DOCUMENT RESUME

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ABSTRACT

Reported are services provided to developmentally or behaviorally disturbed children (0-to-3-years-old) and their parents by the Infant Development Center (IDC) in Mission, Kansas. Outlined is information such as the IDC's primary activities (infant developmental stimulation and parental training and support), secondary activities (such as information exchange), organization (staff and facilities), process flow, research activities, and organizational and fiscal history. The second half of the document consists of sample pre- and posttest scores to indicate developmental progress of 19 children and brief descriptions of services provided to 11 children. (LS)

The Infant Development Center

This report was prepared pursuant to a grant from the Divrsion of Developmental Disabilities United States Department of Health, Education and Welfare. Grantees undertaking such projects under government spohsorship are encouraged to express freely their judgment in professional and technical matters. Points of view or opinions do not therefore necessarily represent official DDD, RSA or SRS position or policy. This project is supported in part by SRS Grant No. 56-P- 35180/7-01 for Social and Rehabilitation Services, Developmental Disabilities Administration, William M. Ferguson, Regional DD Consultant.

THE INFANT DEVELOPMENT CENTER

This report describes an infant center. It does not pretend to describe the decisions necessary for the development of each child and their parents.

Jack Birr

IDC - 1

I. Service Name: Infant Development Center (IDC)

II. Items: Infant Stimulation, Parental Training, Parental Emotional Support, Occupational/Physical Therapy, Follow Along, Placement

III. Primary Participant(s)
a. Children 0-3
b. Family of Children

IV. Primary Activity(s)
a. Infant Developmental Stimulation
b. Parental Training and support

V. Secondary Activity(s)
a. Information Exchange
1. library functions (in organization)
1.1 Toy
1.2 Literature
2. meetings (in/outside communities)
3. workshops (outside communities)
b. Baby-sitting Cooperative
c. Follow Along
d. Transportation
e. Service Placement
f. Research
g. Outreach

VI. Admittance Limits.
a. Chronological: 0-3 years of age
b. Biological: no limits, full range
c. Behavior: no limit, all behavior problems admitted
d. Finance: 1. no fee to participants
2. Donations accepted
e. Geographical: open to Kansas

EDC 2

Organization

Staff		% of Time on IDC
	Speech Pathologist (Director)	100%
	Occupational Therapist	100%
	Registered Nurse	50%
	Teacher (1) [Early Childhood Education]	100%
	Teacher (2) [Early Childhood Education]	50%
	Social Worker	25%
	Administrative Assistant (Secretary)	100%
Support Staff	Pediatrician [Consultant]	
	Physical Therapist [Consultant]	
	Volunteers	

Location: 5408 West 58th Terrace
Mission, Kansas 66202

Building: Contemporary, Brick, One floor, 7 Rms., approximate area 1000 sq. ft.

Room Utilization:		% of Area
	MU; Conference, testing, Director office	10%
	MU; Educational room	10%
	MU; Therapy workroom	25%
	MU, Library, Entrance, evaluation room	25%
	Secretary's office	7%
	Kitchen	12%
	Bathroom	7%
	Hallway	4%

(MU means multiple use)

IPC - 3

Financial Resources Utilized

A. Title I, Public Law 89-313, Elementary and Secondary Education Act

B. Public Law 91-517, Developmental Disabilities Assistance Act

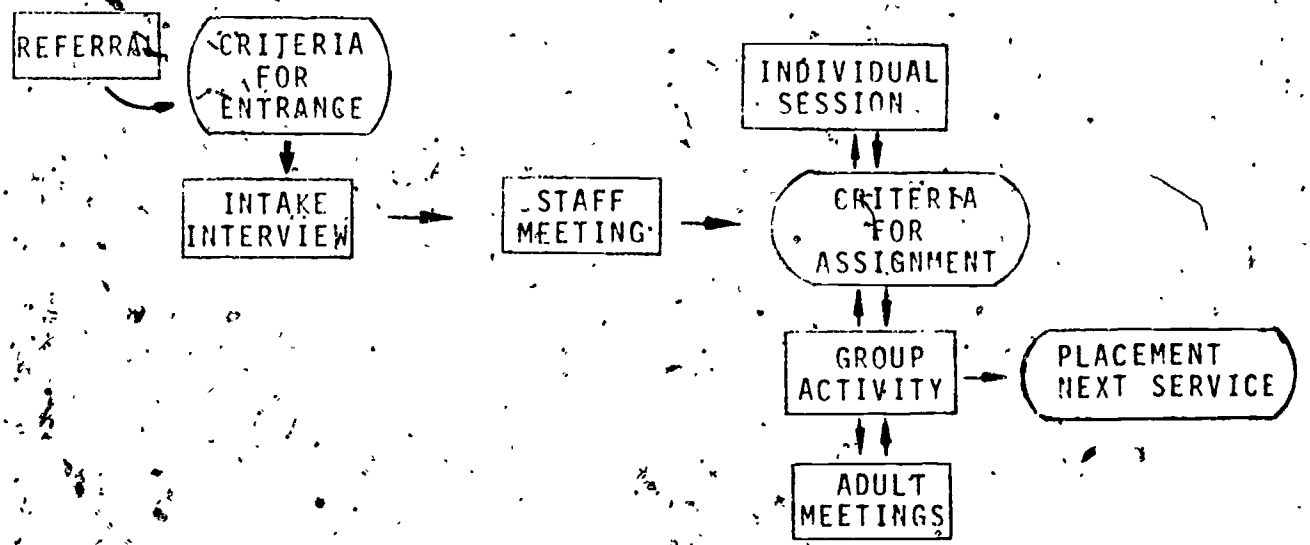
C. Johnson County purchase of service agreement and Revenue Sharing

D. Donations

Administering Agency United Cerebral Palsy
3914 Washington
Kansas City, Missouri 64111

IDC

Process Flow



Referral Services:
a. University Affiliated Facility at Kansas University Medical Center
b. Local Pediatricians
c. Pediatric Neurologists
d. Parents who have been served or are in the program now
e. Welfare Department
f. Social Workers
g. Newspaper Articles
h. no service referral necessary

Criteria for entrance: child of 0-3 years of age with parents who have decided that the child is developmentally or behaviorably disturbed

Intake Interview: (conducted by staff)
a. Release of information form signed
b. Record transferred from referral
c. Case history filled out by mother
d. Document parent's primary concern

to be used for basis of beginning treatment
e.1. Take photographic record of child
2. Get clearance signed for use of pictures
f. Setting of Developmental goals for child

Staff Meeting: Staff meets for assigning parents and child to individual sessions and group sessions. Parent is seen as primary programmer of childs development

Assignment Criteria:
Individual: The child and parent goes to specific professional for preliminary intensive instruction
Group: Parents and child are matched with existing groups in relation to developmental problems of child, and in keeping with the amount of parents knowledge and emotional level of involvement

Control: Developmental tests are given on periodic basis, among those used;
(Denver) Denver Developmental Screening Test
(Bayley) Bayley Scales of Infant Developmental
(Par) Preschool Attainment Record
(Reel) Receptive-Expressive Emergent Language Scale
(Vineland) Vineland Social Maturity Scale
(Mecham) Mecham test of Listening Accuracy
(Portage) Portage Guide to Early Education

Group Spinoff: Parent's group for interaction between parents without children present

IDC: 4.3

Process Goal: The child by five years of age will have normal development

Termination Criteria: Treatment limited by chronological age

Placement: Each child is placed in the next service indicated by the childs development i.e. Crippled Children's Nursery School, Head Start, and pre-schools

Control: Each child is continued until placement is assured in other service

The following text, for the most part, has been excerpted from "1974 Evaluation of the Infant Development Center" by Lee Ann Britain, Director of I.D.C. The following will give depth to the preceding outline of service.

"The ultimate prognosis for any handicapped child is as much dependent on the functional effectiveness of the family in dealing with the problems such a child creates as in the child's own capabilities. Direct involvement of the family as therapists in a specific program developed by the professionals for their child is in itself an effective way of mobilizing the family's energies towards constructive efforts."

Paul H. Pearson in Physical Therapy Services in the Developmental Disability

IDC:1

(The primary activities of the Infant Development Center are centered around the child and parent).

The objectives of the Infant Development Center continue to be to provide a program of comprehensive service including:

Emotional support to the parents, and specific instructional techniques of developmental education for both families and children.

(Within the service, there are supplementary activities to aid the primary participants. Along with the instruction to the child and parent there is extensive information exchange).

A library of current books and materials is maintained for use by the parents and an equipment pool of adaptive equipment is available.

Throughout the child's involvement in the Infant Program we strive to make the family aware of community services such as, public schools' special education programs, lectures and seminars, parent groups related o their child's exceptionality, Kansas Cripp[illegible] Children's Commission, genetic counseling

In addition to serving children and their families, another objective is to share our expertise with other agencies and communities interested in serving the very young child. The center director is available for presentations to groups, workshops etc., and the center is open to visitors. Philosophy, test and intake forms, equipment sources and specifications etc., are shared with interested individuals and groups upon request. Motivating interest in the concept of early intervention and aiding potential new centers across the state and country is an important function of our local program.

(There are Friday morning meetings with mothers and weekly evening meeting with the parents without the children present).

At the parents' request, a Friday morning Parent Discussion Group was initiated. This has been rather informal but structured to some degree by the program director serving as group leader. Feelings and concerns have been freely expressed [in these sessions] allowing staff to gain much insight into families actions and reactions. These group sessions have served much as a catalyst to circumvent crisis, correct misinformation, alleviate feelings of guilt and isolation, and to motivate program change.

A Babysitting Coop has been formed by the mothers. For the most part, homes are used but the center is available for this purpose each Thursday.

(Follow along).

A minimum of one home visit by the staff nurse is a routine service for each family at some point during their involvement in the program. Her goal is to offer parental support, determine possible problems, assess the child's developmental level [as he often functions at a higher level in the home than in strange surroundings] and to explore her area of expertise such as nutrition, hygiene, medication etc.

Car pools are arranged for families without transportation and families who live close to one another are often scheduled together to promote new friendships.

(Service placement and follow along - The I.D.C. assures that the child will be placed in the next appropriate service, i.e., preschool, Head Start, Crippled Children's School etc.).

(Research - The I.D.C. is currently involved with three research activities:

A. Study of parent attitudes, the target population will be mothers attending the I.D.C. and will compare attitudes between mothers in the Friday morning meetings and those not attending the group.

B. A second project will show pre and post test scores in thirty children consisting of ten Down's Syndrome, ten Cerebral Palsied, and ten delayed development children [mentally retarded but not physiologically limited] with thirty children with the same problems without formal intervention program such as the I.D.C. The study will allow an evaluation of such an early intervention program.

C. The I.D.C. is also a member of the National Collaborative Project on Comprehensive Service to Infants and Their Families. This national project is sponsored by United Cerebral Palsy of New York and is funded through the Bureau for the Education of the Handicapped. There are twenty such projects throughout the 50 states designated as "Ripple" Centers. Their projects are involved in research involving extensive collection and compilation).

Computer printouts to date have revealed that of the twenty infant programs, the Kansas program serves:

1) The youngest child [referred at early age by M.D.'s in Kansas]
2) The largest percent of intact families
3) The greatest number of children and families served

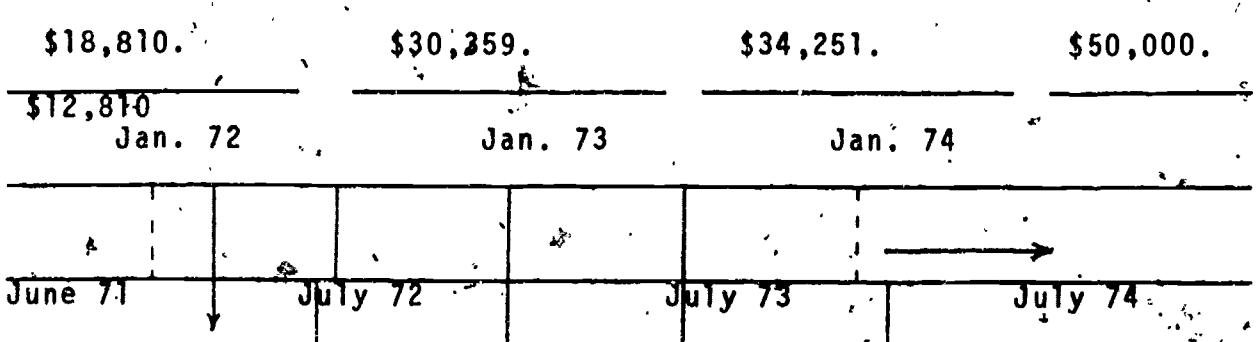
(Admittance Limits - The I.D.C. has only one limit to the admittance of a child and that is the age of the child. The following are examples showing the range of children served).

