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ABSTRACT

This practicum focused on the improvement of parent/caregiver relationships with approximately 65 children (ages birth through age 3) prenatally exposed to drugs or alcohol. The project utilized six Infant Development Instructors and local health support services. The 8-month program implementation involved Infant Development Instructor training, dissemination of information regarding available services to caregivers, pre-assessment and post-assessment of child/caregiver involvement, and implementation of a caregiver support group. Results indicated increased access by caregivers to more services; observed improvement in 3 of 11 desirable behaviors; and substantial improvement in the amount, quality, and appropriateness of these behaviors. The Infant Development Instructors showed substantial improvement in attitude, and caregiver attendance at the two support group locations remained consistent throughout the 8-month period. Extensive appendices include documentation of increased numbers of substance-exposed infants; the attitude survey of Infant Development Instructors; the parent/caregiver questionnaire on local available services; suggestions for Infant Development Instructors' home visitations; an infant developmental intake checklist; a list of curriculum model programs; and an agency referral guide. (Contains 55 references.) (DB)

Improving Child/Caregiver Relationships of Prenatally Substance-Exposed Children Birth to Three with Early Intervention Techniques Facilitated by Infant Development Instructors

by

Susan S. Klingler

Cluster 37

A Practicum II Report Presented to the
Ed.D Program in Child and Youth Studies
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

Nova University

1992

PRACTICUM APPROVAL SHEET

This program took place as described.

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This practicum report was submitted by Susan S. Klingler under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Child and Youth Studies and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

9-16-92
Date of Final Approval of Report

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I would like to thank my husband, Richard; son, Sean; and daughter, Nichole, for their support and interest in this educational practicum endeavor. I would like my young son, KoDee, born during the first year of the Doctoral Program in Child and Youth Studies, to know that his growth and development gave me the encouragement to complete this final report.

Additionally, I would like to express my appreciation to the Program Manager, the Infant Development Instructors, and all the support staff who directed, assisted, and supported this Practicum.

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ABSTRACT

Improving Child/Caregiver Relationships of Prenatally Substance Exposed Children Birth to Three with Early Intervention Techniques Facilitated by Infant Development Instructors. 1991: Practicum II Report, Klingler, Susan S., Ed.D. Program in Child and Youth Studies. Descriptions: prenatally substance exposed infants/crack babies/alcohol drug exposed/infant development program/interagency health/support services/support group/assessment instruments/home visitation/early intervention/family centered services/caregiver

The focus of this practicum was to improve caregiver/child (prenatally drug/alcohol exposed) relationships with assistance from the Infant Development Instructors and local health/support services. As a corollary aim, an overall increase in Infant Development Instructors' satisfaction with the program is anticipated along with increased caregiver compliance.

Eight months of implementation included Infant Development Instructor training, dissemination of information for caregivers to access all local health/support services, pre- and post-assessment of child/caregiver involvement and the implementation of a support group for caregivers of prenatally substance exposed children. Prior to training, instructors completed an attitude survey scale related to the assessment and implementation of the Infant Development Program. Responses receiving the highest ratings assisted the practicum objectives. The caregivers were rated at the beginning of implementation by a Parent/Caregiver Involvement Scale (P/CIS). As implementation progressed, instructors utilized current strategies/techniques gleaned from consultant at staff meeting during home visitations with infants through three year olds. Caregivers completed a questionnaire regarding knowledge and current access of local health/support services.

With the increased knowledge of health/support agencies, more services were accessed by the caregiver for the child and family. The P/CIS scale showed improvement in three of the eleven behaviors observed as well as increases of one level or more in each of the three domains: amount, quality, and appropriateness of the behavior. Of the twenty-five health/support services measured, fourteen showed increases between seventy-five and five hundred percent. When re-surveyed, the Infant Development Instructors showed improvement of attitude, two increased over fifty percent. Caregiver attendance at S.P.O.K.E. (Support for Parents of Kids Exposed) remained consistent at both locations throughout implementation.

Permission Statement

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SUSAN S. KLINGLER

CHAPTER I

INTRODUCTION

Description of the Work Setting and Community

The original, pioneer center for the handicapped to promote occupational skills, (the writer's work setting), has expanded since it first opened its doors in 1964. The first center, a small building, was originally founded by a group of parents who later became the local county's Association for Retarded Citizens (ARC). The parents felt that their children needed further instruction. Because federal funding was limited initially, the center existed on the dollars earned from a flea market booth. This first center served a total of fourteen individuals on an ongoing basis. At that time, the center provided vocational evaluating services. The second occupational center was located in an old bowling alley with approximately 19,000 square feet.

By 1974, the centers trends had changed from providing maintenance skills for individuals to more work related training. The center changed its name to a rehabilitation center, avoiding the flea market label. As developmental

training dollars became available through the state, a stronger workshop model was developed. During the early 1980's, the center was servicing approximately 115 adults, providing developmental training, adult basic education, consumer education, workshop, food service, janitorial training, and carpentry. By 1990, the developmental training center employed a staff of over sixty.

In 1979, the center developed an Infant Development Program to work with infants born with mental or physical handicaps. The center hired instructors to work with the parents to help them understand the infants' delays and disabilities. The center also subcontracted clinical services from a pediatrician and registered therapists in the areas of physical, speech, and occupational therapy, as needed to assist the children. By 1980, there were thirty-six children in the Infant Development Program and a waiting list.

Presently, the Infant Development Program serves an ongoing case load of approximately sixty-five children ranging from infancy to three years. The Infant Development staff consists of six instructors (three full time, one three-quarter time and two part-time), one Program Manager, and one Consultant/Collaborator and shared clerical and bookkeeping personnel. In 1990, the center moved out of the bowling alley. The rehabilitative service has a new location and building with better facilities. The staff who provides

services in the field have their offices on the second floor of the Chamber of Commerce building.

The county encompassing the writer's in-field work setting has a population of 112,000 and is geographically coastal in location and sub-tropical in climate. The research center is located in the County's Chamber of Commerce building in a city having a population of 16,900. The county has an unemployment rate of 8.2%, with a personal annual income of $22,450.

The clients of the Infant Development Program range in age from birth to three years. The majority of clients come from a low socioeconomic background. Approximately 30% are white, and the remaining 70% are minority categorized as follows: 40% African American, 20% Hispanic, and 10% Guatemalan. Of the total case load (sixty-five children), 45% have tested positive for prenatal drug exposure, cocaine being present in all cases. T. Berry Brazelton states, "If we worked with these infants from the first it would cost us one-tenth or one-hundredth as much as it will cost us later. To educate them and keep them off the streets, to keep them in prisons will cost us billions" (Toufexis, 1991 p. 59). The remainder of the Infant Development Program case load consists of 15% abused and/or neglected children, or children of teenage parents.

Writer's Work Setting and Role

The writer holds a Bachelor's Degree in Psychology and Sociology, a Master's Degree in Elementary Education, and a specialized degree in Specific Learning Disabilities (SLD). The writer has been an elementary and secondary educator for five years and a Learning Disability Specialist for eight years. Additionally, the writer has worked as a consultant with the county's Exceptional Student Education (ESE) for over a year.

The writer presently works with an Infant Development Program under an Early Intervention Program grant. The writer spends part of the time at the center, collaborating with the Infant Development Program Manager on special projects, training programs, and the agenda for the county's Task Force on Substance Abused Children. The writer also collaborates with grant writing and the development of a video presentation for the center's county-wide Infant Development Program. The remainder of the writer's time is spent working directly with the Infant Development Instructors and supervising a case load of twenty-three prenatally drug-exposed infants through three year olds.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

Although we cannot be certain about exactly which specific intervention is best for each child in need, we do know a great deal about the development of all young children and families. When newborns have acute medical conditions that can impair development or even threaten life itself, early treatment is essential (Carpenter, 1989). Presently, there are twenty-three prenatally exposed infants through three year olds in the writer's case load. Each child varies in degree of developmental deficiency, but a need for early intervention strategies was evident in all cases.

Substance abuse during pregnancy is found among women from all races and socio-economic strata as well environmental settings. What these women often have in common is a history of unresponsive childhood rearing and a problem with meeting the needs of their own substance-exposed child. Intervention is essential for these children.

The Infant Development Program Manager recognized the increase of substance-exposed infants through three year olds in the program. The assessment, Individual Education Plans (IEP), and developmental interventions are adequate; however, the Infant Development Program Manager sees a need to develop new interventions for the Infant Development Instructors to work more effectively with the substance exposed children birth through three and their caregivers.

The parents of these prenatally substance exposed children may need some special training to meet their child's need (Carpenter, 1989). These parents often declined to participate in the current Infant Development Program. Frequent absences were noted on the parent/caregiver's part from instructor home visitations. These sessions are devoted to increasing age appropriate developmental behavior in their children. This fact indicated a strong need for increased parental compliance in the Infant Development Program to improve an appropriate parent/child interaction.

There are six homebased instructors in the Infant Development Program. Often, these instructors had returned from scheduled evaluations or development sessions without improved results or data of any kind, but with stories of excuses from neighbors and tales of locked doors. Overall, most adults who frequently use drugs and alcohol are "substance abusing parents, unstable, move frequently, lack

telephones, fail to keep appointments and drop out of sight while using illicit drugs" (Howard, Beckwith, Roding & Kropenske, 1989).

It was as if these parents felt that by ignoring the assistance of the Infant Development Instructor the problem with the substance exposed child's developmental concerns would go away. Common parental fears between birth and age four are rejection and/or abandonment of children as they become more independent (Greenspan & Greenspan, 1985).

Most of these families were without a telephone for communication. Occasionally a phone number was noted, but the receiver of the call often neglected to deliver the message of appointment time to the parent/caregiver of the client.

According to J. Cashell (personal communication, October 27, 1991), the mothers truly want the best for their children but do not know how to access anything in the immediate area to help the child. If the parent were back on drugs/alcohol, it took priority over everything, including the children. These women are extremely fearful their children would be removed from the home, so they did not accept any services because they did not trust the system.

Seeing the disregard on the part of the parent and contending with unexcusable noncompliance has an adverse affect on the Infant Development Instructors. Where

energetic anticipation could previously be seen, a repetitive cycle of hope followed by disappointment has led to discouragement and reduced enthusiasm. Ideally, the parent/caregiver is defined as one who routinely takes care of the child and would be anxious to greet the Infant Development Instructor and learn new interventions to improve the development of their infant through three year olds (defined by Farran, 1986). Unfortunately, the reality is unanswered doors, (though conversation inside can be overheard) and a host of excuses. "Programs that involve parents produce greater gains than those that do not" (Baker, Heifetz & Brightman, 1973; Murphy, Heifetz & Brightman, 1975 cited in McDade & Varnedoe, 1987).

The problem was a need for improved relationships and intervention strategies between the homebound instructors and the parent/caregiver of the prenatally exposed child (birth through three) to improve the development of the child by teaching the parent/caregiver age appropriate nurturing skills.

> The reflective self plays a central role in parenting. The infant is as helpless mentally as physically. The caregiver needs to have the capacity to contain the infant's overwhelming affects, anticipate his or her psychological as well as physical needs, adapt readily to his or her perspective, and manipulate the external world to fit it. Attunement requires an awareness of

> the infant as a psychological entity with mental experience. It presumes a capacity on the part of the parent/caregiver to reflect on the infant's experience and represent it to the infant translated into the language of actions the infant can understand. The baby is, thus, provided with the illusion that the process of reflection of psychological processes was performed within its own mental boundaries. This is the necessary background to the evolution of a firmly established reflective self. (Fonagy, et al 1990, p. 207).

Problem Documentation

In the writer's county, there has been an increase of substance-exposed infants being born at the local hospital (see Appendix A). In more populated neighboring cities, the figures are increasing every month. There are 375,000 drug-exposed children born every year in the United States (Griffith, 1988; McRobbie, et al, 1989). The local Children's Service Council has been tracking the number of drug-exposed births (see Appendix A). Some of the potential candidates (substance-exposed newborns) go undetected as certain tests are not required of all women during delivery. Current findings from surveys in Harlem, New York, present some of the problems created by prenatal substance-exposed children which have tremendous implications for the school

systems and society as a whole. The results are synthesized in Appendix B from testimony by the U.S. House of Representatives Select Committee on narcotics abuse and control concerning drug-exposed children. The women who admitted to taking drugs or are "high" during labor usually test positive and the infant is referred by Health and Rehabilitative Services (HRS) or the County Health Department to the Infant Development Program.

Many support groups and agencies have been formed to assist women who abuse drugs/alcohol during pregnancy. A county Task Force for Substance Abused Children was created, consisting of professionals who in some way are involved with either the drug-using female (pre- or post-natal) or the exposed newborn.

Infancy is a period of total dependency of a young child, and the family environment can lead to a positive or negative development (Jordan, Gallagher, Hutinger and Karnes, 1990). Although the Infant Development Program deals with infants through three year olds, its major goal was to involve the parent/caregiver to work as a team to enrich the development during the early childhood years.

