey-Bass Publishers.

Greenspan, S. I. (1992). Infancy and Early Childhood: The Practice of Clinical Assessment and Intervention with Emotional and Developmental Delays. Conn: International Universities Press, Inc.

Harms, T., Cryer, D. & Clifford, R. (1990). Infant/Toddler Environment Rating Scale. New York, NY: Teachers College Press.

This 35 item rating Scale is one of the more widely used of its kind. Designed especially for use in infant/toddler programs, the scale is designed to give one an overall picture of the quality of group care.

Harms, T. & Clifford, R. (1980). Early Childhood Environment Rating Scale. New York, NY: Teachers College Press.

This 37-item rating scale is designed for ages up through preschool. It provides one with an overall picture of the surroundings that have been created for children and adults that share an early childhood setting.

Hohmann, M. Banet, B. & Weikert, D. (1979). Young Children in Action. Ypsilanti, MI: High Scope Press.

Jones, E. & Nimmo, J. (1994). Emergent Curriculum, Washington, DC: National Association for the Education of Young Children.

Karnes, M. (1982). You and Your Small Wonder. Circle Pines, MN: American Guidance Service.

Sparling, J., Lewis, I., Ramey, C. T., Wasik, B. H., Bryant, D. M., & LaVange, L. M. (1991). Partners: A curriculum to help premature, low birthweight infants get off to a good start. *Topics in Early Childhood Special Education*, 11, 36-55.

The "partners in learning" curriculum is a well validated and widely used early intervention curriculum covering the first 2 years of life. It has the advantage of an assessment system, tracking system, curricular activities, and materials all in one package. Our professional and paraprofessional staff have found it to be useful.

Scholastic Series: Learning Through Play: Practical Guides for Teaching Young Children. New York, NY: Scholastic Inc., Early Childhood Division.

Art, Blocks, Cooking, Dramatic Play, Language, Math, Music & Movement, Problem-Solving, Sand, Water, Clay, Wood, Science

Villarreal, S F., McKinney, L., & Quackenbush, M. (1 991), Handle with Care: Helping-Children Prenatally Exposed to Drugs and Alcohol. Santa Cruz, CA: ETR Assoc.

A helpful book in understanding and working with families affected by substance abuse. Includes information on characteristics of families and children, assessment, learning styles and teaching strategies, and working with families.

Wolery, M. & Wilbers, J (1994). Including Children with Special Needs in Early Childhood Programs. Washington, DC: National Association for the Education of Young Children.