Case No.	Description	Estimate Potential	Age
008	Down's Syndrome, cardiac defect	trainable	3
010	Down's Syndrome	trainable	3
007	bilateral cleft lip & palate, visual prob.	normal	3
023	Premature, visually impaired	educable	2
029	Down's Syndrome	trainable	2
036	severe C.P., hydrocephalic	res. placement	2
018	severe C.P., hydrocephalic	res. placement	2
034	Down's Syndrome	trainable	2
038	severe C.P.	res. placement	deceased
041	cerebral hypotonia	trainable	3
052	cleft lip & palate, mild O.H.	educable	2
053	battered child	L.D. class	3
064	severe C.P., sensory deprived	sub-tainable	2
066	cerebral palsy, mild	educable	2
067	chromosome abnormality	educable	2
071	microcephalic, cataracts	trainable	2
072	severe C.P.	sub-trainable	2
073	Meningomylocele, hydrocephalic	educable, O.H.	2
077	Down's Syndrome	educable	3
083	post encephalitis	trainable	3
084	post meningitis	educable	2
086	Prader Willies syndrome	trainable	2
087	delayed speech, hyper- -ive	educable	3
092	enviromental deprivation, neglect	regular class	1
105	severe C.P.	sub-trainable	1
106	hydrocephalic	educable	2
108	microcephalic, C.P.	educable	2
109	mild C.P.	regular or L.D.	3
112	Meningomylocele, hydrocephalic	educable, O.H.	2
113	cerebral palsy	educable, O.H.	3
114	premature, developmental delay	L.D. class	2
166	Down's Syndrome	trainable	1
167	Microcephalic, hard of hearing	educable	6 months
168	cerebral palsy, M.R.	educable	2
169	delayed speech	normal	2
170	M.R., moderate to severe	trainable	8 months
171	premature	L.D.	7 months
001	seizures, behavior	L.D.	3
172	pos-meningitis, blind, over-all delay	educable	2
173	severe brain damage	profound	3
174	mild C.P., behavior problem	L.D.	2
175	premature, blind	educable, high	5 months
176	mild, C.P.	educable, high	1
177	mild orthopedic problem	normal	8 months
180	environmental deprivation	normal	1
181	cerebral palsy	educable	2

Case No.	Description	Estimated Potential	Age
182	premature, mild delay	L.D.	1
183	C.P., abuse, developmental delay	L.D.	1
184	delayed speech, mild C.P.	L.D.	3
186	gross motor delay	normal	1
187	mild over-all delay	L.D.	1
188	Hurler's Disease	educable	2
189	Down's Syndrome, cardiac defect	trainable	1
185	Down's Syndrome	trainable	1
190	mild C.P.	L.D.	1
191	post-meningitis	normal	2
192	M.R., behavior problem	trainable	3
193	M.R.	educable	2
194	gross motor delay	normal	9 months
195	meningomylocele	educable	2
196	M.R.	trainable	2
197	diagnosis deferred	normal	2
198	C.P. and M.R.	trainable	1
116	cerebral palsy	educable	2
118	cerebral palsy	trainable	2
120	battered child,blind	educable, O.H.	2
121	cerebral palsy, seizures	educable, O.H.	2
124	Down's Syndrome	trainable	2
128	Down's Syndrome	educable	2
129	left hemiplegia, mild	regular or L.D.	2
133	epileptic	regular or class	1
134	delayed speech, mild O.H.	L.D. class	3
135	hypoglycemia, mod. delay	E.M.R.	deceased
136	cerebral palsy, percep-motor defect	L.D. class	3
137	strokes at 8 mo's, mild gross motor delay	L.D. class	2
138	Meningomylocele, hydrocephalic	E.M.R., O.H.	2
140	over-all developmental delay, mod.	E.M.R.	2
141	delayed speech	normal	3
143	brain damage	profound	1
146	delayed speech	educable, high	3
149	hydrocephalic	trainable	2
151	Cornelia de Lange Syndrome	trainable, low	1
152	seizure disorder, blind	trainable	5 months
155	spastic quad.	trainable, low	8 months
156	brain stem only, deaf-blind	profound	6 months
157	athetoid, C.P. severe	educable	2
158	Hirshsprung's Disease	trainable	3
159	cerebral palsy, blind	severe	2
160	Down's Syndrome	trainable	3
161	Cystic Fibrosis	normal	1
162	behavior problem	L.D. class	2
163	delayed speech	normal	3
164	delayed speech	L.D. class	3
165	Epileptic	educable	10 months
199	Diagnosis deferred	educable	1
200	deaf	normal	6 months
201	behavior problem	normal	2
202	cerebral palsy	trainable	4 months
203	M.R.	educable	3

IDC: 2

ORGANIZATIONAL HISTORY



Start program: FEB'72
Location: SCHOOL
Time:
ONE DAY A WEEK
Staff: (1) SPEECH PATH.
(2) R.N.
(3) O.T.
(4) TEACHER
(5) SECRE-TARY

Continuing program: JUNE'72
Location: MOVED TO CHURCH NEAR SCHOOL
Operating time: ONE DAY A WEEK
Staff: added PT

Continuing program: SEPT.'72
Location: CHURCH
Operating time: EXPAND-ED TO TWO DAYS A WEEK
Staff: SAME

Continuing program: JULY'73
Location: MOVED FROM CHURCH TO RENTED HOUSE
Operating time: EX-PANDED TO FOUR DAYS
Staff: SAME

Continuing program: SEPT.'73
Location: HOUSE
Operating time: FOUR DAYS A WEEK
Staff, added;
PEDIATRIC CONSULTANT
TEACHER 50%
SOCIAL WORKER 25%
Staff, departed: PT

The Center is open from 9:00 a.m. to 3:00 p.m. each week day except Thursday.

Monday	9:30 to 11:00	Mothers' Group
	11:00 to 12:00	New Children
	12:00 to 2:00	Staffing
	2:00 to 3:00	Children
Tuesday, Wednesday and Friday	9:30 to 3:00	Children
Thursday	Babysitting Coop	

IDC: 3

FISCAL HISTORY

Fy'72	Original grant	$18,810
	Late start - expenditures	12,810
		$ 6,000
Fy'73	From Fy'72	$ 6,000
	Grant, Title I	18,810
	Additional monies from State of Kansas	3,000
	Additional monies from Title I	2,549
		$30,359
Fy'74	Grant, Title I	$18,810
	Additional monies from Title I	5,441
	Additional monies from State of Kansas	10,000
		$34,251
Fy'75	Grant, Title I	$24,000
	Additional State of Kansas Funds	7,000
	DD Funds	12,000
	Revenue Sharing	7,000
		$50,000

REPRESENTIVE BUDGET

Fy'74	$34,251.00
Salaries (including consultants)	24,000.00
Equipment	
Educational	1,058.00
Office	100.00
Transportation	65.00
Plant operation, utilities etc.	978.00
Rent and matching	3,540.00
Maintenance	40.00
Total	$32,394.00

$1,857------- Fy'75

* somewhat high due to move to unfurnished rented house

PROCESS

IDC: 4.

(Referrals for the most part, come from sources within the community i.e., doctors, pediatricians, hospitals, etc. However, this is not a prerequisite for admission).

However, familes need not have a formal referral but may merely telephone the center for information and/or an appointment. Initial contact may be either a home visit by the staff nurse or an intake interview and assessment in the center.

(Intake interview)

The intake interview is conducted by the director and staff at initial contact in the center. The parent (or parent surrogate or entire family) is given a tour of the facility and an explanation of the program. The I.D. sheet, screening form and release forms are completed and the parent is given the case history form to be completed at home and returned the following week.

The parent is questioned, at intake, as to the primary concern and this expressed concern will form the basis for the child's program. We believe that the parents know their children better than any one else does so we do not dictate the program but, rather, encourage the parent to be an active participant in goal-setting. For example, if a mother is concerned about her child's inability to chew solid foods or sleep through the night, it would be foolish for staff to ignore this and work, perhaps, on pulling to stand.

A snapshot is taken of each child at intake and repeated at approximately three month intervals. These photos become a permanent part of the child's file and aid in recording his progress. Duplicates are often made and given to the familes. Pictures are not used for publicity without a release signed by the parent.

A release of information form is also signed at intake so that the child's physician may be informed that his patient has enterec the Infant Program. He is asked to share pertinent information and recommendations with us. A report is then returned to him at termination regarding the child's progress while in the program. This serves a two-fold purpose of total communication and insurance of comprehensive service to the child and his family.

An appointment for the following week will be arranged and the child will be discussed in staffing that same afternoon.

(Staff Meetings - At staff meetings a number of decisions will be made regarding the child and parent based on the intake interview. If the child needs individual attention, then it will be scheduled. During the intake interview, "The parents' feelings and understanding of the problem are explored to give us a clue as to degree of realism, acceptance etc. Expectations and long and short term goals are also discussed." This will form the rationale for placement in a group of similar children and parents).

Generally, a new child is worked with on a one-to-one basis for several sessions.

Children who are working toward similar developmental goals and mothers who seem compatible are often scheduled in small groups of three, four, and five.

This eases staff load, provides stimulation for the children, and promotes new friendships and incidental counseling for the parents.

Emphasis is placed on the instructional categories of: cognitive, personal-social, fine-motor adaptive, language and gross motor skills with progress being currently recorded.

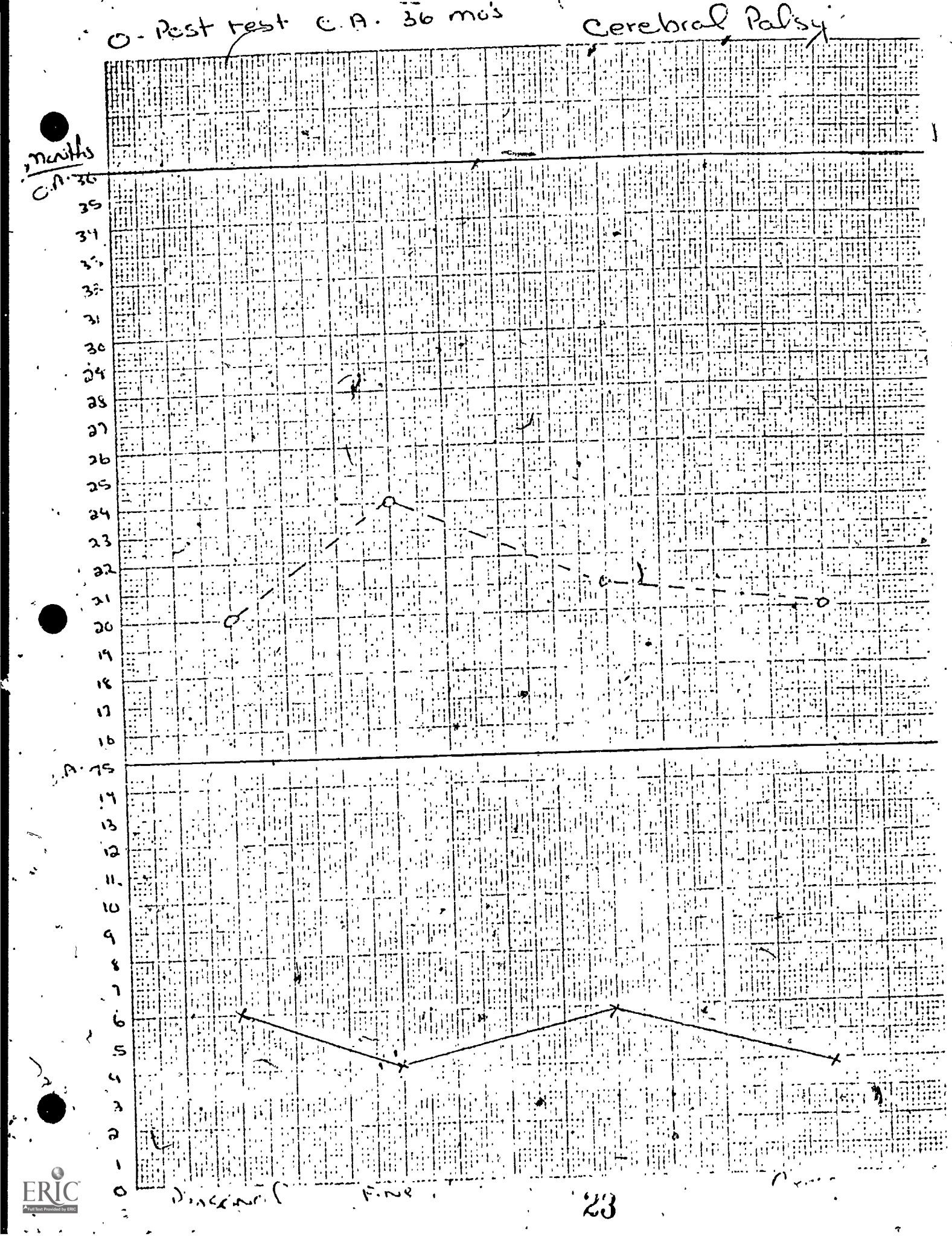
(As a developmental program, the results of this program are measurable. The child's development is subjected to a number of tests and the data collected is also used to improve the project and to be used by others who are involved with Infant Development).

Documentation is beneficial in an effort to prove the validity of a rationale for a program for 0 to 3 year olds with delayed development. Data is collected to reflect progress. Individual lesson plans are formulated and updated for the benfit of the child, parent and staff. A further objective involves compilation of clear and concise curriculum and other materials for dissemination outside of the I.D.C.

(at about the age of 2 1/2 the I.D.C. initiates the search for furture placement).

Prior to the child's third birthday, we explore future program possibilities with the family. Once the appropriate program is selected, the I.D.C. shares all information and maintains contact until the child enters the next situation. Follow-up is, of course, an integral part of the Infant Development Center.

The following are some examples of pre and post test scores to indicate developmental progress.