There was a need to develop techniques to integrate the substance-exposed child, the parent/caregiver, and the Infant Development Instructor. Current research supports early intervention as an optimal health service expanded to meet the needs of the entire family (Tingey, 1989; Lazzari &

Kilgo, 1989). The caseload of substance-exposed infants through three year olds is part of the Infant Development Program which has only recently been funded under an Early Intervention Grant. Therefore, the instructors have not yet been equipped to assist families with specific training or intervention to improve the parent/caregiver and child relationship to enhance appropriate development.

An attitude survey/questionnaire (adapted from T.E. Estes, 1979) was distributed to the six Infant Development Instructors (Appendix C). All six instructors strongly agreed that the parents were uncooperative with keeping instructor appointments (#5). Five of the six strongly agreed that parent/caregiver training would benefit from the intervention process (#10). All six strongly agreed that a list of coordinated health/support services should be made available to distribute to and assist the parent/caregiver and the client (child) (#11).

Informal observation was noted by the writer on many home visitations. The Infant Development Instructors need new, updated, current intervention techniques to improve their relationship with the caregiver and ultimately work toward improving the development of the infant through three year old. There is an extraordinary challenge that both parent/caregiver and professionals (instructors) encounter with interventions to fit the child's needs adequately (Carpenter, 1989).

Table 1 illustrates the percentage of encounters between the Infant Development Instructor and the parent/caregiver of the substance-exposed and nonsubstance-exposed clients in terms of scheduled visits/appointments in a three-month period.

Table 1

A Three-Month Count of Completed Visitations of Both Substance-Exposed and Nonsubstance-Exposed Clients of the Infant Development Program

July 1, 1991 - October 1, 1991

Substance Exposed Client	Nonsubstance Exposed Client
total # of children = 23	total # of children = 23
* compliance = 81%	compliance = 92%

*Infant Development Instructors noted figures could be skewed as four of the twenty-three substance-exposed children were in day care and compliance reflected 100% for those children although no parent was present.

A breakdown of the caregivers of these substance-exposed infants through three year olds in the Infant Development Program is in Table 2. Caregivers were more often the grandmother and/or mother. Many children spend their days in a day care facility.

Table 2

List of Caregiver and Use of Day Care for Substance Exposed Infants Through Age Three

Infant	Caregiver	DayCare
1	Mother	
2	Grandmother	
3	Mother	X
4	Fostercare	X
5	Fostercare	X
6	Fostercare	X
7	Relatives	
8	Grandmother	X
9	Mother	
10	Mother	
11	Mother	X
12	Mother	X
13	Mother	X
14	Fostercare	
15	Grandmother	
16	Grandmother	X
17	Grandmother	X
18	Grandmother	
19	Grandmother	X
20	Grandmother	
21	Mother	X
22	Mother	
23	Fostercare	

The living environment and primary caregivers of the twenty-three substance-exposed children were analyzed in Figure 1. (Three other children who live in a shelter home are served by the agency, but, because they have no consistent caregiver, they were not included in this study.)

A breakdown of compliance for the first quarterly period (before implementation) is found in Table 3. Children who were ill or hospitalized were not penalized for non-compliance. The reason some children were seen more

often than others is because Health and Rehabilitative Services (HRS) Developmental Services and Children Service Council have different visitation/time requirements.

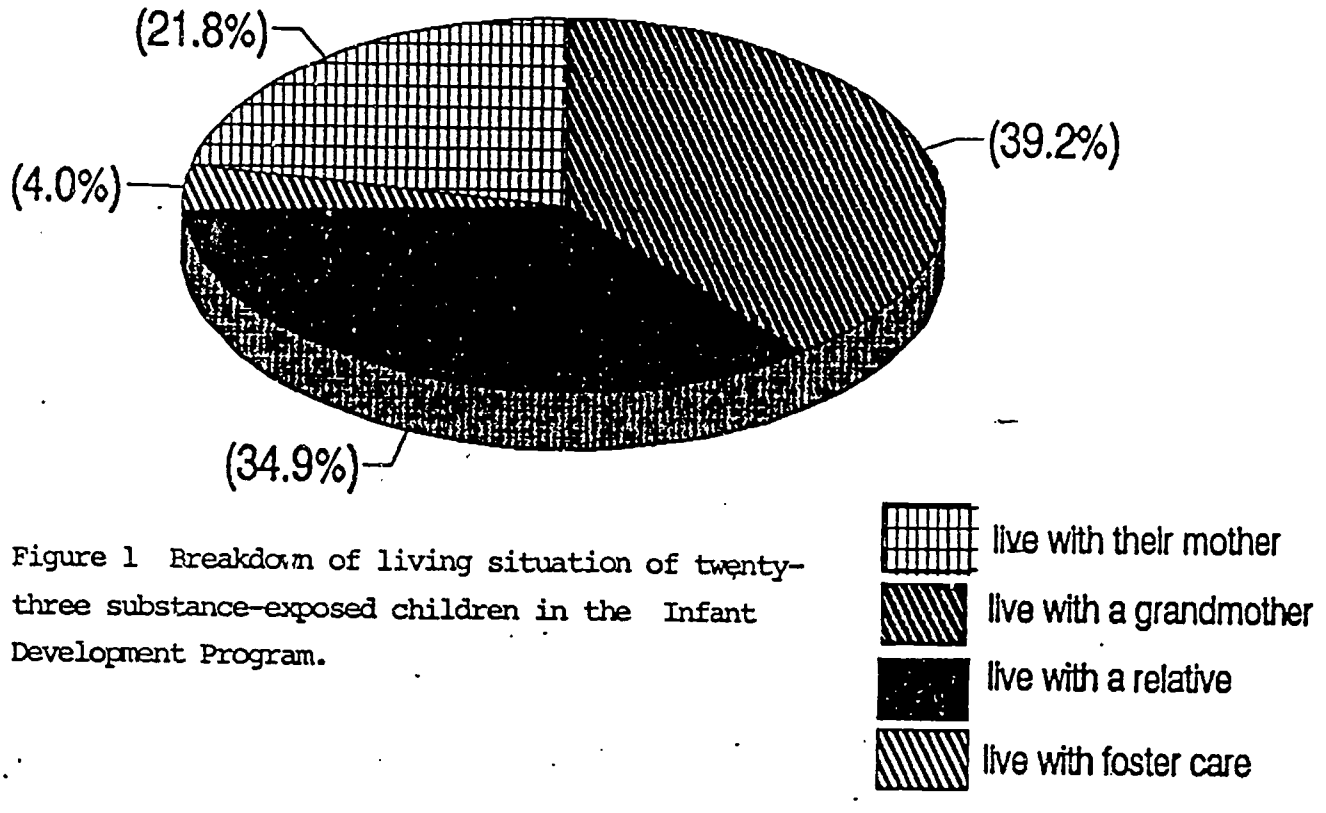

Figure 1 Breakdown of living situation of twenty-three substance-exposed children in the Infant Development Program.

Table 3

Compliance of Visitations 7/1/91-10/1/91

CLIENT	VISITS ATTEMPTED	VISITS COMPLETED
1	9	8
2	12	10
3	13	13
4	14	12
5	1	1
6	5	5
7	12	6
8	12	12
9	21	7
10	12	6
11	10	10
12	11	10
13	6	5
14.	8	7
15	16	8
16	16	14
17	19	18
18	18	17
19	20	19
20	5	4
21	13	12
22	5	6
23	2	2

Experts suspect that our public educational system contains a large number of substance-exposed children. Most of these children are of normal intelligence. These children exhibit subtle deficits which may affect their overall performance and may remain undetected. Updated research with substance-exposed preschoolers shows that these children have great difficulty functioning effectively in the traditional school setting. According to Odom-Winn and Dunagan (1991), these children are Pervasively Developmentally Delayed. "The children are globally delayed

in some, if not all, developmental areas (behavioral, physical/motor, communication and intellectual. Each area of delay impacts on the others" p.1. Without early intervention programs, preschool children are at risk of becoming drop outs or even a third generation of substance-users (Harping, 1991). Not only does the child at risk have needs for intervention, but also the parent/caregiver needs training and communication (Fitzgerald & Fisher, 1987).

Causative Analysis

One of the problems is the non-participation on the part of the parent/caregiver. The problem could exist for one of a number of reasons. For instance, the mother may still be using drugs and cannot comply with Infant Development Instructor meetings and simply makes herself unavailable. Another scenario was the mother is in treatment, court-ordered or voluntary drug rehabilitations and is unable to meet with the Infant Development Instructor or even to see her baby. In other instances, the mother had a caregiver or day care looking after the baby while she was either looking for employment, working at a job, or unfortunately seeking drugs. The parent was often unaware of local health/support services that could assist both herself, her exposed child, and other siblings in the family setting. Another possibility was that the Infant

Development Instructor did not have the intervention strategies to make the visit more meaningful to the parent/caregiver. It was not easy forcing oneself on the young client through the parent/caregiver. The drug-exposed babies were likely to have health problems, perhaps causing them to be difficult, demanding, and much less responsive than the average baby.

The inability of these babies to communicate their needs effectively, combined with frequently inadequate parenting skills on the part of the mother/caregiver, made bonding even more difficult. Sixty to ninety percent of infants born to mothers with a recent history of narcotic abuse showed clinical withdrawal symptoms. Possible effects of prenatal exposure to cocaine are found in Appendix D (Cashell & Vodenicker, 1991). The term Neonatal Absentinence Syndrome (NAS) is the descriptor given to newborns who are sensitive to noise, show poor coordination, irritability, excessive yawning, and difficulties with sucking and swallowing (Chasnoff, 1988; McRobbie, et al, 1989). These babies often avoided eye contact, disliked much noise and responded better when held or rocked in a prone position. The lack of bonding and nurturing left these infants with no boundaries. There were no limits for the children because the adults did not set up rules; therefore the children created their own boundaries. Sometimes these children were never really children, because

they often became primary caregivers for younger siblings. who were prenatally drug-exposed. Their lives from infancy were always to extremes; they were either ignored or overprotected. Magrid and McKelvey (1987) described this as the "vicious cycle of the non-responsive infant" (p. 68). Another study of cocaine-exposed infants discovered signs of central nervous systems irritability (Cook, Peterson & Moore, 1990). Symptoms of children exposed to cocaine include hyperactivity, short attention span, loss of control of temper, being easily annoyed by others, often initiation of physically cruel play, and physical fights (King, 1992).

When a child is not physically responsive, the mother questions what she is doing wrong and becomes nervous and fearful. As the anxiety intensifies, and the infant withdraws even further. The cycle repeats itself (Magrid & McKelvey, 1987). During the first year, the infant needs to internalize a strong parent, or the infant fails to gain trust. The environmental at-risk factors of substance-exposed children are listed in Appendix E.

Relationship of the Problem to the Literature

With the mounting concern of the rising incidence in the population of children who are prenatally exposed to drugs/alcohol, many forms of early intervention are developing. Research concludes that if organic deficits

caused by prenatal drug exposure cannot be remedied, early intervention including the parent/caregivers can be implemented. The term "family center" has been increasingly used to enhance the early intervention to a more family-oriented service (Dunst, Johanson, Trivette & Hamby, 1991).

The gradual evolution of increased family involvement has accelerated with the impact of Public Law 99-457 (providing appropriate education to handicapped children birth to three). "This law defines "early intervention" services as developmental services designed to meet the needs of handicapped infants' or toddlers' developmental, physical, cognitive, language, social, and self-help skills" (Hutinger, 1990, p. 31).

The writer has experienced first hand the results of P.L. 99-457 through an increase in the number of young children referred for enrollment in Pre-Kindergarten Classes of Varying Exceptionalities (VE). These children with special needs are finally able to receive services, become mainstreamed, and avoid isolation. For the most part, parents have appeared more willing to take advantage of the services and assistance provided. However, some parents were unaware of local services and agencies that assist developmentally delayed or prenatally substance-exposed children.

Because of parents often lacking critical information, the identification processes and services for families of

handicapped children must proceed swiftly. "Section 676 of the Act (P.L. 99-457) requires timely, comprehensive, and multi-disciplinary evaluation of the functioning of each handicapped infant and toddler and the needs of the family must be performed in order to appropriately assist in the development of the child" (Garland & Linder, 1990, p. 30). "Networking is necessary among agencies to meet the complex service needs of children and families and to build stronger bases of advocacy" (Garland & Linder, 1990, p. 9). New approaches in the writer's work setting involved and utilized teams of therapists to meet the developmental needs of the client. These approaches accelerated the pace of needed services at appropriate developmental stages. Multidisciplinary teams can assess and implement overlapping skills to reinforce better the intervention and development of the child. Even so, parents/caregivers of clients were often still unaware of available health/support agencies.