O - Post test C.A. 36 mo's
Cerebral Palsy
months
C.A. 36
35
34
33
32
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C.A. 75
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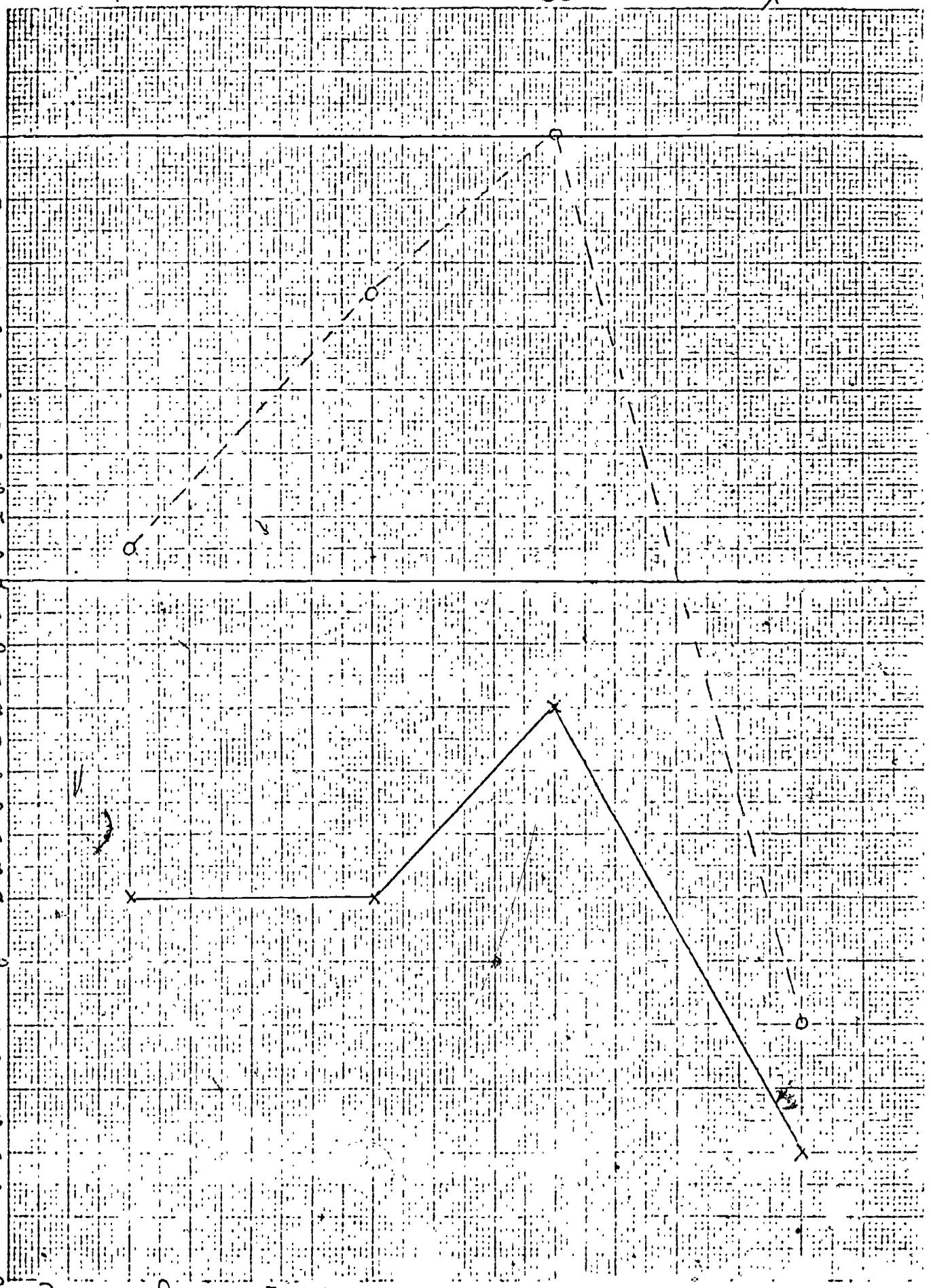
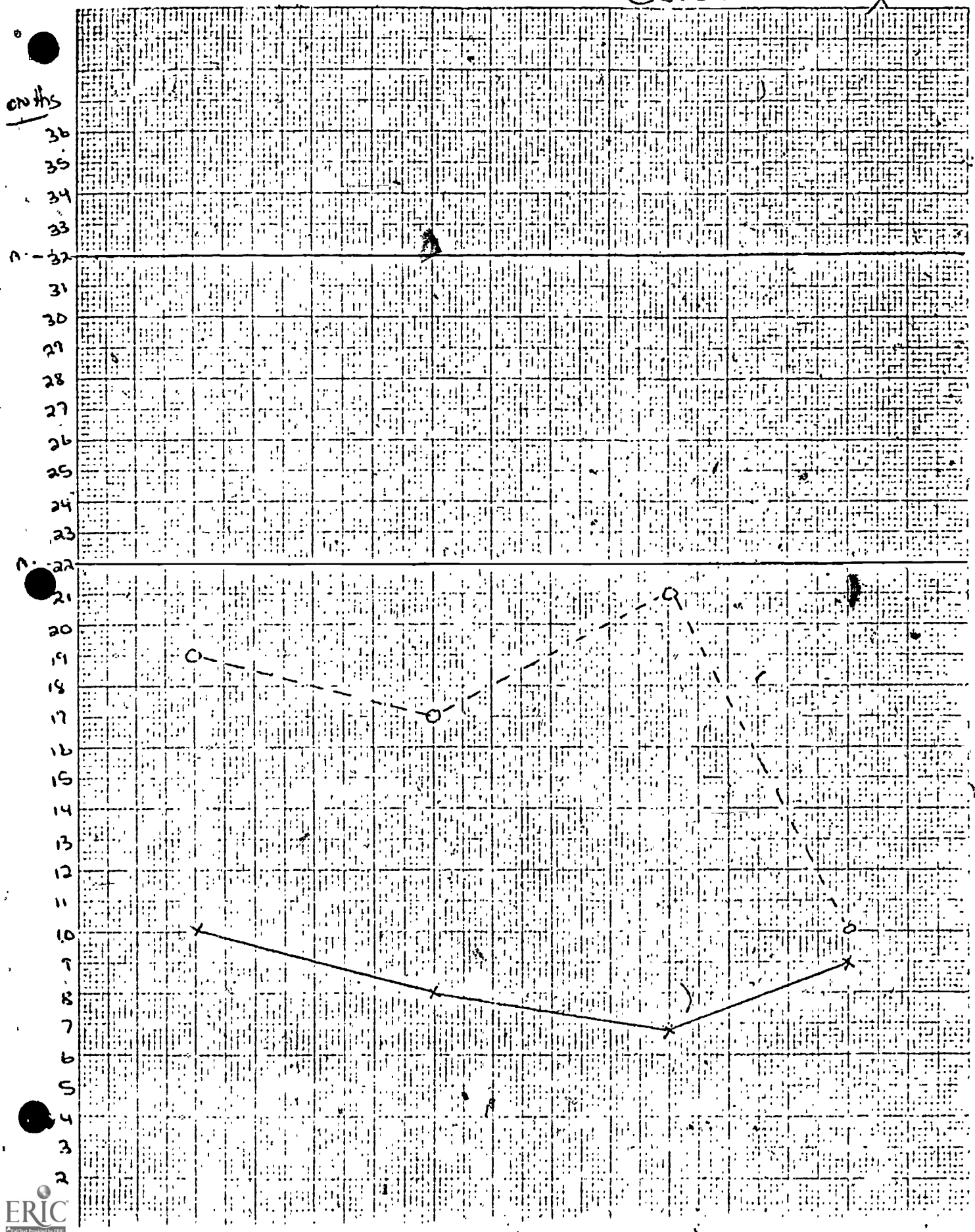
X Pre-Test - C.A. - 22 mos
O Post Test - C.A. - 36 mo's

Cerebral Palsy



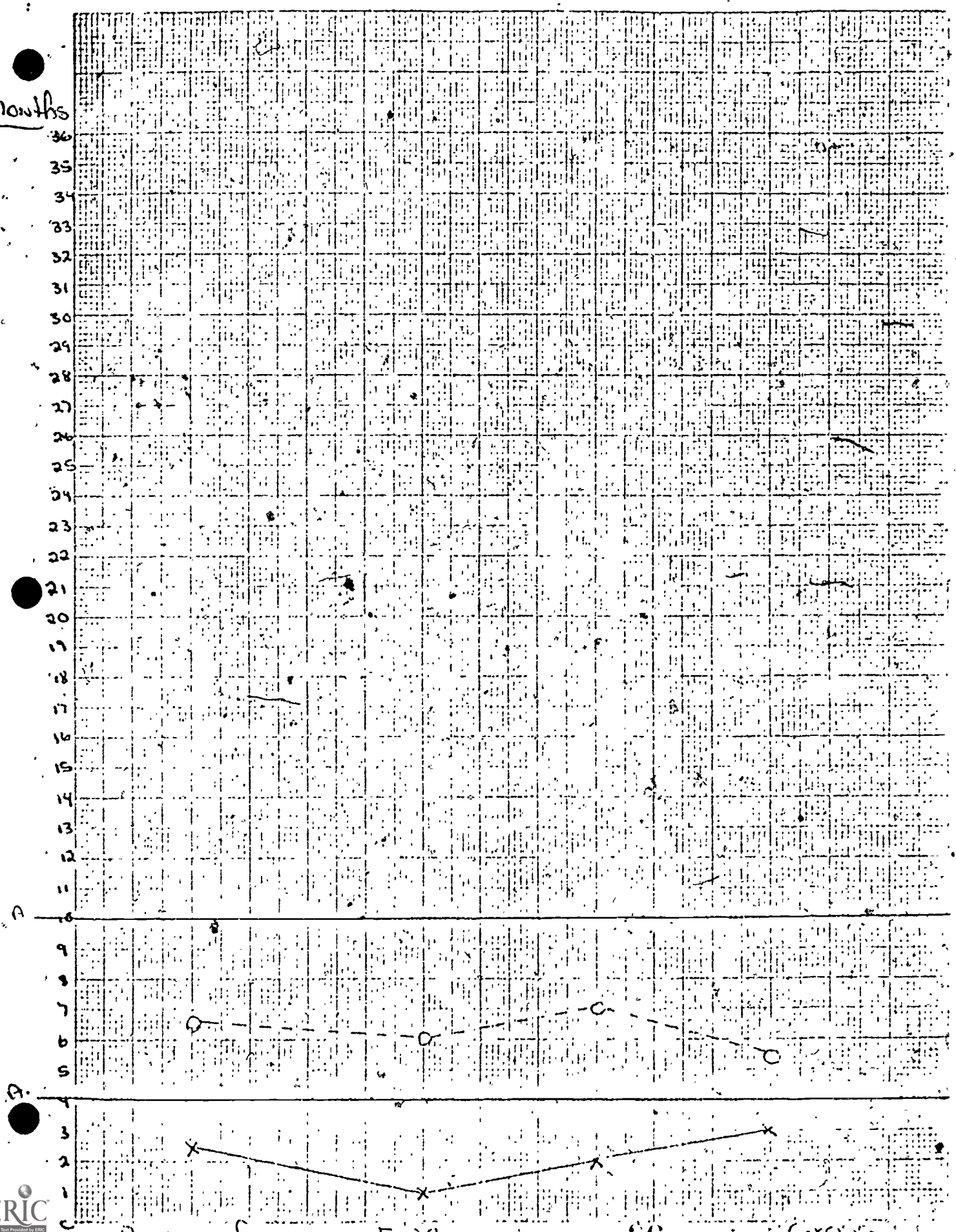
× Pre Test C.A. [illegible] mos. D. 1-05-11

⊙ Post Test C.A. 32 mos. Cerebral Palsy

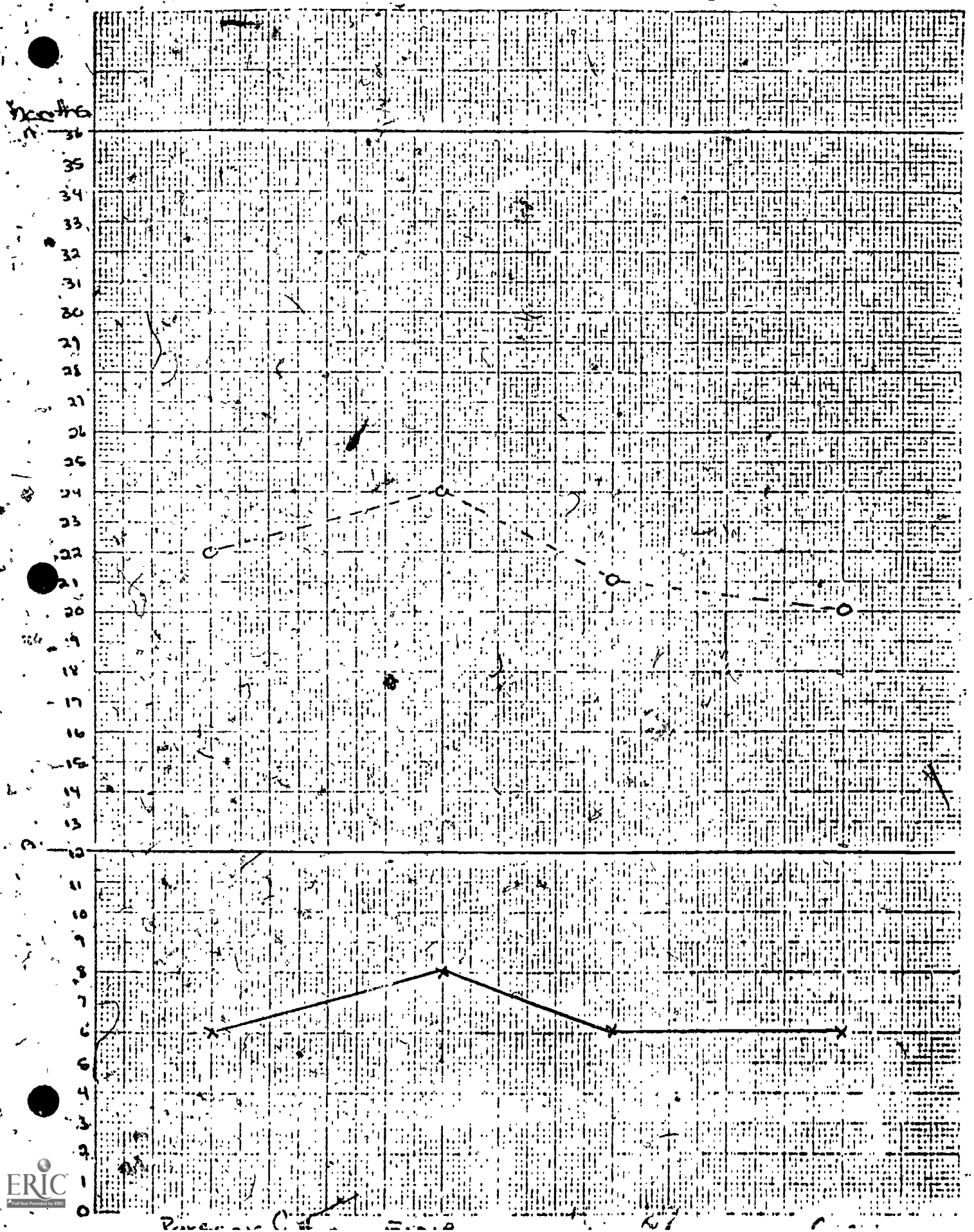


O - Post Test C.A. - 10 mos

Down's Syndrome



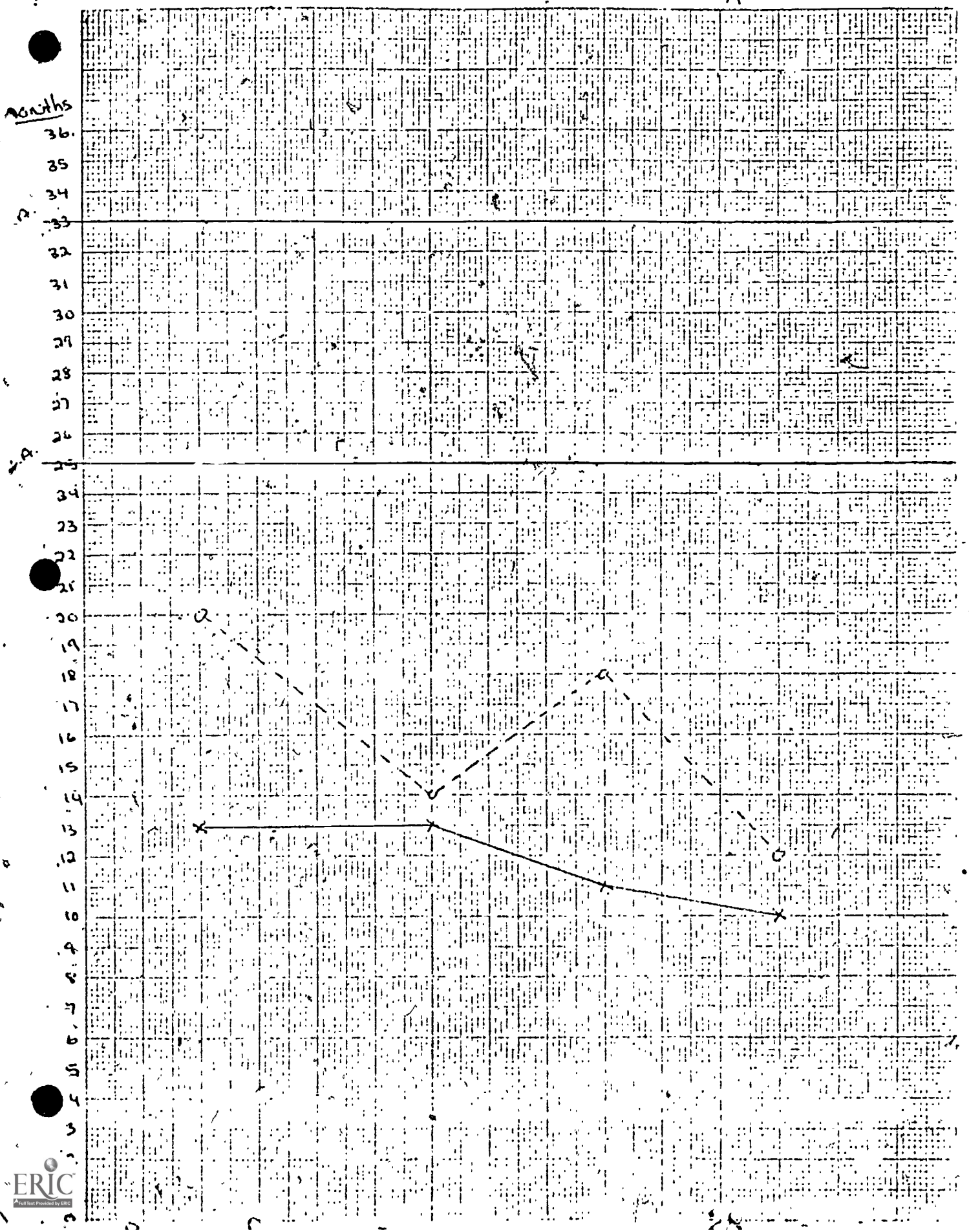
O. Post test C.A. 36.mo's Down's Syndrome