Screening of children referred from various outside agencies must be gathered, diagnosed, and studied to identify needy children and families (Hutinger, 1990; Rosenberg, Robinson, Finkler & Rose, 1987). The screening policy currently used by the Infant Development Team of Instructors involved gathering the client's history in a brief interview with parent/caregiver and a Denver Development Screening of the child, if the situation permitted. Screening is the most comprehensive way to get

the most information in the least amount of time (personal communication, October 18, 1991, A. Brigance). The assessment procedure is more formal. Necessary paperwork must be signed and documented before a more formal assessment instrument, the Hawaii Early Learning Profile (HELP), was conducted. In essence, screening was the attempt to determine if the referral and developmental delay would qualify for the program and warrant follow up procedure with assessment. "Screening, the broad initial testing of a child, should take a minimum of time and should not provide assessment information" (Hutinger, 1990, p. 38).

Once the formal intake information, pertinent documents, and signatures have been completed the substance exposed child officially enters the Infant Development Program. This is the point where the system needs strengthening. The instructors do not have time to address the current intervention strategies and techniques/skills to work with the parent/caregiver of substance-exposed infants to three year olds. These skills could both assist the instructors with appropriate parenting skills to improve the developmental stages of the infant. Thousands of cocaine babies are born each year. It may take months or even years for the child to be developmentally age appropriate. Some exposed children may never fully recover from the damage inflicted on their prenatal bodies. "Many medical

physicians think cocaine babies will continue to have problems when they enter school" (Shulman, 1991, p. 42).

A number of program models and philosophies have emerged around the United States. The Northwestern Program in Chicago developed and utilized an early intervention model claiming 40% success providing medical care, nutritional counseling, and training in present skills. The mother are identified prenatally, and, once the infants are born, they stay with the program. Approximately 80% of the parents remained involved during the first year, and but then the figures dropped to 50% during the second year (Schneider, Griffith, Chasnoff, 1989). After birth, babies communicate with their primary caregiver. Newborns affected by cocaine are unable to respond physiologically to the caregiver. When compared with non-exposed infants, drug-exposed newborns exhibit tendencies of "depressed interactive abilities," they are easily disturbed, difficult to comfort, and unable to give any positive feedback to the caregiver (Schneider, Griffith & Chasnoff, 1989).

Effects of substance exposure on children are still uncertain. It is too early to know whether the behavioral effects identified in cocaine-exposed newborns will actually continue into early, later childhood, or even adult life (see Appendix F). Only a few longitudinal studies with large population samples have been completed, and more are

definitely needed to comprehend the effects of prenatal exposure (Cook, Peterson, Moore, 1990).

The writer had a lengthy interview with M.C. Teixeira, C.E. Calloway, and D. Bryant (personal communication, September 20, 1991) from Operation PAR (Parental Awareness and Responsibility) in Pinellas County. The writer controlled the conversation by asking many questions related to effective communications between the instructor, parent/caregiver, and the child. The major point made by M. Teixeira was that the substance-using mother and infant should stay together.

The facility was conveniently spread over locations throughout the county. The second stop was an arranged tour of the developmental room for infants through three year olds. The mothers lived in a detached dorm-like housing and kept the babies through three year olds at night. The writer felt that Operation PAR Program, modeled the procedures from the Los Angeles Unified School District PED (Prenatally Exposed to Drugs) Program with some modification.

A difficult aspect of implementing a program is to involve and train parents/caregivers. Although the alcohol/drug-exposed child is the client, the parents' interactive behavior is crucial for success. The parents actually become the client (McDade & Varnedoe, 1987). Stress and strains of life may not be directly created by

the infant but may prevent the parents from providing the infants with the care they need and deserve. If parents are having trouble being involved with the baby, a family situation could be the problem (Greenspan & Greenspan, 1989). Historically, the involvement of the parent has been perceived as an expected universal characteristic. However, with changing family living patterns, a growing variety of models are emerging: transactional model, family life cycle model, ABCX model, and family systems (Robinson, Rosenberg, Beckman, 1990).

"Babies born to women who used drugs during pregnancy are at increased risk for child abuse and neglect" (Vodenicker & Cashell, 1991, p. 2). Vodenicker and Cashell cite the "types of families of substance abuse" in their family relationships and psychodynamics. Each type of relationship has a parental reaction and a subsequent effect on the infant through three year old. The characteristic categories are as follow: confused, inconsistent, denial, vicarious, symbiotic, overprotective, overpermissive, rigid, disinterested, neglectful, fragmented, and rejectful. These families of the substance abusers live to extremes of either being ignored or overprotected with their substance-exposed offspring (Vodenicker & Cashell, 1991).

With all the varying treatment these substance-exposed infants and children receive in the home environment, it is a wonder that any bonding can take place. When these

categories of family dynamics are more fully understood, perhaps the Infant Development Instructors will be able to work toward more effective communication and thereby increase parent/child relationships. The children prenatally exposed to cocaine face problems, including neurological damage, that can promote developmental and learning disorders. Most young toddlers exhibit short attention spans and frequent temper tantrums. Additionally, these children often have difficulty with certain speech sounds, poor motor skills, unpredictable mood swings, poor immune systems, hyperactivity, difficulty concentrating, extreme problems working with their peers, a lack of empathy with the feelings of other children (including pain), unresponsiveness to praise, and seemingly emotionally starvation, and exhibitions of inappropriate affection (Spires, 1990).

The issue of the alcohol/drug-exposed infant is increasingly evident. While monitoring skill acquisition in the area of language, social emotional, cognitive, and motor development is necessary, these areas are not necessarily the single or most adequate assessment of the child's progress. Trained observation and the use of peers, parents, and caregivers can provide valuable information to assess problems. There is no one correct screening test/assessment or intervention appropriately applicable to all substance-exposed infants. Instructors need to solicit

and encourage parental/caregiver involvement to better structure and enhance a total model for improving effective communication.

A phone conversation with S. Adubato (personal communication, September 3, 1991), director of Project Boarder and Abandoned Babies: Intervention, Education and Support Services (B.A.B.I.E.S.) in New Jersey, was extremely interesting. Part of the project was to provide on-site training in infant care for parent/caregivers of the at-risk infants. Her program assisted families with topics such as appropriate infant development, stress management techniques, and separation, and loss of skills.

While attending the Florida Federation Council for Exceptional Children (FFCEC), the writer attended a session with D. Vodenicker and J. Cashell, entitled "Dealing with Children: The Product of Cocaine/Substance Abuse." The speakers stressed how desperately these women with substance-exposed children need services like WIC (Women, Infant and Children) and AFDC (Aide for Dependent Children), but they either have difficulty accessing the service or are not trusting of the service for fear the child will be taken away. Also mentioned were the facts that these women display poor coping skills, need affection, feel powerless, have difficulty controlling their lives, and have a poor self-esteem. These handicaps are often carried over to their young children. This is evidenced by the fact that

they often lack bonding skills, nurturing skills and establish no boundaries with their children (Vodenicker & Cashell, 1991).

A letter from Judith C. Burnison, the Executive Director of the National Association for Perinatal Addiction Research and Education (NAPARE), discussed issues on prenatal substance exposure presented at the Testimony to the U.S. House of Representatives Select Committee on Narcotics Abuse and Control, July, 1991. A six-year, longitudinal study by NAPARE of three hundred children prenatally exposed to illicit drugs found that almost all of the children tested within the normal range cognitively. The infants exhibited symptoms of neuro-behavioral deficiencies. Some seemed to outgrow this handicap by the age of three or four. They could be taught and learn to achieve normal levels of social, emotional, and intellectual development. One-third or more of this group exhibited degrees of varying severity of attention span and language development. However, less than five percent were true cases of attention deficient disorder with hyperactivity (ADHD). These children appeared to have a low tolerance for frustration as well as stimulation. They might react by losing control or simply withdrawing from the situation. If the infant left the hospital to face an environment that exacerbated rather than alleviated problems, failure to thrive was eminent. The mother needed counseling or the

early life of the child faced poor nutrition, little medical care, and possible abuse and/or neglect. Often the exposed infants were sent to foster or shelter homes where the caretakers might not have had the adequate training to meet the special needs of the baby. Bonding might not ever occur as these frail infants were passed from home to home. Learning could be a barrier to the child because of unsettled lifestyle and assorted caregivers. Not only the population of exposed children needed assistance and training, but also the families/caregivers (Burnison, 1991).

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

This practicum was initiated as an interest that developed from attending conferences and working on committees of the local County Task Force on Substance Abused Children. Though still involved with the County Exceptional Student Education (ESE), the writer requested employment as a consultant with the local Infant Development Program. Assessing the needs of the six Infant Development Instructors and the program manager has helped focus this practicum. The goal of this practicum was to facilitate a more positive, appropriate parent/caregiver and child interaction involving more effective communication between the parent/caregiver and the liaison Infant Development Instructors during home visitation.

Behavioral Objectives

The following specific objectives were projected for this practicum:

1. A one level increase in appropriate behavior between parent and substance-exposed child is anticipated. With the current updated information the Infant Development Instructors will share with the parent/caregiver, the rating will be observed as well as measured using the parent-child early relational assessments entitled Parent/Caregiver Involvement Scale (Farran, 1986) selected from the Assessments of Infants: A Guide for Early Intervention Professionals (Gibbs & Teti, 1990).
2. A second anticipated outcome will be an increase of 75% in the use of pertinent health/support services to assist the parent/caregiver as well as the child. The writer will prepare an agency referral program guide for the Infant Development Instructors to hand out and review monthly with the parent/caregiver. The writer will measure the caregiver orally and informally with a pre- and post-questionnaire on present knowledge and use of local health/ support services.
3. There will be a 50% increase in positive attitude of the instructors toward the Infant Development

Program demonstrated by the comparison of the pre- and post-attitude survey scale (adapted by T.H. Estes, 1979) due to an improvement in overall techniques assimilated from research and shared at bi-monthly staff meetings. Current research on intervention, screening, and homebase visitation protocol will be addressed. Two speakers from another county, (a Parent Specialist and Pre-K Staffing Handicap Specialist) will be scheduled to address the instructors and perhaps the County Substance Abused Children's Task Force.

4. There will be an increase in attendance of the parent/caregiver support/build self-esteem group that will meet monthly in neighborhood church and school facilities. Special programs will be featured and clothing, toys, and prizes given. Child care will be furnished free to the substance-exposed infant in the program and any other siblings attending the meeting.

Measurement of Objectives

The measurement of the objective to increase appropriate behavior between parent/caregiver and the substance exposed child was obtained from a reliable and valid Interdisciplinary Assessment selected from the

Assessment of Infants, A Guide for Early Intervention (Gibbs & Teti, 1990). Letters were sent to four author/designers and publishers of the instrument. The assessment began every family of the twenty-three substance-exposed children at the beginning of the implementation and again seven to eight months later. Observations at midpoint (month four) were reviewed. The dyad was anticipated to improve one level in each domain of behaviors measured.

Another measurement created by the writer was used to show pre- and post-increase of health/support agency services by 75% (Appendix G). This measurement will be responded to orally by the parent/caregiver's answering the questions about knowledge and use of agencies posed by the Infant Development Instructor and/or the writer.

An adapted attitude survey scale created by Thomas H. Estes, 1979 was projected to show a 50% improvement with the Infant Development Instructors toward their job proficiency. This was measured and compared with the instructors' attitude survey completed in September. The improvement increased through the assistance of requested current research on interventions, and organization of handouts for caregivers lectures by experienced parent specialists from other counties.

The writer began a support group for caregivers of the substance-exposed children in the Infant Development Program. The monthly meetings were held in church or school

facilities in the area where many of the parent/caregivers reside. The writer planned to get the "grassroots" support and had cooperation from the neighborhood minister. The group was under no pressure from lectures regarding their prenatally substance-exposed child. One measure of success was judged by the increase in monthly attendance.

CHAPTER IV

SOLUTION STRATEGIES

Discussion and Evaluation of Possible Solutions

The problem was a need to provide the parent/caregiver with appropriate techniques and strategies (by the interaction with the Infant Development Instructor) to assist parent/caregiver with more effective communication and nurturing skills for their substance-exposed child, birth through three years. A number of potential solutions were synthesized from a variety of literary sources and personal contacts.

Substance-exposed births have been recorded for a number of years; however, only since 1988 have medical doctors as well as educators been involved with the treatment, study, and tracking. Because of the newness of the field, many intervention ideas have not yet been published. The Los Angeles Unified School District PED Program, as well as Operation PAR in the State of Florida, has been involved with teaching and nurturing interventions for several years. Research has been gleaned from

additional sources as well. A series of task force and drug-exposed children's committees are forming all over the State of Florida in response to the increase in number of births and prediction of eventual entrance into the public school system.

Dr. Zuckerman of Boston City Hospital stated that "Only the most intensive care after birth will give these babies a chance, but many won't receive it" (Toufexis, 1991, p.57). Supporting Dr. Zuckerman's theory, Drs. Greenspan and Greenspan (1989) strongly believe that by creating a supportive environment these drug-exposed children will have a chance. The following is a list of Greenspan's suggested solutions (Greenspan & Greenspan, 1989).