X - Pre-test C.A. 25 mos

O Post Test C.A. 33 mos

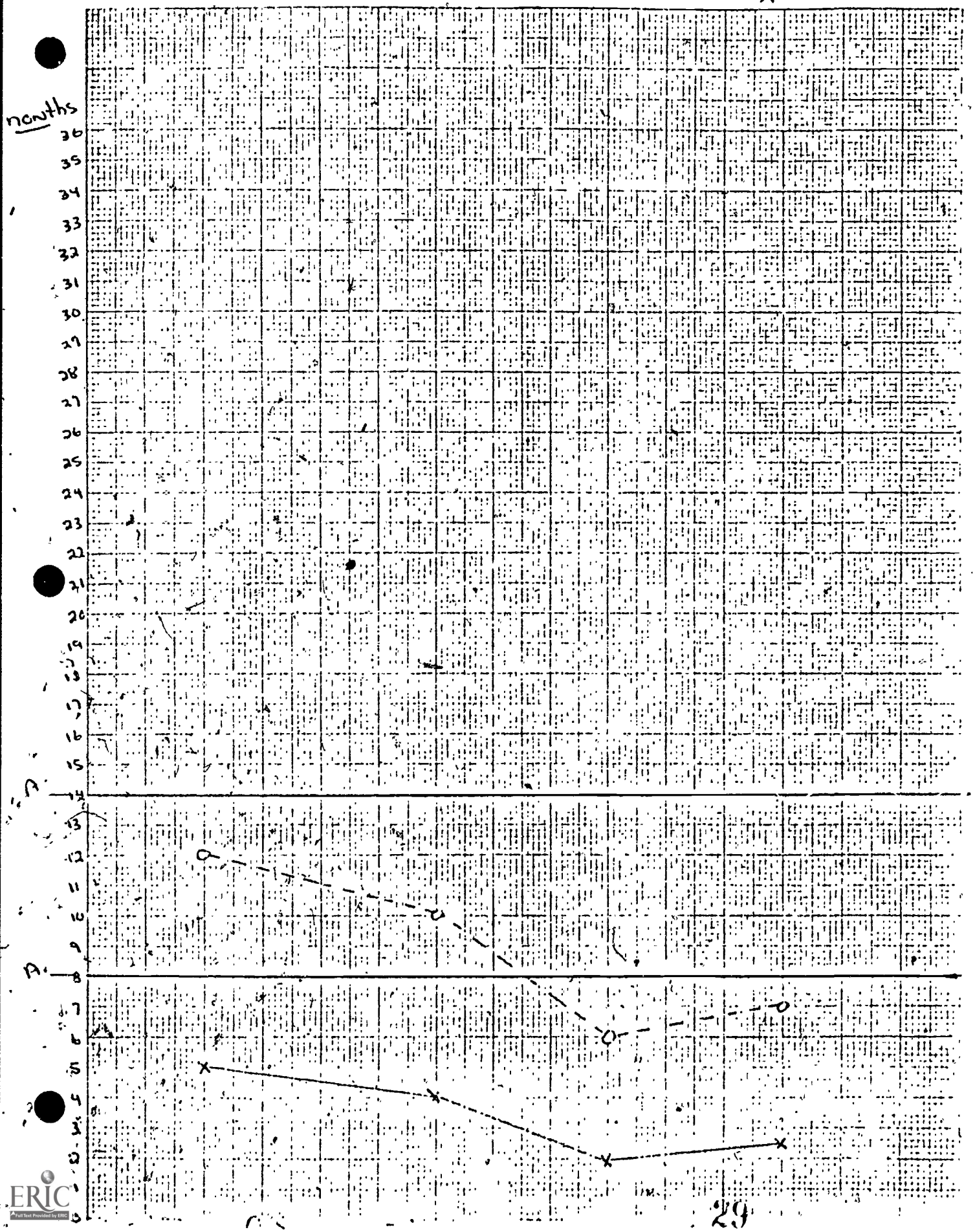
Down's Syndrome



X - Pre-Test C.A. 8 mos
O - Post Test C.A. 14 mos

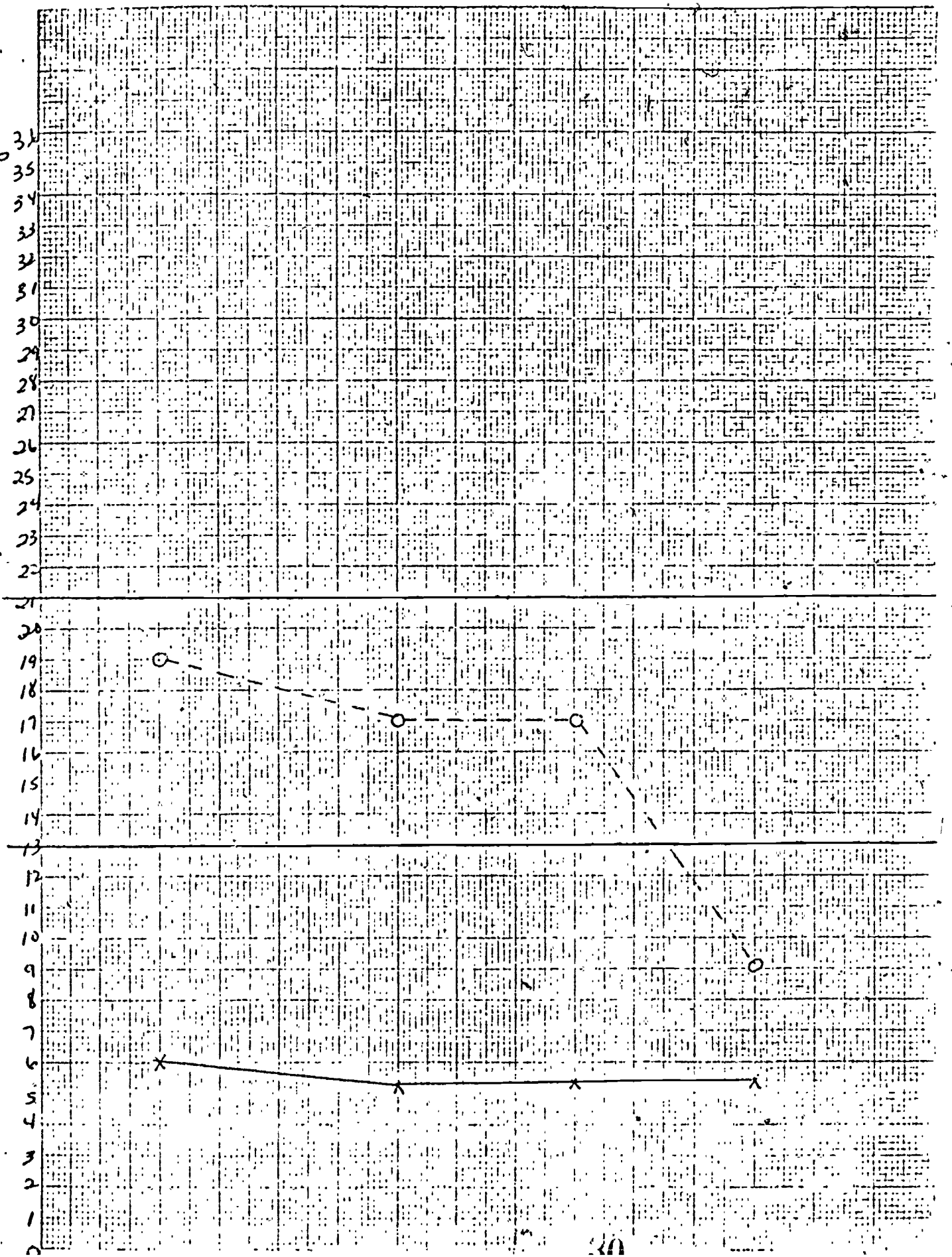
D. 8-1-72

Down's Syndrome



X pre-test C.A. — 13 mo.
O post-test C.A. — 21 mo's

b. 3-4-72
Down's Syndrome

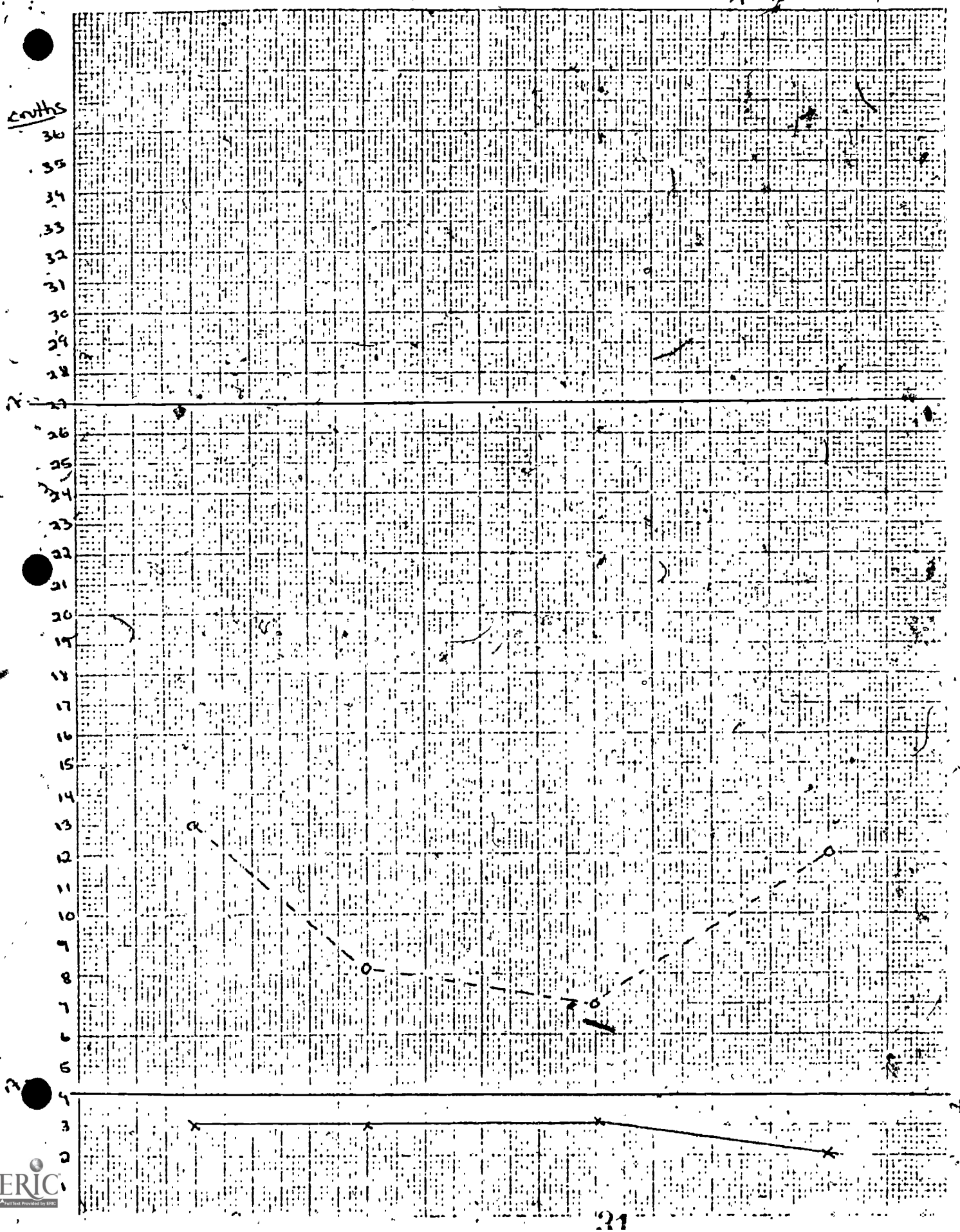


X Pre-Test - C.A. 4 mos

O Post Test - C.A. 37 mo's

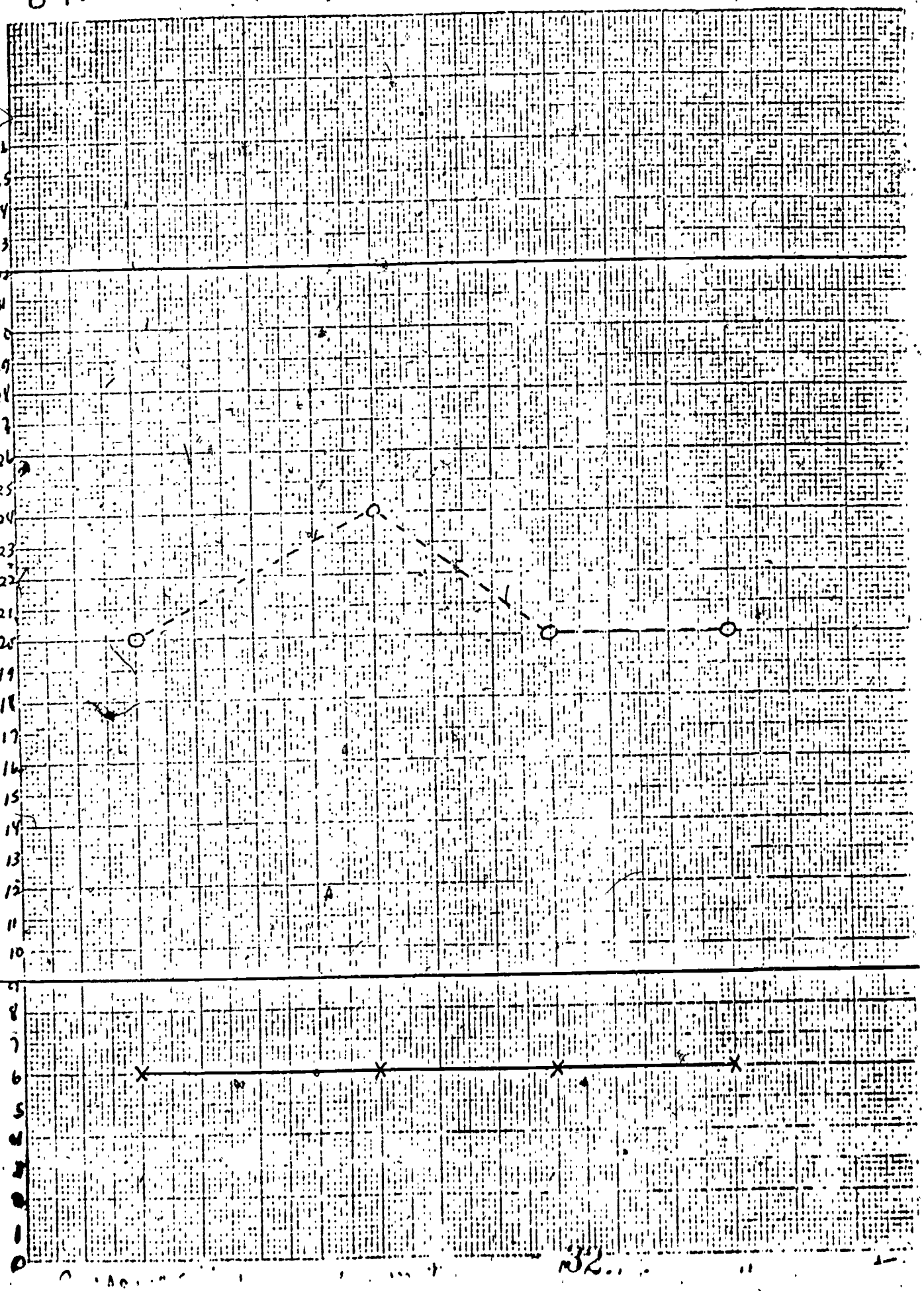
b. - 11-08-11

Down's syndrome

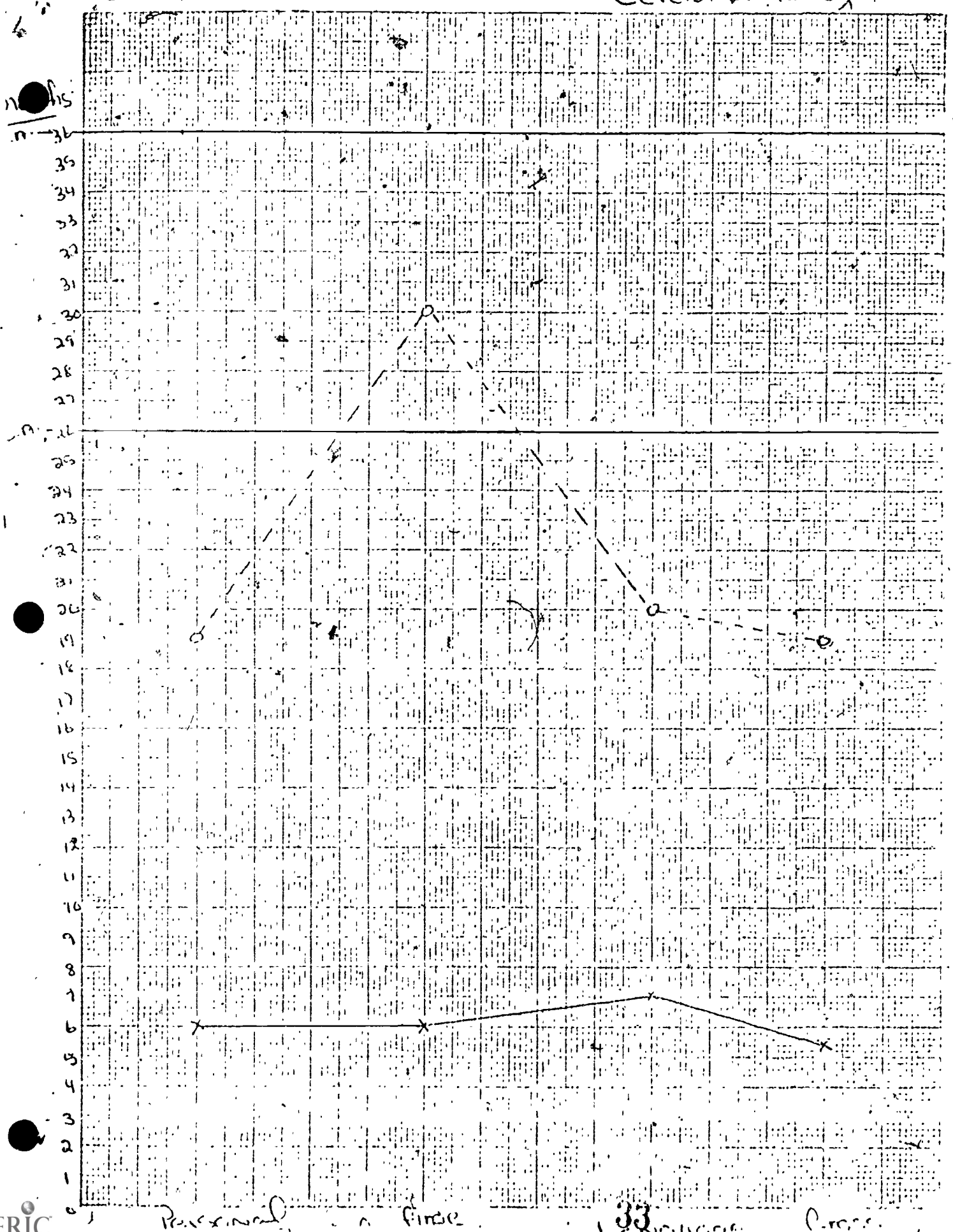


O Post-Test - C.A. — 32 mo's

Down's Syndrome

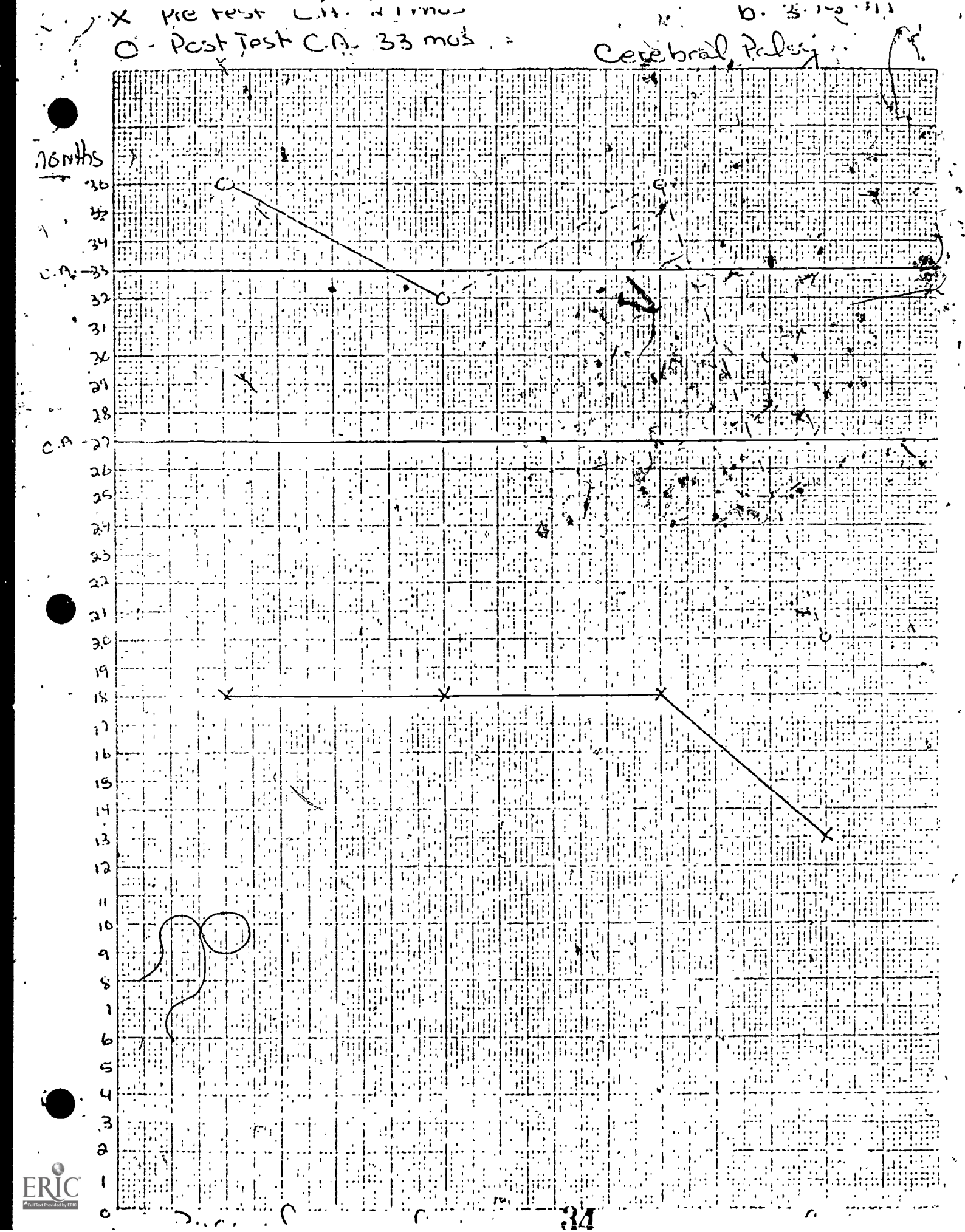


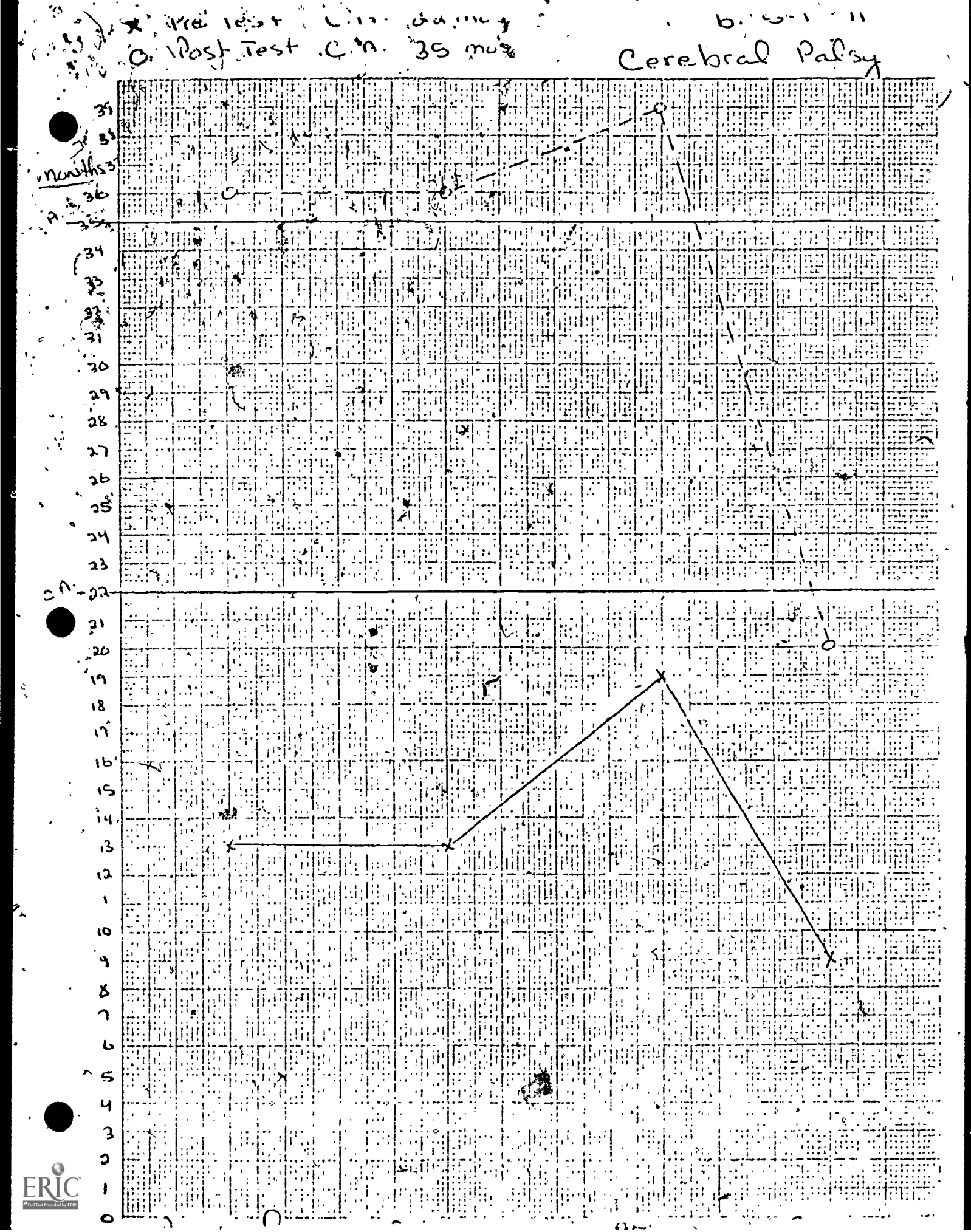
C - Post test C.A. 36. mo's Cerebral Palsy

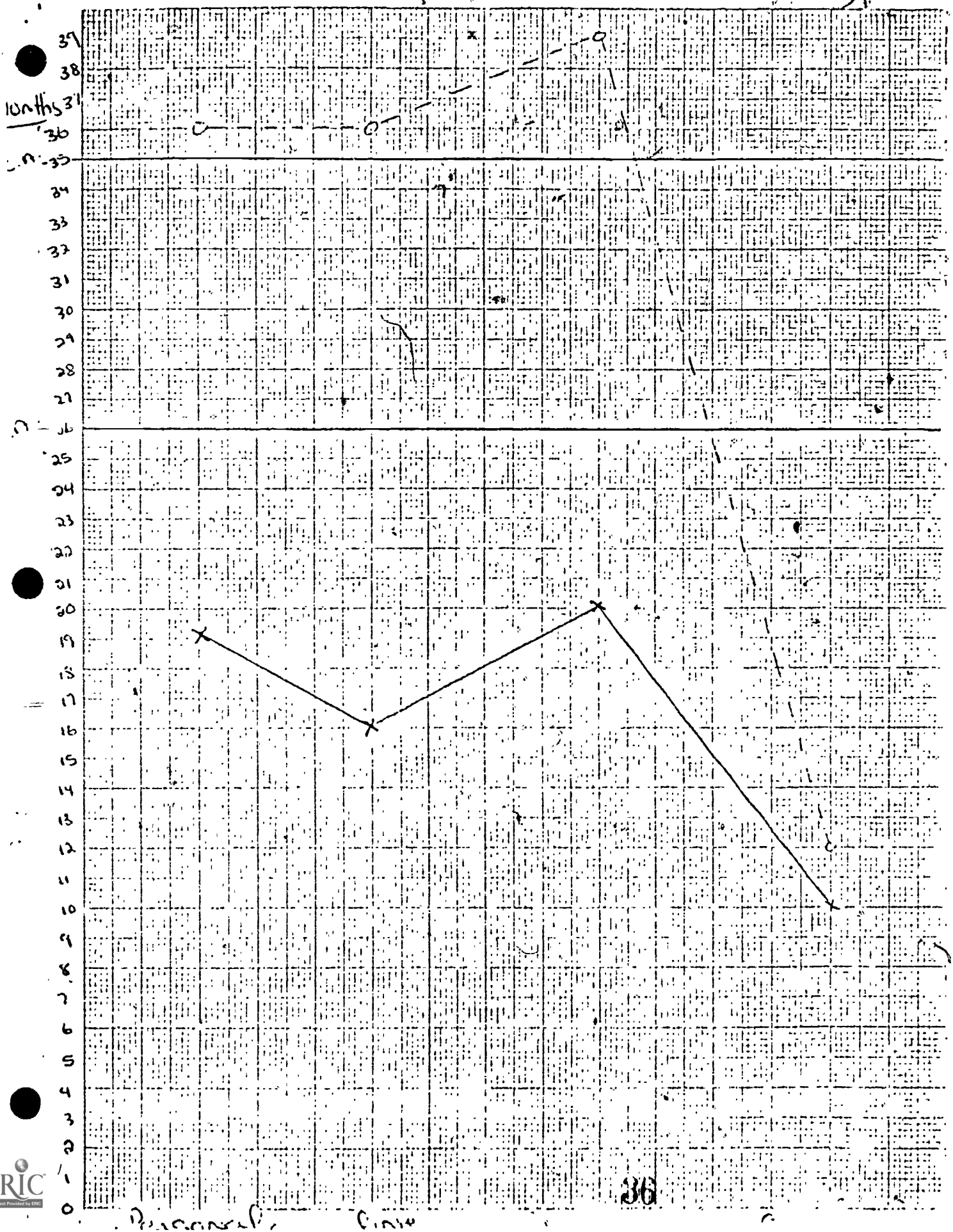


Personal Time

Performance Curve


X Pre Test C.A. 21 mos