1. Admire your child's new abilities.
2. Be a good follower.
3. Bring your child back to organized behavior after being disorganized.
4. Help your child expand the complexity of his play.
5. Recognize your child's need for balance between independence and security.
6. Stay emotionally involved and available when you set limits (p. 43).

Greenspan discussed reciprocal interactions and how mothers must feel/know their babies and respond to their reactions. If a baby became hyperactive, the caregiver should begin rocking and soothing. Passive infants, like so

many substance-exposed children, appeared more listless and needed gentle, encouraging, and supportive environments. Greenspan suggested integrating in all emotional areas utilizing all senses (Greenspan & Greenspan, 1989).

Parents/caregivers needed strategies to be taught by the Infant Development Instructors to reduce stimuli and help with appropriate self-organization for the child. Using masking tape to teach the children boundaries as a form of organizing is effective (Los Angeles School District, PED Program, 1989). These young children would be taught a well defined series of steps. If the young children appeared to exhibit problems in the social skills area, there would be an intervention to teach the following: being aware, being appropriate, making contact, and maintaining a positive self-concept.

LaDawn Wester, a preschool teacher, believed the children of cocaine needed consistency in structure and lots of love. He felt that structure was important and any type of change was reflected in their behaviors. These youngsters were constantly sick with colds and intestinal infections, tired very easily, and exhibited weak immune systems. Other problems included diagnosed neurological damage that caused developmental and/or learning disorders. Some prenatally substance-exposed infants were hyperactive and often had temper tantrums, language problems as well as short attention spans (Spires, 1990).

According to Garland and Linder (1990), "An effective program model depends on administration providing leadership in the following areas: (1) building an early intervention team; (2) creating an environment that supports families as members of the team; (3) setting goals in collaboration with that team; and, (4) communicating goals -- to those who can effect their accomplishment" (p. 26).

The Infant Development Team certainly qualified both Garland and Linder's criteria for an effective, early intervention program. The Infant Development Program could further be enhanced with updated research and other program model ideas. Another issue to prevent Infant Development Instructors from burn out was to have regular meetings, with the team sharing experiences, feelings, goals, and ideas as well as difficulties and successes of home visits (Arnn & Kelsey, 1989).

The writer developed suggestions for home visitation (see Appendix H). Home visitation services can be extremely effective in promoting the health and development of young children; however, funding is expensive (Chamberlain, 1989, as cited in Black, 1991).

Description and Justification of Solutions Selected

Mavrogenes (1990) found that in order to secure effective parent involvement, parent training education

(e.g.: Infant Development Instructors) must present appropriate interventions that relay firm expectations, support, and incentives to the parent/caregiver. Many authorities in the field of early childhood believed that behavior learning and developmental problems exhibited in young children can be deterred if parents were assisted in providing adequate food, safety, and awareness for appropriate development (Poulsen, 1990). Future implications for intervention would evaluate model programs. Included in these programs and strategies was concern for what would benefit the families as well as the children (Fowler, Schwartz & Atwater, 1991).

"Prenatal drug exposure is a community public school district's need to establish a multidisciplinary committee/task force with community participation and support" (Delapenta, 1991, p.11). Strong parent involvement programs and health services programs need to be established. Initial in-service or consultant training may be necessary to maximize effective programs. Birth through two years of age may not have intervention services available to them, but this age group is one where a significant difference can be made (Delapenta, 1991).

Educators and Infant Development Instructors need to understand that "Depression is the most common reason for parental withdrawal and depression can cause a parent to be emotionally unavailable and treat the baby in a mechanical

way and then the infant is emotionally undernourished" (Greenspan & Greenspan, 1985, p.32). "Common parental fears include hurting the new baby, fear of inadequacy, fear of losing independence, fear of being controlled, and fear of sexual feelings" (Greenspan & Greenspan, 1985, p.34). During the period of time between two and seven months, the infants need to form an attachment with a primary caregiver and thrive in a supportive environment (Greenspan & Greenspan, 1985).

A. S. Clewet (1988) contended that typical discipline problems with substance-exposed children required guidance as a possible solution. The young children exhibited difficulties in the self-organization, and caregivers needed guidance from Infant Development Instructors. Redirected techniques should be implemented when the infants flitted from one thing to another, never really focused, had difficulty concentrating or attending to task, did not comprehend the purpose of an activity, exhibited very inconsistent behavior, left a "project" unfinished or over done. Appendix I includes a short self-organization category checklist to be completed appropriately by observation of these substance-exposed infants in either a day care setting or with siblings, during independent work/play, small group, and transition (Clewett, 1988).

During an interview, M. C. Teixeira, MPA, CAP, (personal communication, September 20, 1991) explained that

court ordered treatments and interventions for the exposed mother and prenatally exposed infants strengthened the program at Operation PAR (Parental Awareness and Resp nsibility). Perhaps a more official mandate from a local judge would place the mother and exposed baby together with the Infant Development Instructor to learn positive, appropriate interventions to strengthen the dyadic relationship.

S. Adubato (personal communication, September 3, 1991) also mentioned the sharing of resources and support groups for these parent/caregivers. Additionally, these "boarder" babies and their drug-using mothers need to work toward reuniting with appropriate parenting skills. Parent education is an important component of the intervention program for enhancing normal infant development and for ensuring a strong parent-infant bond. Dr. Adubato has a list of infant and parent mental health concerns (Appendix J). Instruction should begin early enough for parents to learn appropriate and effective caregiving in order to avoid the many problems at-risk infants have. (Florida Department of Education Hot Topics, 1990).

A systematic approach is necessary for team building. Teams are made, not born (Tewell, 1983, cited in Jordan, Gallagher, Hutinger & Karnes, 1990). The leadership goal and challenge was obvious: To create and support an environment in which both the professionals (Infant

Development Team) and families participate in setting goals (Jordan, Gallagher, Hutinger & Karnes, 1990). This type of team approach further strengthened the program management.

At the inception of the screening cycle, infant projects do not emerge as fully developed programs. Trust must be established, and community organization (such as the local County Task Force on Substance Abused Children in the writer's community) must be involved. In continuing with the assessment cycle, activities including valid tests and systematic observation must be conducted, usually in the child's home. The main objective is to get the services to the children as soon as possible (Jordan, Gallagher, Hutinger & Karnes, 1990).

The writer communicated directly with the Infant Development Instructional team to enhance the rapport with the parent/caregiver and the client. The child's activity hinged on the skills that the parent developed; however, the participation of each family varies. Emphasis must be placed on the family needs to encourage participation. A simple Infant Development Intake Checklist was created by the writer to facilitate organization (Appendix K).

A selected list of curriculum programs for birth to three year olds appears in Appendix L. Selected assessment instruments in a variety of measurable areas are listed in Appendix M. Included are category assessments for developmental, sensorimotor, parent report, parent-child

interactions, social, language and communication, and medical measures administered by Early Intervention Staff (Jordan, Gallagher, Hutinger & Karnes, 1990).

In servicing these prenatally substance-exposed infants to three year olds, the interest of the client and the age appropriateness of skills were given paramount consideration. The writer and Infant Development Program worked toward the transactional dyadic model in which the behavior of both parent/caregiver and child influenced the behavior of the other. In this type of primary intervention, the adult was assisted on how to observe and interpret the infant's behavior and appropriately respond to the infant's cues (Jordan, Gallagher, Hutinger & Karnes, 1990; Brown, 1991).

Traditionally, family involvement models have been based on the individuals, (e.g. parent counseling) or the dyad (e.g. parent mediated intervoluntary such as behavior management). Programs typically offered services for parents rather than the entire family with the mother as the primary recipient. Families are complex, interdependent systems; however, what happens to one member affects all the others (Karnes & Stayton, 1990). With the effect of Public Law 99-457, the plan for the child, (birth to thirty-six months) was altered from the Individual Education Plan (IEP) to the Individualized Family Service Plan (IFSP) (Baily, Buysee, Edmondson & Smith, 1992).

The writer continued utilizing the Hawaii Early Learning Profile (HELP) model with additional strategies gleaned from the literature as well as personal contact information to work with these infant through three year olds. The writer will share information regarding play interactions, interventions, and strategies using the role of toys in parent/caregiver involvement of prenatally substance-exposed newborns and infants (Table 4).

Table 4

Intervention Strategies and Techniques for Substance Exposed Infants

Newborns

Intervention	Strategy
position body to improve posture; encourage midline orientation position on side	overcome gravity and increased extension tone
hydrotherapy to improve muscle tone, behavioral state, and feeding	rolled up cloth diapers placed between legs and along spine for support swaddle and vertical rock as method for calming
increase weight gain	massage newborn 15 minutes daily, starting with the head and working down the entire body
assist oral hypersensitivity	gentle but firm tactile stimulation of the face will improve feeding
reduce oversensitivity	observe signs of yawning, sneezing, hiccuping, gazing, aversion, spitting up, color change, and crying

(table continues)

Intervention	Strategy
avoid stressful input	speak softly and rhythmatically hold infant in a vertical position facing away from parent/caregiver
decrease facial and oral hypersensitivity	tactile stimulation to facial and oral areas
improve parent handling	observe Brazelton's Model for appropriate behavior demonstration and return demonstration of appropriate handling

Infancy

Intervention	Strategy
improve movement patterns to enhance interaction and exploration	supine flexion with lower extremity rotation prevent extensor thrusting in sitting and standing
decrease extensor tone	discourage supported standing discourage use of jumpers and walkers carry in flexed position slow, gentle movement through space
increase antigravity strength	prone positioning pivoting in prone position sitting with support for short periods
improve parent handling	demonstrations and return demonstrations of appropriate play and carrying positions and handling techniques
increase pelvic mobility	lift pelvis up and flex legs towards the chest
keep infant soothed	dim all lights
improve upper extremity tone	allow arms to reach out to grasp object

(table continues)

Intervention	Strategy
sit as appropriate developmental activity (5 mo.)	not placing the infant in the sitting position for long periods of time, avoid jumpers
supported standing enjoyed by cocaine-exposed infants	use the abundance of extensor tone not encouraged too long a period, avoid walkers

(Schneider, Griffith, Chasnoff, 1989, p. 74-84; Whitlow, 1989)

Greenspan (1980), cited in Brown & Gottfried (1985), has identified four negative patterns in effective communication between infant and caregiver: "(1) developmentally and affectively retarded (showing lack of social responsiveness, emotional bonding, and inattentiveness to the environment); (2) depressed (showing inhibition, withdrawal, aimless quality of play, and sad and depressed facial expressions); (3) ambivalent (showing sudden shifts from engagement and pleasure to withdrawal and anger); (4) angry (showing active, disorganized play and low frustration tolerance, with frequent outbursts of anger)" p. 109.

"Several recent prospective studies with nonclinical populations of infants suggest that emotional incompetence in infancy may be predictive of later maladaption (Sroufe, Fox & Pancake, 1983; in Brown and Gottfried, 1986). The parent-child interaction and social-emotional development is emerging into: (1) play and attachment; (2) social

competence; (3) emerging skills; (4) promoting positive affect; (5) fun, attachment, and sociability, and; (6) affective regulation as a risk marker (Beckwith, 1984, cited in Brown and Gottfried, 1985).

Social play promotes secure attachment, pleasure in tasks, and sociability with others. Persuasive evidence exists that deviant parent-intake dyads, such as biologically at-risk infants and maltreated infants, differ markedly from normal dyads in their enjoyment and play with each other (Egeland, Sroufe & Erickson, 1983; Schneider, Rosen & Cicchetti, 1984, cited in Brown & Gottfried, 1985).

The Infant Development Instructors were reassured of the importance of selecting age-appropriate toys. Adults (as well as child-development specialists) rated the safety of toys followed by teaching a new skill most important. Durability, flexibility, attractiveness, and ability to hold a child's attention followed in rank importance (Fallon & Harris, 1989).

Additional model programs that could be applicable and introduced into the Infant Development Program are listed as follows:

1. Development Education -- Birth through Two (DEBT Project)
2. Supporting Extended Family Members (SEFAM)
3. Early Childhood Day Care Model Project
4. Tuesday's Child

5. Adolescent-Infant Development Program
6. Project Linking Infants in Need with Comprehensive Services (LINCS)
7. Macomb 0-3 Rural Project
8. Multi-Agency Project for Preschoolers (0-5) (MAPPS)
9. The Coping Project (Children's Optimal Progress in Neurodevelopmental Growth)
10. The Family Day Care Project

For substance-exposed children age 18 months to three years, a Self-Organization Checklist adapted from ERIN would be more appropriate (Appendix I). Additionally, strategies are needed to assist prenatally-exposed children with adjustment to day care or preschool (Appendix N) (Jordan, Gallagher, Hutinger & Karnes, 1990).

Since the passing of P.L. 99-457 in 1986 and the development of the Individualized Family Service Plan (IFSP) the intention of legislation has been to work with the disabled children and their families. This plan will be incorporated to include the parent/caregiver. Turnball and Turnball (1982) feel the early childhood special education programs shared common program ideas: "1. The parents and the child should be part of process from which they are so often removed in a shared decision making. 2. Parent participation should increase the appropriateness of educational services. 3. Parents should receive counseling

and training to prepare them to be part of the child's education at home" (p. 116).

Three models of Early Intervention were researched: Multidisciplinary, Interdisciplinary and Transdisciplinary. The Infant Development Program used a synthesis of each early intervention strategy. Primarily, the writer concentrated on the transdisciplinary model:

Assessment -- the team members (Instructors) and family of substance the exposed child conduct a comprehensive assessment together. Parent Participation -- parents were encouraged to be an active part of the Infant Development Team. Service Plan Development -- both Infant Development Instructors and parent/caregiver developed a service plan based on the family priorities, needs, and resources. Service Plan Responsibility -- the responsibilities of the Infant Development Instructors are to provide, assign, and implement the plan. Lines of Communication -- regular Infant Development Team meetings were held with ongoing transfer of information, knowledge, and skills shared by Instructors and outside speakers. Guiding Philosophy -- Infant Development Instructors were committed to teach and work together across discipline boundaries to implement a unified, comprehensive plan to serve these infants through three year olds. Staff Development -- this integral component was conducted by

the Infant Development Manager with collaboration from the writer. (Woodruff, G. & Hanson, C., 1987, as cited in Jordan, Gallagher, Hutinger & Karnes, 1990, p. 66).

The Office of Special Education and Rehabilitative Services (OSPRS) funded a demonstration project for high-risk infants, including those prenatally exposed to drugs. The results of this early intervention project illustrated effectiveness by (1) being family centered, (the most effective early intervention programs did not focus solely on the child but address the entire family unit); (2) programs including children prenatally exposed to drugs improved outcomes when utilizing social community services available in the area/community; and, (3) the service provider (Infant Development Instructors) needed to collaborate with trained multidisciplinary teams (Devila, 1991) (e.g. members of local Task Force on Substance Abused Children). These were the steps the writer pursued during implementation.

The process was to encourage interdependence between community and family. A progressive program model should have several types of help-giver roles: empathetic listeners, teachers, therapists, consultants, resource enablers, mobilizers, mediators, and advocates (Fletcher & Deal, 1991).

Report of Action Taken

The actual implementation of the practicum followed the calendar plan presented in the proposal for the eight-month period (November 30, 1991, through July 15, 1992). With full knowledge and permission of the Infant Development Manager and the Director of the facility, the implementation began. The attitude survey conducted by the writer and completed by the six instructors was evaluated (Appendix C). The writer concluded from the results that three questions in particular took priority (the results were marked "strongly agreed"). Six instructors rated parent/caregiver non-compliant, uncooperative in keeping appointments (see #5, Appendix C). Five of the six instructors "strongly agreed" that parent/caregiver training would benefit the intervention process. The final question, which all six instructors strongly agreed upon, was the need for a coordinated list of appropriate health/support services to distribute to the parent/caregivers of the clients.

The first month of the implementation included researching and reporting current literature on prenatally-exposed infants and young children to the Infant Development Team. Part of the writer's implementation included a synthesis of pertinent current articles, handouts, or video tapes presented during the Infant Development Staff meeting. The writer critiqued current articles related to infant

development and drug/alcohol-exposed infants, designed and passed out handouts or showed relevant videos. The month was also spent visiting some of the twenty-three substance exposed children and caregivers in the program involved in the writer's practicum implementation.

During the second month, the writer provided information to the instructors and screened all of the children that entered the shelter home for abused children or those referred there by HRS Developmental Services, Child Find, local Health Department, or a physician. Many of these young children qualified for the program, but the prenatally substance-exposed children from the shelter were not included in the study as they had no permanent or consistent caregiver. These children were often sent to foster homes or returned to their families. The length of time the children spent in the shelter ranged from days to months.

An interesting occurrence happened at the shelter home. Local news has been filled with discussion of the twin babies born HIV positive. Apparently, sometime between fifteen and eighteen months, the antibodies of the mother are taken over by the child's. One twin was dying from the disease while the other twin tested negative and was thriving. Somehow the healthier boy was transferred to the shelter where the writer often screened children. Noted in the writer's log were comments related to the screening of

the HIV negative twin who appeared to show no significant signs of developmental delays.

During the second month, handouts with current early intervention strategies were passed out to assist the instructors working with exposed children. All but one instructor had substance-exposed children in their caseloads. With the assistance of the program Manager and with suggestions from the instructors, the writer developed a survey of all appropriate service/support agencies in the area that could assist this clientele. While visiting the various homes where the children resided, the writer or instructor orally questioned the caregivers asking if the family had knowledge of the various agencies and if these services were used (Appendix G). Compliancy scores were totaled for the month of October through January. Generally speaking, many of the clients had heard of the agencies but were not aware of what the function of the agency was nor how to access them.

The writer researched and found a suitable assessment for parent/caregiver and child involvement. This program, entitled Parent/Caregiver Involvement Scale Workbook, with accompanying text and video, was written by Farren (1986). After a telephone conversation with Farran, the writer was pleased to learn the instrument was appropriate for the substance-exposed dyad and preceded with plans to implement the assessment.

During this month, the writer organized a support group called SPOKE, an acronym for Support for Parents of Kids Exposed. This support group was formed to meet the objective of improved parent/caregiver and child relationship/interaction. The purposes of the group were to build self-esteem among the caregivers and focus on the positive rather than the negative aspects of prenatally substance-exposed children. Flyers were designed and mailed to the caregivers. The meetings were held in two areas for the convenience of the families. A church outreach facility in the neighborhood where many of the families resided was chosen and set up for the first Tuesday and Thursday of each month (see Appendicies Q and R). Noted in the log was the fact that many letters of invitation were returned because the Infant Development Office had a record of only street addresses. The mail in that area was not delivered to the home, only at the local post office box. The writer made long distance calls to each family having a telephone and requested their post office box address. The notices were then remailed. The writer was pleased to have articles published about S.P.O.K.E. in four local newspapers. Each month, the writer submitted information concerning speakers/presenters for the upcoming meetings. This information along with the intention of the support group was printed.

The third month of implementation saw the support group, S.P.O.K.E., come to fruition with the first meeting. At both locations, the writer invited an ex-crack addict and her job training coach to attend. The now-rehabilitated drug using woman told her story of being incarcerated and losing her baby. This story was all too familiar to those in attendance. The speaker's struggle to regain custody of her child was filled with courage. Most in attendance were curious about how she secured a job. The job training coach was able to answer their questions and refer them to appropriate similar agencies. After refreshments and a descriptive poster session, the caregivers were given bags to fill with toys and clothing donated for their children.

The meeting at the second location followed the same format. Fortunately, the writer provided child care as one grandmother arrived with her substance-exposed grandchild along with sixteen more children (all related). Unfortunately, the writer received a phone call saying that there were complaints about the noise the children made (although they were outside for the most part) from other tenants of the building. The owner refused to permit the group to meet at that facility again. The writer made numerous attempts for relocating the meeting cite. Finally, a local program produced a teacher's lounge facility for the future meetings. The writer secured the room by signing a contract from the local Board of Education.

The writer observed and recorded interaction with a variety of substance-exposed infants through three year olds and their parent/caregiver.

Strategies for working with Young Children Prenatally Exposed to Drugs were distributed to the instructors at the staff meeting. The writer discussed Fenichal & Eggbern's (1990) training element number three (recorded initial interaction for facilitating treatment of goals, IED's). This element involved community-based service programs and instruction that improved program effectiveness.

Month four continued with sharing with the instructors current research and updated video presentations on early interventions as previewed by the writer and selected from Florida Diagnostic Learning Resource (FDLRS). A conference presentation on substance-exposed children was organized by the writer. A small grant request was applied for to Children's Service Council (CSC) to cover the fees for the out-of-town speakers. This presentation was planned for members of the County Task Force on Substance Abused Children, pre- K special educators as well as the staff from one elementary school. One of the monthly meeting with the Infant Development Instructors discussed positive and negative concerns regarding interventions with parent/caregiver and child. This month the S.P.O.K.E. group featured consultants from Mary Kay Cosmetics. The writer

achieved the goal of making each member feel good and worked on improved self-esteem.

The fifth month of implementation followed a similar pattern from the previous month. The writer met with the Infant Development Instructors and discussed the completed surveys regarding parent/caregiver knowledge of health/support agencies. The writer compiled and distributed additional Agency Referral Guides (Appendix O) and Summary of Referral Agencies (Appendix P) to be used by both the Instructors and caregiver. Compliancy scores were tallied by the Program Coordinator (January through April).

S.P.O.K.E. met with a noted increase in attendance. The speaker was from Operation Crime Stop and shared helpful advice on how not to be victimized. One group location has several spanish speaking members. The speaker was bi-lingual and able to address the entire group. The group at the second location was very interested in personal safety and crime prevention. As the meeting closed two ladies in attendance asked the date of the next meeting. The writer observed camaraderie among the group. This group consisted of mothers and grandmothers of the prenatally substance exposed child. Noted in the writer's log was every family brought their exposed infant - three year old with them along with other siblings and cousins.

During the fifth month, the writer presented for approval information concerning request for funding for the

presentation on Substance Exposed Children to the Children's Service Council (CSC) Board for approval. The Board unanimously approved the request, and the interagency program was publicized county-wide by the writer (See Appendix R).

The writer screened seven prenatally drug-exposed infants referred to the Infant Development Program by the local health department. A set of twins and two other babies were under six weeks of age. The three remaining babies were under six months of age. All seven babies were healthy; however, bonding appeared difficult as observed by the writer and expressed by the caregivers. These infants were immediately placed on the waiting list.

The writer continued with the bi-monthly in service staff development program. The flyers (Appendix R) regarding the presentation on Techniques, Management, and Activities for enhancing the quality of education for substance-exposed children entering the school system were mailed during the sixth month. The writer received many responses for meeting attendance as well as written confirmation from the director of CSC.

S.P.O.K.E. met again this month in both locations. The speaker discussed self esteem, played music, and distributed hand outs. The writer and volunteer assisted with the nineteen children (including three-month old twins) accompanying the adults to the meeting. The caregivers were

most appreciative of the donated toys and clothing. One mother stayed late and expressed her feelings about wanting to move out of the drug/crime neighborhood. She was waiting for her Aide for Dependent Children (AFDC) caseworker to complete the necessary paperwork. Unfortunately, the speaker was unavailable for the next S.P.O.K.E. meeting at the second location. The writer decided to use the portable video/monitor and show the new video on the Infant Development Program as well as several videos from FDLRS on nurturing and cuddling young children. There were several Spanish speaking caregivers who enjoyed the visual presentations.

During the seventh month of presentation, the writer assisted the instructor who worked with pregnant teenagers and mothers. Although the girls appeared to be drug free, some admitted to using alcohol and cocaine. The writer discussed the harm of using any drug during pregnancy. Many questions followed. The young mothers were working on parenting skills. The instructor used the medium of music and movement activities to facilitate development and involvement with their children.

The presentation concerning substance-exposed children was well attended. The planned meeting room was moved to another facility to accommodate the larger group. The school superintendent requested video taping the seminar. The writer followed through by contacting a media

specialist. Those attending this session included members of the local Task Force on Substance Abused Children, pre-K special educators, elementary school teachers, principals, social workers, nurses, and physicians.

S.P.O.K.E. had its final meetings the month of July. The writer used video tape about the Infant Development Program as well as a child caring presentation from FDLRS. Those in attendance expressed a desire to resume the support group in the fall. The second location meeting of S.P.O.K.E. featured the coordinator of Project LIFT (Leading Industry Forward to Tomorrow). The discussion centered on literacy, training, and jobs for tomorrow. Several young mothers were eager to seek employment. This group also expressed a desire to maintain the support group.

The writer researched literature and wrote twenty-five companies, requesting information on screening infants with development delays. Additionally, the writer called the local high schools' service group sponsors to determine if they were interested in collecting appropriate age/developmental toys to put in the "welcome bags" to be distributed to the child/caregiver at the intake meeting.

During the final month of implementation, a post assessment of the Parent/Caregiver Involvement Scale (P/CIS) was administered to all parents/caregivers. The results are compared with the pre-test in Table 5. A follow-up survey concerning accessed health/support services was conducted.

The recorded results appear in Table 6. The attitude survey was again administered to all instructors and compared with the initial survey. The results are recorded in Figure 2.

The writer wrote various companies, requesting samples/coupons of baby products (shampoo, diapers, etc.) to place in the welcome bag.

The writer arranged a luncheon to include the entire Infant Development Department. At that time, results of the Attitude Survey Scale of Assessment and Intervention of the Infant Development Program and the Practicum in general were shared and recommendations were made.