O - Post Test C.A. 33 mos
Cerebral Palsy
Months
C.A. - 33
C.A. - 27


X Pre Test C.A. 35 mos
O Post Test C.A. 35 mos
Cerebral Palsy
Months
C.A.


O Post test C.A. 35 mo's. Cerebral Palsy
months
C.A.
39
38
37
36
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32
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29
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26
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24
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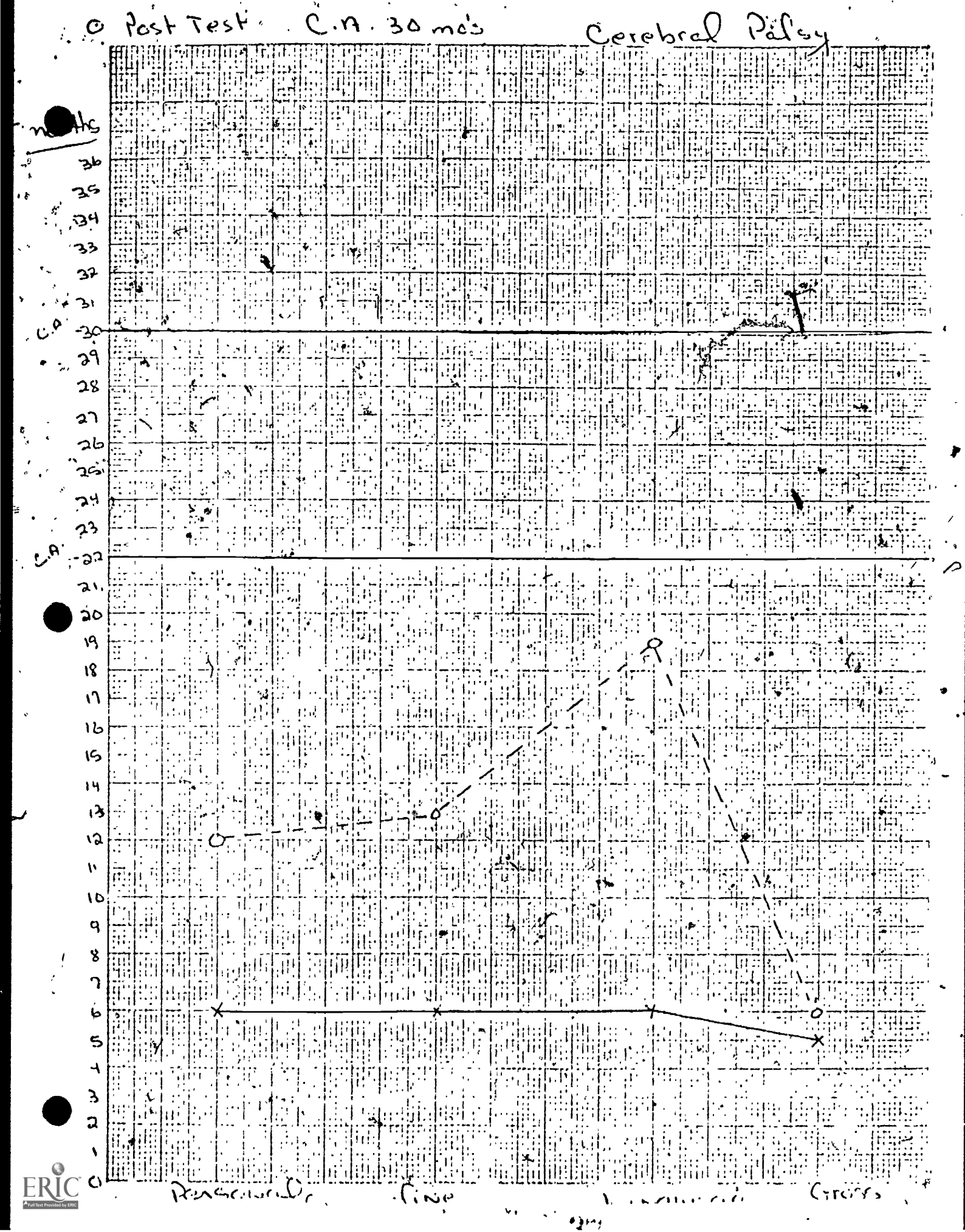
Post Test C.A. 30 mo's
Cerebral Palsy
months
36
35
34
33
32
31
C.A.
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28
27
26
25
24
23
C.A.
22
21
20
19
18
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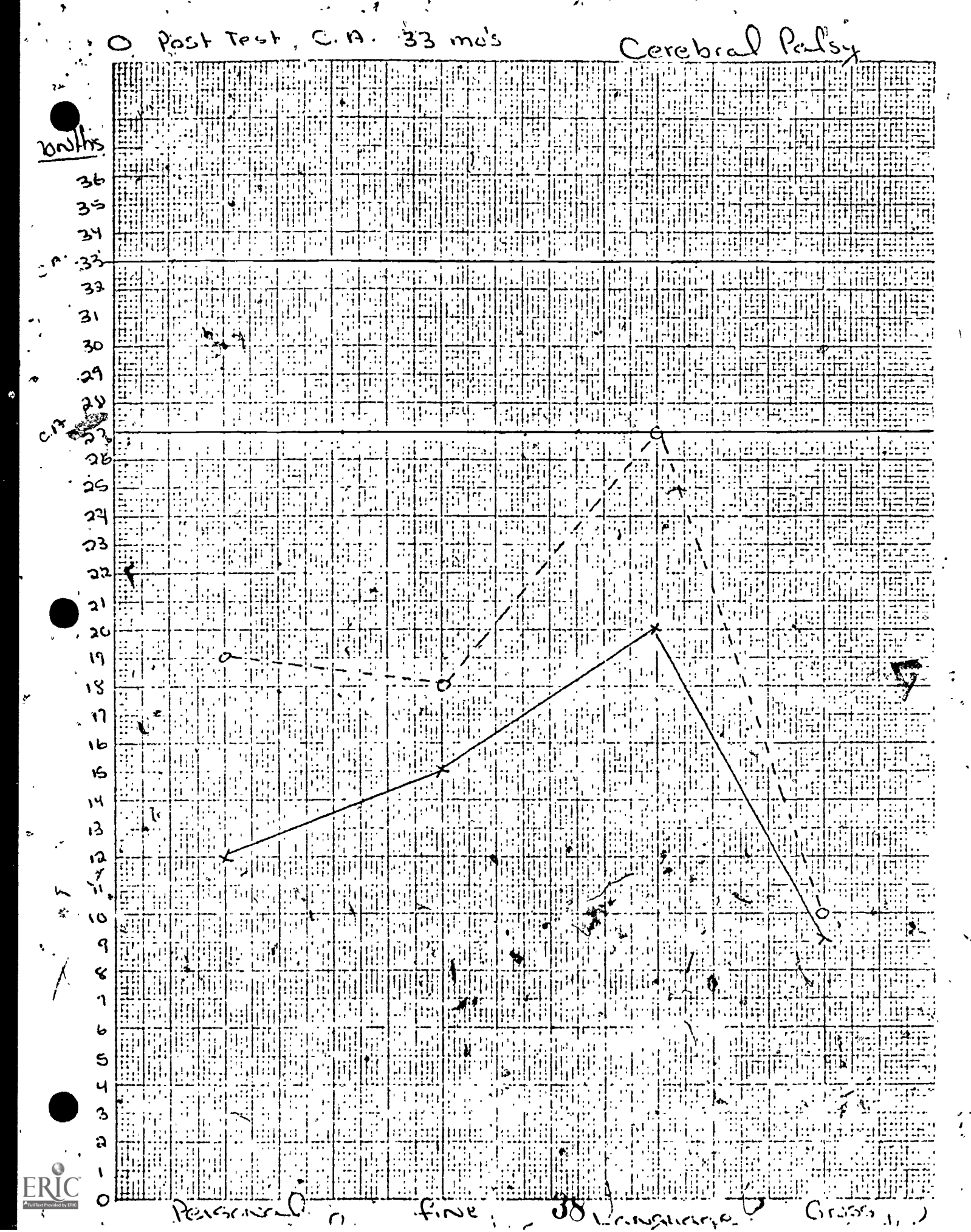
1
0