CHAPTER V

RESULTS, DISCUSSION AND RECOMMENDATIONS

Results

The problem that needed improvement was the development of techniques to integrate the prenatal substance-exposed child, the parent/caregiver, and the Infant Development Instructor. The solution strategy began with an attitude measure survey/questionnaire concerning assessment and intervention of the six Infant Development Instructors (See Appendix B). The writer tallied the points and selected the three categories marked "most strongly." Objectives and implementation developed from the analysis of the questionnaire revealed the following major concerns: (1) parents/caregivers were often non-compliant with home visitation; (2) parents'/caregivers' training could benefit the child through an intervention process; (3) a list of coordinated health/support services would assist the parent/caregiver, child, and family.

Objective one projected that there would be an increase of one level in appropriate behavior between

parent/caregiver and substance-exposed child. This objective followed the strong agreement of the instructors that parents/caregivers needed interventions to provide a more appropriate relationship with their substance exposed child. As assessment was selected from Interdisciplinary Assessments of Infants: A Guide for Early Intervention Professionals. The assessment listed in the aforementioned guide, entitled "Parent/Caregiver Involvement Scale," by Farran, was selected and administered as a pre-intervention measurement with every parent/caregiver and child (prenatally drug/alcohol exposed) in the Infant Development Program. These assessments were completed during the first six weeks of implementation. The post intervention scores were collected from observation of interactions between the parent/caregiver and child during the beginning of the eighth month of implementation. The results of the Parent/Caregiver Involvement Scale showed overall increased involvement in the eleven behavior domains of amount, quality, and appropriateness.

Table 5 represents the pre- post-test and increase score of the average of twenty-three caregivers in the designated behavior categories (e.g. physical involvement) in the domain areas of amount of teaching behavior, quality of teaching behavior, and appropriateness of teaching behavior. In the area of amount of teaching behavior for

Table 5

Pre/Post Parent/Caregiver Involvement Scale

Behavior	Domain								
	Amount			Quality			Appropriateness		
	Pre	Post	Increase	Pre	Post	Increase	Pre	Post	Increase
Physical Involvement	3.8	4.1	.3	3.5	3.8	.3	3.5	3.9	.4
Verbal Involvement	3.4	3.9	.5	3.1	3.5	.4	3.1	3.3	.2
Responsiveness of Caregiver to Child	3.8	4.2	.4	3.5	3.5	.0	3.4	3.6	.2
Play Interaction	2.6	3.5	.9	2.5	3.2	.7	2.2	3.2	1.0
Teaching Behavior	2.6	4.1	1.5	2.6	3.8	1.2	2.5	2.9	.4
Control of Child's Activities	2.9	3.3	.4	2.8	3.1	.3	2.8	3.2	.4
Directives-Number of Commands/ Demands made of Child	3.1	3.6	.5	2.7	3.0	.3	2.7	3.2	.5
Relationship among activities in which caregiver was included with child	2.9	3.1	.2	3.0	3.1	.1	2.9	3.2	.3
Positive Statements	3.0	4.1	1.1	3.0	3.9	.9	3.3	4.1	.8
Negative Statements & Discipline	2.8	2.7	-.1	2.5	2.4	-.1	2.6	2.9	.3
Goal Setting	2.1	3.0	.9	2.1	3.1	1.0	2.1	3.4	1.3

the purpose of teaching a particular skill, there was an increase of 1.5 in the post-test level over the pre-test score. The second increase in the amount domain was an improvement in positive statements of 1.1 levels. In the domain of quality, teaching behavior of caregiver to child increased 1.2 levels. The overall quality of goal setting (caregiver's flexibility, ability to adjust self, environment, or child so that success was met with an activity) increased one level. The domain of appropriateness increased one level in play interaction behavior (adapting toys with child's developmental level) and 1.3 levels in reasonableness of adult expectations in goal setting. Two of the eleven behaviors in each of the three domains (amount, quality, and appropriateness) were improved by one or more levels. There was an overall increase in every behavior with the exception of negative statements and disciplines (including discipline, redirecting criticism, threats, hits, and impatience) which decreased by one level in amount and quality (intensity, negative statements). This decrease by nature of the behavior was an improvement in the caregiver's involvement with the child. Therefore, overall improvement of one or more levels was observed in three of the eleven behaviors in both the amount and quality domain and two out of eleven behaviors reflected in the appropriateness domain.

The second objective was to assist caregivers with increased knowledge of appropriate health/support services. This need was reflected in the Attitude Survey of Infant Development Instructors. A list of all appropriate services in the community (e.g. medical assistance, drug treatment, counseling and support, and public assistance) was complied. Each caregiver projected increasing by 75% the use of pertinent health/support services. The writer and/or the instructor orally questioned each caregiver about knowledge and actual use of each agency (Appendix G). Following the parent/caregiver questionnaire, the writer provided a list of phone numbers and addresses of each agency. This list was distributed to each family with a substance exposed child in the Infant Development Program (Appendix O). A second list, Agency Referral Summary (Appendix P), briefly described the function and qualification for each agency.

The instructor used the Agency Referral Summary to answer caregivers' questions about various assistance programs. During the last month of implementation a post-test (Appendix G) was administered. The results showed that more health/support agencies were accessed by the caregiver after implementation of the Agency Referral Lists. The familiarity of services increased due to the fact that caregivers were exposed to the names and specific services offered by the various agencies. Table 6 analyzes the

increased use of individual services offered by the various agencies.

Table 6

Accessed Health/Support Services by Caregivers: Comparison of Pre/Post

	Heard of Program		Use of Program		Increase %	
	Yes	No	Pre	Post		
PUBLIC ASSISTANCE						
SSI	17	6	13	19	6	46
WIC	20	3	17	23	6	35
AFDC	21	2	17	23	6	35
Food Stamps	21	2	15	20	5	33
JTTC	6	17	0	4	4	400
Abuse Registry	17	6	1	4	3	300
Medicaid	20	3	13	15	2	15
Medicaid Taxi	5	18	5	9	4	80
COUNSELING AND SUPPORT						
CHS	1	22	1	5	4	400
ARC	5	18	0	2	2	200
Parent to Parent	7	16	2	7	5	250
Catholic Charities	15	8	1	6	5	500
FDLRS	5	18	0	5	5	500
DEI	1	22	1	3	2	200

(table continues)

	Heard of Program		Use of Program		Increase	
	Yes	No	Pre	Post		
MEDICAL						
CMS	15	8	7	11	4	57
DBS	2	21	0	0	0	0
CCMO	3	20	1	4	3	300
Deaf Services	5	18	0	1	1	100
MMH-OT	5	18	1	3	2	200
MMH-ST	11	12	6	9	3	50
ICHC	7	16	6	7	1	16
MMER	17	6	12	20	8	66
MCPHU	10	13	10	15	5	50
DRUG TREATMENT						
Alpha	2	21	3	7	4	133
New Horizons	3	20	4	7	3	75

Of the twenty-five health/support agencies listed, only one agency, Division of Blind Services, did not increase. There was no need for this service among drug-exposed children or caregivers in the program. Many of the agencies were already accessed; therefore, the increase was not great. However, the following fourteen agencies increased between the projected 75% and 500%: Children's Home Society Play Group, 400%; Association for Retarded Citizens Respite Programs, 200%; Parent to Parent, 250%; Catholic Charities, 500%; Florida Diagnostic Learning Resource Service, 500%; Children's Case Management Organization, 300%; Job Training

(county wide), 300%; Developmental Evaluation and Intervention, 200%; Abuse Registry, 300%; Deaf Services, 100%; Medicaid Taxi, 80%; County Hospital Occupational Therapy, 200%; Alpha, 133%; and New Horizons, 75%. Overall, the type of programs that showed increase were various counceling and support groups geared to the family as well as the child and diagnostic services to assist medical needs and pre-school intervention programs. Another increased area was the drug treatment programs and the use of job training services.

A third objective projected an increase of 50% in positive attitudes of the instructors with regards to assessment and intervention in the Infant Development Program. This increase in qualitative reflection about assessment and intervention was demonstrated by comparison of the pre-post attitude survey scale (adapted by Thomas H. Estes, 1979). The results were analyzed by assigning a number to each response value (A, B, C, D, or E). All the negative statements were represented by a one for A, two for B, three for C, four for D, and five for E. The positive statement responses represented by the opposite: five for A, four for B, three for C, two for D, and one for E. The attitude change toward assessment was noted by subtracting the pre-attitude survey points from the post. The higher the score, the more positive the attitude.

Out of a possible one hundred points, all six of the instructors increased in positive attitude to scores of 62, 75, 89, 65, 76, and 83 (See Figure 2). The pre-test scores reflected a positive attitude. The projected 50% increase was met by two of the six instructors. The two instructors increased pre-scores by fifty-five and fifty-eight percent, respectively. As indicated in Figure 2, all the instructors scored higher on the post-test attitude survey scale scores, reflecting a more positive attitude.

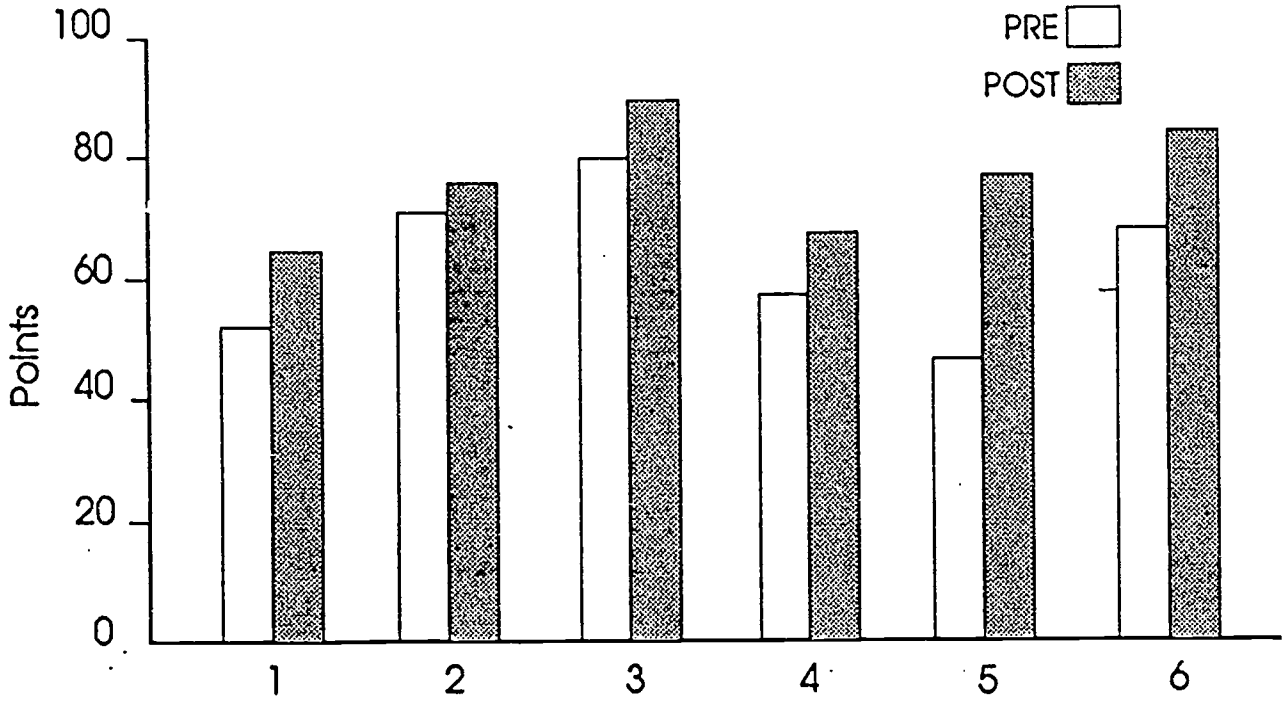

Figure 2: Infant Development Instructor Attitude Survey - Pre/Post Comparison

The fourth objective involved the projection of increased attendance at the S.P.O.K.E. support group. This group met in two locations for a period of six months. Figure 3 reflected the monthly attendance of caregivers, children, and other adults (speaker, child care provider) at Site A. Figure 4 represents the attendance at another location, Site B.

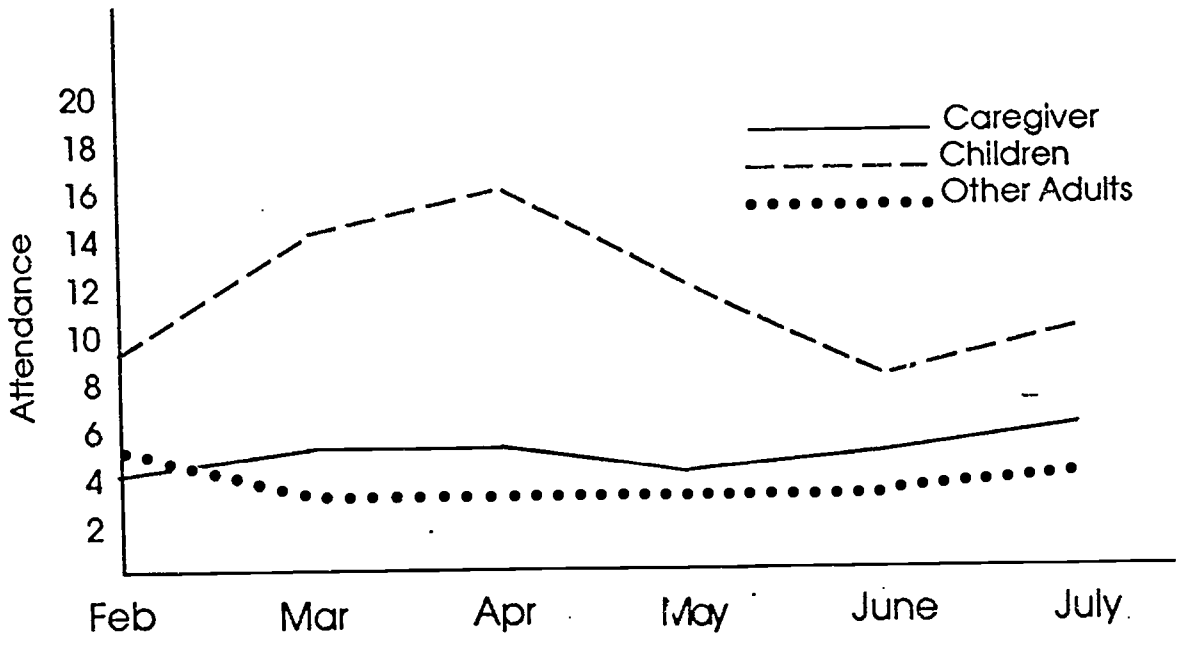

Figure 3 Caregiver, children, and other adult attendance at monthly S.P.O.K.E. meetings - site A.

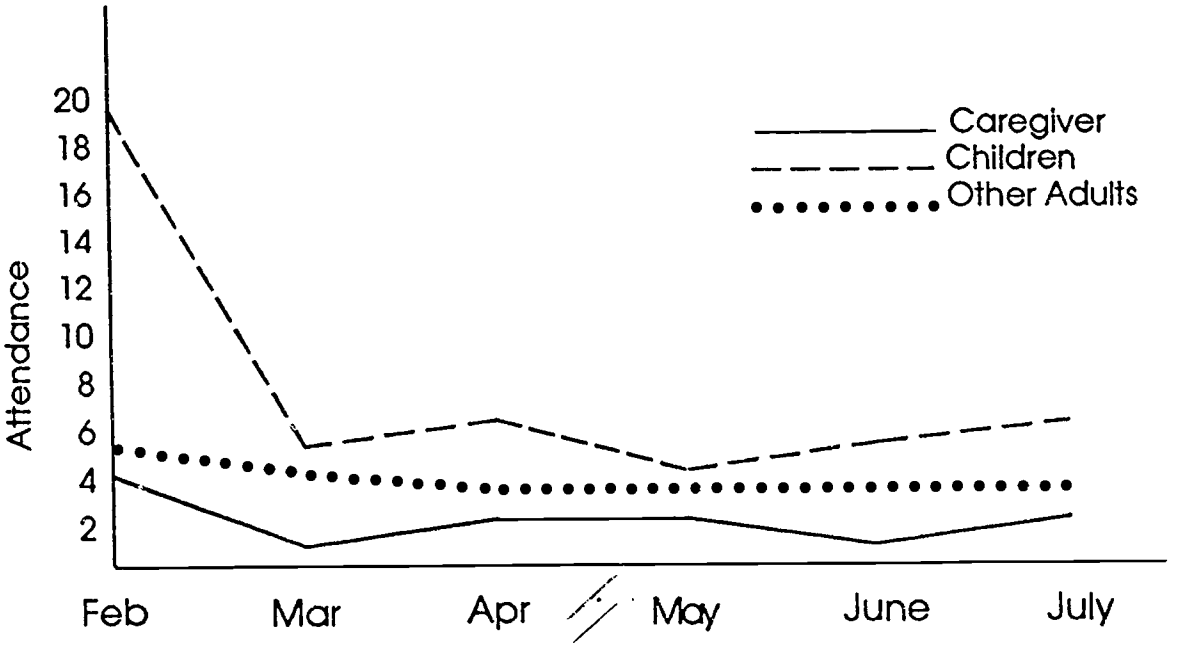

Figure 4 Caregiver, children, and other adult attendance at monthly S.P.O.K.E. meetings - site B.

The writer worked with the Program Coordinator to determine the compliance of the client/caregiver with the Infant Development Instructor at scheduled home visitations. The figures were collected quarterly from July 1, 1991, through July 1, 1992. Reflected in Table 7 was the compliance of the caregivers of the substance-exposed children with the Infant Development Instructor's visitation over a one year period. The instructors maintained consistent routine visitation. Some months reflect varying

amounts of attempted and completed visits. Fifteen of the children are funded under CSC (Children's Services Council) and the remainder by HRS Developmental Service. Each agency has regulations concerning the ratio of visitation and attempted number of visits per quarter. A drop of overall visitations was noted during the winter months due to illness of the child and/or vacation. The yearly compliance showed an overall increase from an average of 81% the first quarter (July - October), 87% the second quarter (November - January), 90% the third quarter (February - April) and 88% the final quarter (May - July).

According to Famularo, Kenschorff, Bunshet, Spwek, and Fenton (1989), "Treatment compliance was significantly lowered in those parents presenting with substance abuse" (p.507). Program intervention is best achieved when all professionals concerned with the family have regularly scheduled times to meet (Cole et al, 1989).

Table 7

Compliance of Caregiver with Instructor Visitation

CLIENT	7/1/91-9/30/92		10/1/91-12/31/91		1/1/92-3/31/92		4/1/92-6/30/92	
	Completed	Attempted	Completed	Attempted	Completed	Attempted	Completed	Attempted
1	8	9	11	12	10	12		
2	10	12	15	17	6	6	8	8
3	13	13	12	12	12	12	13	13
4	11	14	12	12	12	13	11	12
5	1	1	9	10	10	12	11	12
6	5	5	7	10	10	12	12	12
7	6	12	10	11	5	5	10	11
8	12	12	10	11	8	8	11	11
9	7	21	10	11	5	8	9	9
10	6	12	6	10	6	11	7	9
11	10	10	9	11	2	2	5	4
12	10	11	5	6	10	11	10	12
13	5	6	10	11	4	4	7	8
14	7	8	10	11	3	3	9	10
15	16	7	10	6	6	8	8	8
16	14	16	11	13	5	6	12	13
17	18	19	13	14	5	6	9	9
18	17	18	10	13	6	6	8	10
19	19	20	11	13	6	6	7	9
20	4	5	10	11	4	4	8	8
21	12	13	10	11	4	5	6	7
22	5	6	11	11	4	4	8	8
23	2	2	8	8	8	10	10	10

Discussion

The results of the Parent/Caregiver Involvement Scale showed increased levels in ten of the eleven behaviors observed. The one behavior that showed a negative increase was actually a reflection of positive involvement as the average scores reflected a decrease in negative statements and discipline. Therefore, all eleven behaviors improved or remained constant in all domains. The amount, quality, and appropriateness of the behaviors showed that parent/caregiver was more actively involved with overall development of their children at the end of implementation. The positive encouragement and modeling by the instructor

has fostered optimal development in the child and more involvement by the parent/caregiver.

The progress of children at risk is enhanced when they are placed in predictable, secure, and stable environments where they can form attachments with nurturing, caring adults (Cole et al, 1989).

The writer implemented Trad's (1992) eight primary emotions (happiness, interest, fear, sadness, soberness, distress, anger, and disgust) when rating the caregiver - infant dyad. The main reason the scores were low overall could be linked to the lack of "previewing" (Trad, 1992). Previewing refers to a wide variety of interpersonal behaviors emanated from the caregiver to acquaint the infant with upcoming development (Trad, 1992). Often the caregivers appeared unfamiliar with the child's new skills and unable to attach any meaning, purpose, or direction.

At an early age, children learn how to organize relationships and behavior. The optimum was to help them develop successful attachments to caregivers, family members, peers, and others to pave a foundation for future competencies (Harreal, McKinney, Quackenbush, 1992).

After the caregivers of the substance-exposed children were informed with handouts and oral discussions about health support services, many caregivers further questioned the instructors who responded by passing out a more

descriptive handout (Appendix P) or read over the agency description.

In one case, the caregiver did not know that her children were eligible for the WIC program. Having the information and phone number on hand allowed the family to access the needed and available services with or without the help of the instructor. This list actually empowered several caregivers to make some positive changes in their lives.

Results of the attitude survey regarding assessments and interventions used in the Infant Development Program were discussed at a staff meeting. "To have regular meetings with the team during which you share your feelings, goals, and ideas, as well as your successes and difficulties with certain families serves as an important step to prevent "burn-out"" (Arron & Kelsey, 1989, p.41).

In reviewing some of the attitude survey questions, the instructors agreed that child care workers often deal with conflict on a regular basis. "If the conflict is an unpleasant experience and the adult/instructor has developed response strategies for not overacting, the overall appearance will be less painful for both instructor and child" (Braun, 1992, p.29).

Overall, the instructors rated positive on the pre-implementation attitude survey. The instructors attained a higher/stronger positive attitude about assessment and

implementation of the program. This increase was assisted by the Program Manager, presentations, current videos, handouts, bi-monthly meetings, caregiver support groups, and sharing of problems and ideas.

Developing the support group, S.P.O.K.E., was a new community intervention. The overall monthly attendance increased at both meeting sites. The writer believed that the closeness to the residences of the families contributes to better attendance.

Donated children's clothing and toys encouraged attendance as well as individual speakers. The local media provided monthly articles, discussing the organization, upcoming speakers, location, dates, and times. Those in attendance at the meetings were not reminded of the group through the newspaper but rather the phone calls and flyers (Appendices Q and R). By the last meeting, the caregivers at Site A were asking when the group would resume in the fall. "If you make the parents uncomfortable or defensive, chances are they will not follow through on any of your suggestions or instructions" (Odom-Winn & Dunagan, 1991, p.89). The parents/caregivers appeared to make more conversation among themselves during the final meetings and appeared comfortable. Many of the same children in attendance appeared to enjoy the activities provided and to focus on the care provider.

Recommendations

Further recommendations to enhance the improvement of child/caregiver relationships of prenatally exposed children birth to three would be as follows:

1. Develop interagency networking through the use of on-line computers to save duplicating forms, paperwork, and services.
2. Continue with the monthly support group meetings (S.P.O.K.E.). Include caregivers of all "at risk" children and family.
3. Provide each Infant Development Instructor with a laptop or notebook computer for on-site case noting.
4. Purchase software to assist in screening clients (0-3) and evaluating developmental improvement.
5. Hire a bilingual part-time instructor to meet the needs of the increasing Spanish and Kanjobal (Guatemalan Indian dialect) speaking population.
6. Provide transportation for the caregivers to attend support groups and to keep appointments with health services.

Dissemination

The writer has been requested by the Infant Development Program Manager to make a presentation of the final report at the September meeting of the County Task Force on

Substance Abuse. Transparent overlays will be made for graphs and tables to enhance presentation with the use of an overhead projector.

The director of Children's Service Council (CSC) and the director of Exceptional Student Education (ESE) have both expressed an interest in reviewing the final report.

The abstract of the final report will be submitted for possible presentation approval at the Florida Federation Council for Exceptional Children 1992 Convention in Orlando, October, 1992.