O Post Test, C.A. 33 mo's
Cerebral Palsy
Months
C.A.
C.A.
36
35
34
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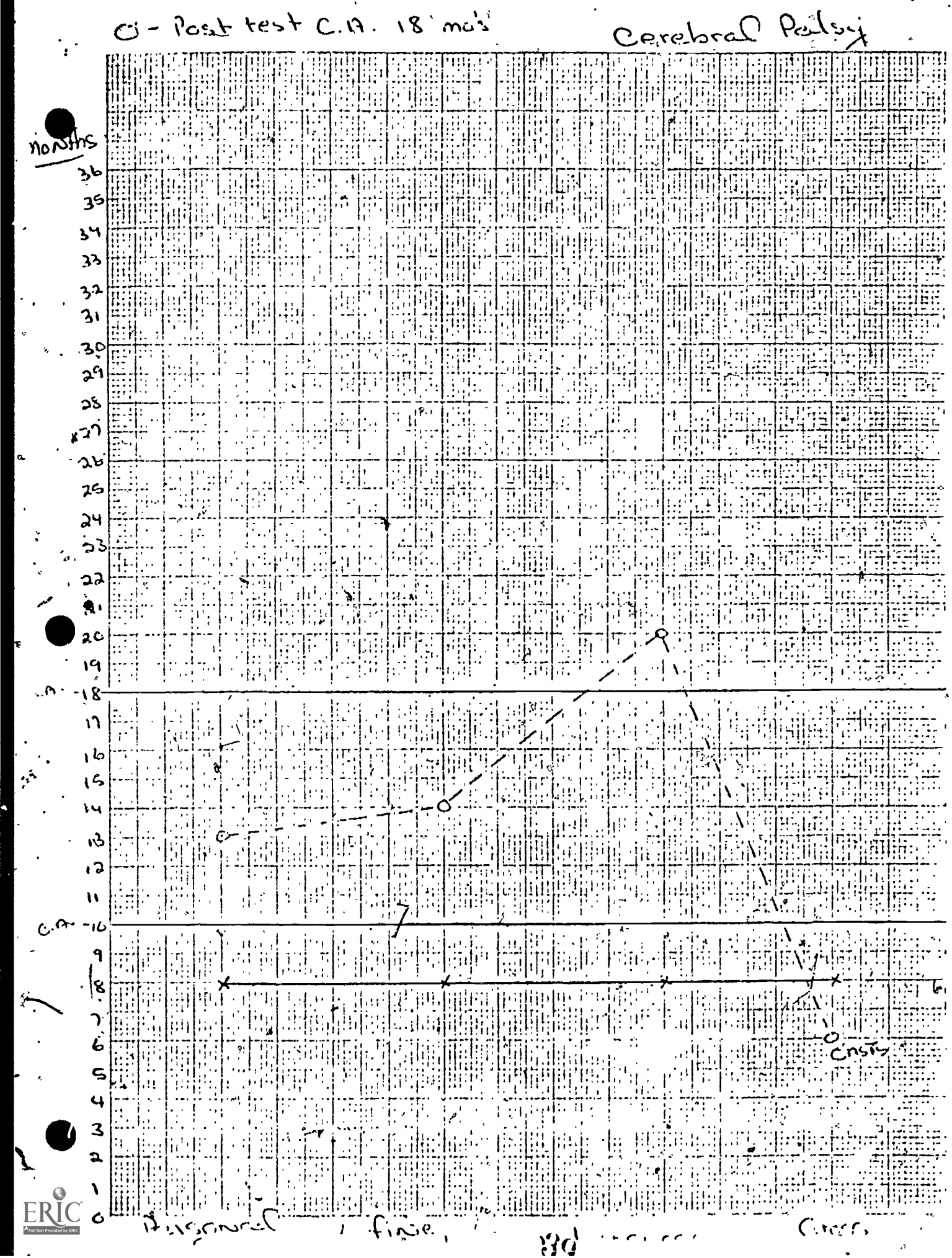
Personal
fine
Language
Gross


C - Post test C.A. 18 mo's
Cerebral Palsy
months
36
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24
23
22
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19
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6
5
4
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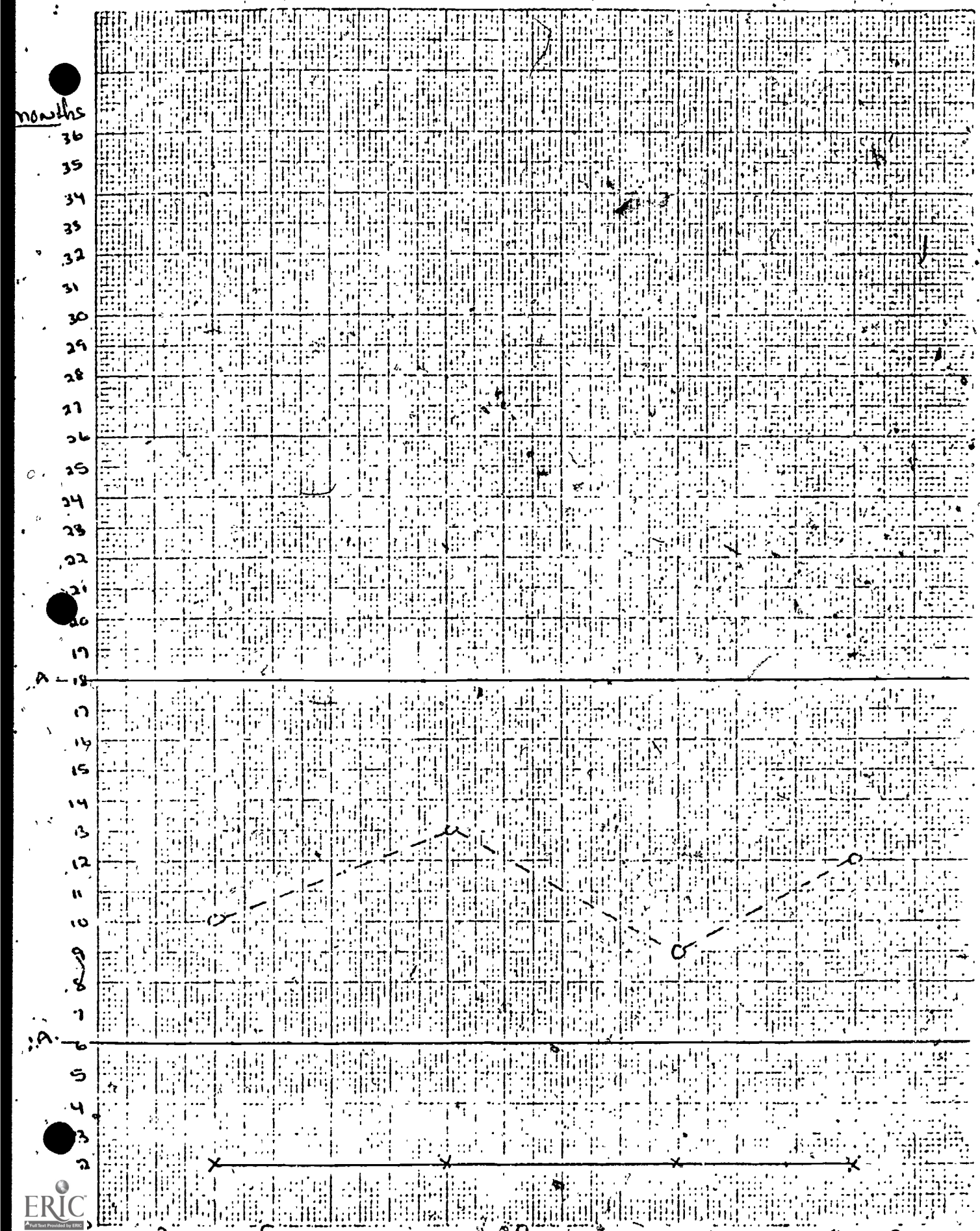
C.A.
C
O
X
O
Chron
Personal
Fine
Gross

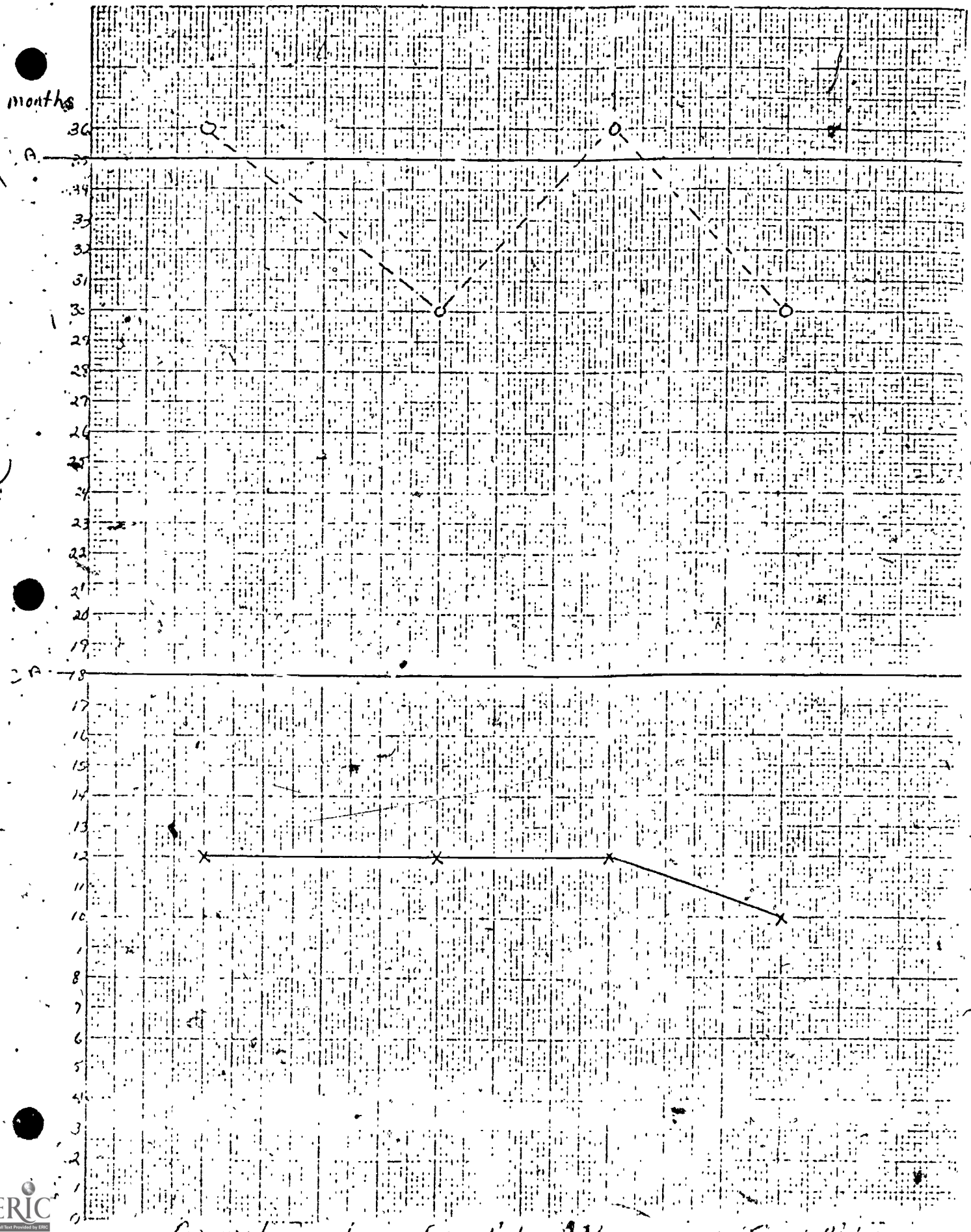
O - Post test C.A. 18 mo's. Mental Retardation



PERSONAL FINE 40 LANGUAGE GROSS

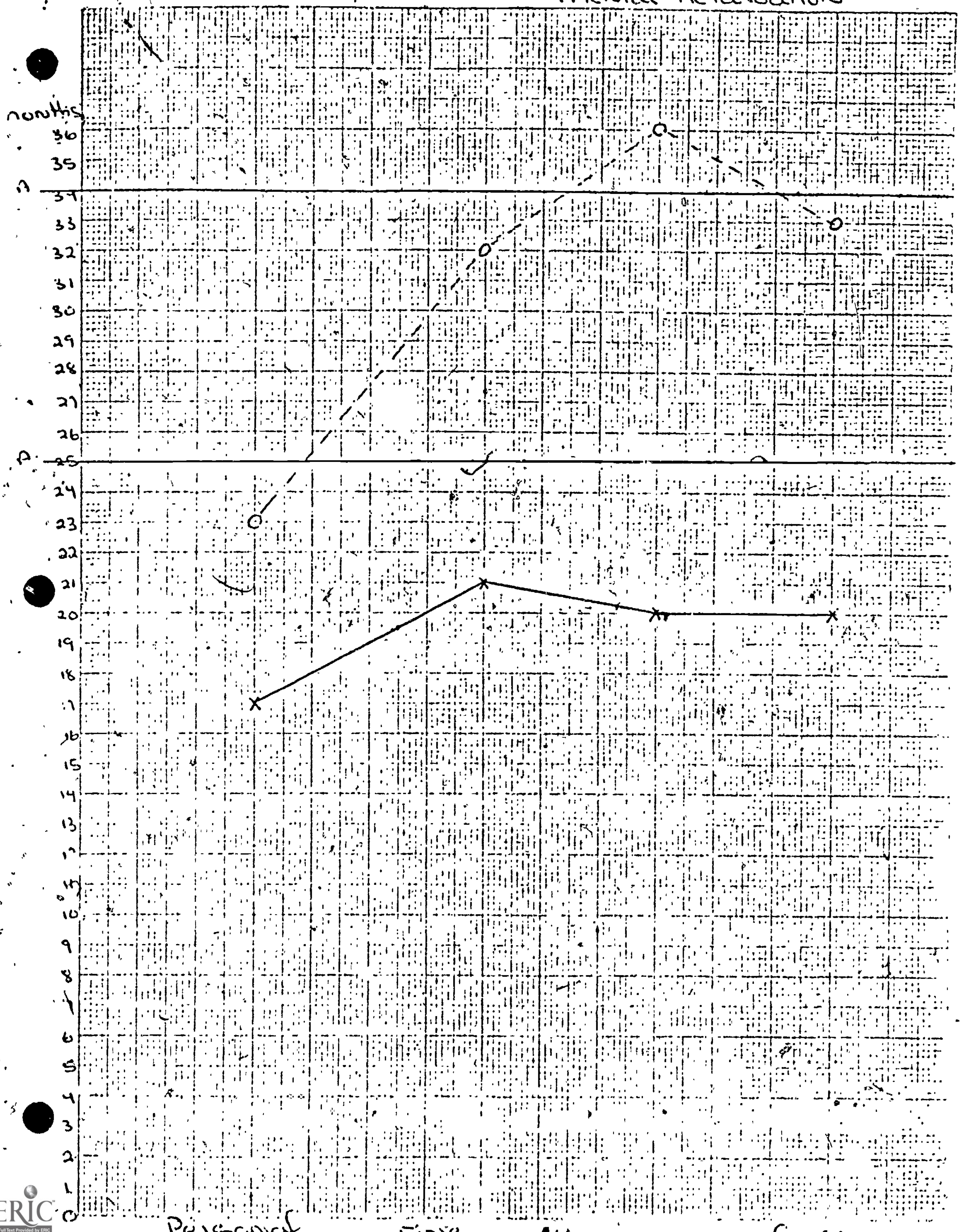
O · Post Test C.A. - 35 mo's

Mental Retardation



O - Post test C.A. 34 mo's

mental Retardation



TO DATE:

(Two hundred and thirty-five children have been served including 72 children presently in the program. The Center's success can be attributed to a number of factors, i.e., dynamic staff, funding availabilities, etc. One element of note is that immediate environment of the service. Although, open to the whole of Kansas, the predominate population served comes from the surrounding community. The service is located in Mission, Kansas, which is a city within Johnson County. Johnson County is a part of the Greater Metropolitan Kansas City area. Johnson County represents 17% of the total metropolitan population. Johnson County statistics reveal a white, highly educated population in the 1970 census was 217,662 with .5% black population. There were 57,748 families with 53,625 being husband-wife families. Of the 115,462, people over 25 yrs. of age 79.6% were high school graduates, and 23% had four years or more of college.

The median income was in 1969, $13,384 and the mean income for '69 was $15,762. Although, within the area, 2.9% of the families were considered poverty level.

Another important factor for success is the relation between the I.D.C. and other agencies and organizations within the field of Health Delivery).

Inter-relation with other program - The infant Development Center enjoys an extremly close relationship with the Kansas University Medical Center. Our Pediatric Consultant is also on staff at the Medical Center. The Growth and Development Clinic refers children to our programs quite frequently and we, inturn, refer families to K.U. Medical Center for such supplemental services as formal audiological evaluations and genetic counseling.

Eight Infant Development Center children were offered hearing tests and psychological testing at no charge recently as a training experience for graduate students. K.U. Medical Center students utilize the Infant Development Center for observation by appointment.

An excellent relationship exists between the Infant Development Center and local programs such as Crippled Children's Nursery School, Pre-School for the Visually Handicapped, Children's Special Education Center, Shawnee Mission Special Services Clinic, Johnson County Mental Retardation Center, Kansas City Association for Retarded Citizens Pre-School, and the Deaf-Blind Program.

Kansas Neurological Institute - has been extremely cooperative in working with our program and has provided Crisis Care for two of our familes this year.

(There is also an advisory board consisting of parents, professionals and consumer organization members).

A sample of ten children has been selected to further illustrate program procedures, techniques and services. These illustrations clearly show the total impact of services on the children and their families. These sample cases are described on the following several pages.

1. This little boy was diagnosed as a "high risk infant" with rigidity in the lower extremities and suspected Cerebral Palsy. He and his mother attended regular sessions at the Infant Development Center and the child was re-evaluated at the age of 1 year. He is functioning at age level in all areas of development. He was released by both the Neurologist and Orthopedist with the report: "No evidence of Cerebral Palsy."

Joe says a few words, follows commands, walks holding onto furniture, demonstrates no lower extremity rigidity and is most alert and personable. The child is re-checked periodically and the mother continues to attend the weekly Mothers' Group meetings.

2. This little girl is a severely involved multiply handicapped child who entered the program at the age of 3 months. She has made some definite gains and contractures and deformities have been prevented.

The parents are totally involved in the program and are active in all phases.

When the question of residential placement was raised by the physician, we arranged for the parents to talk with another parent whose child is in placement and they were accompanied (by the I.D.C. Director) on a tour of K.N.I. Much counseling was extended to help the parents with their feelings.

Their decision to keep the child at home was supported by our staff and the family's improved coping skills is a direct result of close contact with staff and Infant Program.

3. This little girl spent a week in the Intensive Care Unit at K.U. Medical Center this Spring. She was desperately ill and in a coma for several days. Staff was in constant contact with the family, both personally and by telephone. The illness left the child with seizures and partial paralysis. The Center provided a protective helmet for Marion and physical therapy. She has regained complete use of the affected leg and partial use of the hand. Continued support is extended to this family on a 24 hour per day basis which the mother states has "saved her sanity."

4. In April, this family failed to keep two appointments and did not telephone a cancellation. This seemed most unusual and follow-up revealed a devastated mother whose husband had left her.

She returned to the Center and began talking with the Director and Social Worker. She was helped to locate employment as an Inhalation Therapist. The Social Worker took her to Crippled Children's Nursery School to visit and implement the recommendation for Joe to be enrolled at age 3. Legal advice was secured for her in terms of custody, child support etc. Both mother and son survived this traumatic period quite well due, in part, to the able assistance of our Social Worker.

5. This mother asked, at intake, if we could "teach her how to play with her child." He was, at that time, a non-verbal, hyper-active youngster who was functioning between 6 and 8 months behind his chronilogical age level.

Newton and his mother have attended weekly sessions during the past year. Newton attends well, participates in group activities and talks in sentences[

The mother feels secure in her role and truly enjoys her little son now.

To insure objectivity, we referred Newton to K.U. Medical Center for psychological evaluation in May. They agreed with our findings and stated that Newton is now functioning at age level (36 months) and should attend regular pre-school in September.

6. This little girl is the youngest of four and had been badly pitied and indulged. Due to her excessive screaming behavior, our therapist worked with Patricia in her home weekly until a relationship had been established. A behavior management approach was utilized until Patricia would walk on the parallel bars without screaming. She was also placed in a Toddler Class.

In February, the mother stated that her husband had been offered a substantial promotion contingent upon a transfer to Tulsa Oklahoma.. The mother planned to refuse the transfer due to her fears about finding a program for Patricia.

We contacted agencies in Tulsa and were able to compile a list of available programs with costs, addresses and eligibility requirements.

We, of course, shared our knowledge of Patricia with the pre-school in Tulsa and the family made the move without incident.

7. This little Spanish-American boy is a severely involved multiply handicapped child who presented a severe feeding problem for his parents. It took more than an hour to feed him each meal and he was still on bottles and strained baby foods.

The mother expressed a desire for Roberto to eat table foods.

We initiated a program of desensitization, "walking the tongue" to prevent the gag reflex and proper cup drinking to prevent the bite reflex. The mother held the child in a semireclining position and "poured" in the food. Roberto was repositioned in an upright position with his head in mid-line and the mother was taught proper feeding techniques.

8. This little boy was running and talking at age 2 years and then suddenly contracted meningitis.

The child was referred to us prior to his release from the hospital. Support was extended to the mother as well as several treatment and training sessions with Carl being held in his home.

At initial contact this little boy could "do less than a normal newborn" (mother's description). He had no head control and appeared to be totally blind.

Currently, Carl sits alone, stands and takes a few steps with help and vocalizes. He responds appropriately to both visual and auditory stimuli. The "road back" is a long and arduous one but we believe Carl will "make it."

9. At intake, this child demonstrated a mild developmental delay "across the board" with a signigicant lag in gross motor skills.

She has been in the program more than a year and talks in sentences and is ambulatory with cable braces. She is functioning at age level (35 months) in all areas except ambulation.

It is noteworthy that this mother (plus several others) was instrumental in developing the expanded concept of a Pre-School for children like Gretchen for whom there is no appropriate referral source at age 3 years.

10. The maternal grandmother of this little boy telephoned the Center stating that her daughter and grandson had come for a visit and the child had: "destroyed her house in 15 minutes." She expressed concern that "something may be wrong" with Richard and requested and evaluation.

The Center Director observed and tested the child the following day. The mother and grandmother were given specific suggestions in terms of behavior management, self-feeding, development of backward parachute reflex and language stimulation.

They were reassured regarding the child's behavior and development and encouraged to follow the written home program.

This was a one-contact situation for this little boy and a follow-up phone call revealed a greatly improved over-all situation.

11. This family resides on a farm in Fredonia, Kansas, and contacted the Center regarding their 3 year old daughter who had no expressive speech.

At intake, this child was totally non-verbal but demonstrated good receptive language skills.

We outlined a structured home program and demonstrated specific techniques to the parents.

In 6 months, Christy was able to name objects and pictures and verbally respond to a direct question. The parents were encouraged to continue working with her and to enroll her in a regular pre-school in September.