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APPENDIX A

County Tracking of Substance Exposed Births

1991 County Statistics - Resident Birth

		YEAR	JAN.	FEB.	MAR.	APRIL	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	
Total Resident Births		1,118	96	88	102	72	94	90	102	91	99	113	82	89	KEY:
Martin Memorial Deliveries		1,003	87	82	91	60	88	79	90	81	88	105	72	80	S=SIDS
Women's Center Deliveries		85	5	6	8	7	5	8	9	9	10	5	9	4	RF=Respitry.
Home Births-CNM		10	0	0	1	1	1	1	3	0	0	1	0	2	Failure
Home Births-Unattended/UNM		20	4	0	2	4	0	2	0	1	1	2	1	3	HF=Heart
Race	White	725	60	60	68	47	67	61	62	60	61	68	55	56	Failure
	Hispanic	137	9	7	13	8	9	11	19	10	10	21	7	13	FT=Failure
	Guatemalan	112	13	8	11	10	7	10	7	14	8	9	6	9	To Thrive
	Black	144	14	13	10	7	11	8	14	7	20	15	14	11	NN=Non-
Mother 15 YOA or Under	15 YOA	14	1	1	2	0	2	1	2	1	1	1	2	0	Natural Death
	16-18 YOA	106	8	9	8	6	10	8	9	9	11	15	5	8	CA=Abuse
Mothers Marital Status	Single	409	30	32	39	24	38	36	37	30	37	46	31	29	HD= Heart
	Married	709	66	56	63	48	56	54	65	61	62	67	51	60	Disease
Prenatal Care	Private	589	54	48	49	40	56	40	59	66	48	42	44	43	PD=Physical
	MCPHU	501	40	39	49	28	36	47	43	24	49	67	36	43	Deformity
	None	28	3	2	4	4	2	0	0	1	2	4	2	3	RD=Respitry.
Premature Birth Weight	< 5.5 lbs.	54	1	5	8	3	4	4	6	4	4	6	8	1	Disease
Full Term Birth Weight	5-9 lbs.	980	87	72	89	64	81	82	88	78	88	100	70	81	GI=Gastro-
	9+ lbs.	84	8	11	5	5	9	4	8	9	7	7	4	7	Intes. Disease
Substance Exposed	Cocaine	11	0	1	2	1	2	1	0	0	1	3	0	0	CD=Communi-
	Marij.	1	*	1	1	1	1	2	3	5	5				cable Disease
	Alcohol	41	1	7	1	5	5	4	1	0	3	5	8	1	ND=Neurolog.
	Tobacco	198	16	14	20	14	17	16	14	14	13	23	19	18	Disorder
	Poly Sub.	0	4 *	0	1 *	1	2	0	0	0	5				
Fetal Death 20-40 Week Gest.		0	0	2	1	0	0	1	1	0	2				
Deaths 0-12 Months		0	0	1	0	0	1	1	0	1	3				
Deaths 1-5 YOA		0	0	0	0	0	0	0	1	0	0				
Cause of Death-S,RF,HF,FT,NN,CA		*N/A*	*N/A*	*HF,RF*	*Natrl.*	*N/A*	*Prem*	*Prem*	*RF*	*CD*	*Pre*				
Medical Problems-HD,PD,RD,GI,CD,ND		*PD*	*N/A*	*HD*	*PD*	*HD*	*COPD*				*PD*				

1992 County Statistics - Resident Birth

		YEAR	JAN.	FEB.	MAR.	APRIL	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	
Total Births			134	129	159	129	141	110	143						
Total Resident Births			83	74	95	76	87	64	84						*KEY:*
Martin Memorial Deliveries			77	66	83	67	74	58	75						*S=SIDS*
Women's Center Deliveries			5	6	8	8	13	5	8						*RF=Respitry.*
Home Births-CNM			0	1	0	1	0	1	0						*Failure*
Home Births-Unattended/UNM			1	1	4	0	0	0	1						*HF=Heart*
Race	**White**		50	52	58	53	57	46	56						*Failure*
	Hispanic		15	7	9	7	14	5	11						*FT=Failure*
	Guatemalan		4	4	10	9	8	4	9						*To Thrive*
	Black		14	11	18	7	8	9	8						*NN=Non-*
Mother 15 YOA or Under	**15 YOA**		2	0	3	1	0	1	3						*Natural Death*
	16-18 YOA		4	9	8	7	3	4	2						*CA=Abuse*
Mothers Marital Status	**Single**		20	25	34	22	23	20	33						*HD= Heart*
	Married		63	49	61	54	64	44	51						*Disease*
Prenatal Care	**Private**		46	41	43	35	41	34	42						*PD=Physical*
	MCPHU		36	33	51	38	44	27	38						*Deformity*
	None		1	1	1	3	2	3	4						*RD=Respitry.*
Premature Birth Weight	**< 5.5 lbs.**		2	1	5	3	2	4	4						*Disease*
Full Term Birth Weight	**5-9 lbs.**		79	64	83	71	81	55	73						*GI=Gastro-*
	9+ lbs.		2	9	7	2	4	5	7						*Intes. Disease*
Substance Exposed	**Cocaine**		0	3	1	0	1	0	0						*CD=Communi-*
	Marij.		1	0	0	4	0	0	0						*cable Disease*
	Alcohol		2	2	2	3	0	1	3						*ND=Neurolog.*
	Tobacco		4	16	14	21	6	10	18						*Disorder*
	Poly Sub.		0	0	0	0	0	0	0						
Fetal Death 20-40 Week Gest.			1	1	0	1	1	0	1						
Deaths 0-12 Months			0	0	0	0	1	1	0						
Deaths 1-5 YOA			0	0	0	0	0	1	0						
Cause of Death-S,RF,HF,FT,NN,CA							PD	NN							
Medical Problems-HD,PD,RD,GI,CD,ND															

APPENDIX B

Testimony on Drug Exposed Children

U.S. HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

The findings were reported as follows:

1. The greater portion of the mothers were poly-substance users with alcohol consumed by over 50%. (Alcohol can interfere with growth and development significantly.)

2. The mean age of the mother was 27 years.

3. The biological mother was the caretaker in only 25% of the cases.

4. The majority of the caretakers were grandmothers and foster mothers.

5. Prematurity occurred in over a third of the births noted.

6. Head circumferences were below the fifth percentile in one-third of the cases.

7. Growth interference continued well beyond infancy.

8. Most children experienced developmental delays.

9. Delays were seen throughout all age groups and noted in 90% of the children.

10. Delays in fine motor, gross motor, and play skills were noted but not as significant.

11. Hyperactivity, as well as short attention spans, was noted in over 30% of the cases.

12. Hypertonicity was noted in 30% of the cases, some showing signs of cerebral palsy.

13. Autistic disorder (a rare disorder said to occur with a frequency of 3-10 children per ten thousand live births) was present in 8% of the children. This is quite high.

14. Explosive behavior, difficulty interacting with peers, difficulty with transitions, indiscriminate attachment,and feeding disorders were all noted to a great degree in this population.

(Adapted from Testimony on Drug Exposed Children Effective Intervention, July 30, 1991).

APPENDIX C

Attitude Survey of Infant Development Instructors

SCALE TO MEASURE ATTITUDES TOWARD
ASSESSMENT AND INTERVENTION

A = strongly agree
B = agree
C = undecided
D = disagree
E = strongly disagree

	A	B	C	D	E
1. The quality of the assessment for screening is satisfactory.					
2. Parent/caregiver training would benefit from the intervention process.					
3. The training of staff for interviewing caregivers is adequate.					
4. The duration of time between the initial screening and intake is adequate.					
5. Parents are not compliant with instructor in regards to meetings.					
6. The amount of time spent with each client is fair and evenly divided.					
7. Paperwork and reports complied by the instructors are too lengthy and time consuming.					
8. The amount of time spent by the instructor in traveling to clients' homes is reasonable.					
9. Guidelines are sufficiently clear in following the hierarchy of developmental strategies.					
10. Computer usage for IEP reports would reduce paperwork and be more timely and cost efficient.					
11. A list of coordinated services is available to distribute to clients.					

	A	B	C	D	E
12. Instructors would benefit from attending training sessions on assessment and intervention techniques.					
13. A protocol fact sheet for home visitation would be helpful.					
14. Quarterly meetings would be held to discuss interactive service results with HRS Developmental service/agency.					
15. Caseloads would be divided by regional areas.					
16. Appointments are scheduled at productive times to best interact with the infants through three years old.					
17. Instructors are satisfied with the Lanier Early Learning Profile, Hawaii/developmental model currently in use.					
18. Welcome bags, including an age-appropriate toy would be an added benefit to home visitation.					
19. A toll free number would be available for emergency situations.					
20. Instructors are apprised of new and updated literature and research on home-based intervention strategies.					

Include <u>three</u> statements of need that would improve your role as Infant Development Instructor.

APPENDIX D

Possible Effects of Prenatal Exposure to Cocaine

Possible Effects of Prenatal Exposure to Cocaine

A. On Pregnant Woman/Mother

1. Rapid heart beat; possible heart failure resulting in death
2. Construction of blood vessels
3. High blood pressure
4. Uterine contractions
5. Restlessness
6. Slow digestion
7. Depression/paranoia
8. Weight loss
9. Seizures
10. Stroke
11. Difficulty breathing
12. Premature delivery
13. Miscarriage

B. On Developing Fetus

1. Lack of oxygen due to restricted blood flow
2. Rapid heart beat (up to 200+ beats per minute)
3. Constriction of blood vessels
4. Premature birth/death
5. Possible malformation of genital/urinary tract/kidney
6. Possible malformation of appendages (esp. hands)
7. Bleeding of the brain (hemorrhage)
8. Possible prune belly syndrome
9. Miscarriage
10. Premature labor
11. "Abruptio placentae"
12. Cerebral stroke
13. Stillbirth delivery

C. On the Newborn

1. Small head circumference
2. Low birth weight
3. Irritability/disturbed sleep patterns
4. Tremors
5. Rapid heartbeat and breathing
6. Difficulty eating
7. Diarrhea
8. Possible birth defects
9. Increase risk for Apnea/Sudden Infant Death Syndrome (SIDS) (15% in drug users; 0.3% in nondrug users)
10. Stroke

11. Possible brain damage
12. Breast feeding (drug stays in milk up to 48 hours after taking)
    a. dilated pupils
    b. hypertension
    c. tachycardia
    d. extreme irritability
    e. loss of appetite
13. Withdrawal (1-2 weeks)

D. On Birth to Toddler

1. Difficulty bonding
2. Difficulty keeping eye contact
3. Difficulty feeding, lack of appetite
4. Poor physical development/clumsy
5. Inability to change moods; extreme highs and lows
6. Poor speech traits
7. State regulation poor

APPENDIX E

At-Risk Environment of Substance-Exposed Children

At-Risk Environment of Substance-Exposed Children

The Child

May have multiple home placement.

May live with other young children who are at-risk.

May be abused and neglected.

May experience numerous physical health problems.

May receive inconsistent and intermittent true nurturing.

May have a caregiver who is overwhelmed or untrained in dealing with the child's emotional needs.

May be exposed to chaotic, unpredictable and unstable living conditions.

May be particularly sensitive to the stress that impacts his/her daily life.

May require specialized school curriculum and services.

May experience school failures.

Adapted from Vodenicker & Cashell, (1991).

APPENDIX F

Risk Factors in Drug-Exposed Preschool Children

Risk Factors in Drug-Exposed Preschool Children

Poor Organization Behavior

Exhibits behavior extreme.

Low tolerance for stress.

Testing limits.

Difficulty organizing self play.

Limited attention and/or concentration on tasks.

Decreased adaptive persistence with tasks.

Difficulty reading social signals.

Impulsive behavior.

Difficulty in forming peer relationships.

Easily overstimulated.

Sporadic mastery of spatial-motor tasks.

Inconsistent use of problem solving strategies.

Difficulty with word retrieval.

Poor Attachment/Sense of Self

Decreased use of adults for solace, play, object attainment, and conflict resolution.

Attachment to strangers at random.

Decreased response and demand to verbal praise.

Regressive behavior.

Difficulties in making choices.

Delay in imitation, language, and representation play.

Adapted from Vodenicker & Cashell, (1991).

APPENDIX G

Parent/Caregiver Questionnaire on
Local Referral Program

Parent/Caregiver Questionnaire on
Local Referral Program

	heard of program		using program	
	yes	no	yes	no
PUBLIC ASSISTANCE				
Social Security Income (SSI)				
Women Infant Children (WIC)				
Aide for Families with Dependent Child (AFDC)				
Food Stamps				
COUNSELING AND SUPPORT				
Childrens Home Society Play Group (CHS)				
Association for Retarded Children (ARC)				
Parent to Parent (support group)				
Catholic Charities				
Florida Diagnostic Learning Resource Service (FLDRL)				
Children's Medical Services (CMS)				
Division of Blind Services				
Children's Case Management (CCM)				
Job Training				
Developmental Evaluation and Intervention (DEI)				
Abuse Registry				
MEDICAL SERVICES				
Deaf Service Center of the Treasure Coast				
Medicaid				
Medicaid Taxi (Meal Wheels)				
County Memorial Hospital				
County Memorial Hospital Speech Therapy Dept.				
Community Health Center				
County Memorial Hospital Emergency Room				
County Public Health Unit				
DRUG TREATMENT				
Alpha				
New Horizons				

APPENDIX H

Suggestions for Infant Development Instructors
Home Visitations

Suggestions for Infant Development Instructors
Home Visitations

Preparing the Visit

1. Necessities of what absolutely must take place at visit that day.

2. Select activities (toys, etc.).

3. Select materials, or handouts, or forms needed for the visit.

The Visit

4. Set the stage for a positive visit.

5. Ask to wash hands or use handi-wipes before touching the child.

6. Listen and ask how did the week go? The parent needs to talk and be heard.

7. Activities--discuss the goals and engage the caregiver in the activity and encourage her to do it on her own. Involve the other siblings with some extra toys.

8. Progress and Direction use lots praise and reinforcement for the parent and discuss some future goals.

9. Sharing--plan time to talk with the parent/caregiver so real warmth and communication is felt.

10. Documentation (informal) jot some notes while in the care before formal paperwork at the office.

11. Extras--send a card/note saying how well the session went or how you look forward to the visit being better next time.

Adapted from Arnn, L. & Kelsey, 1989, Strategies for Early Intervention Programs p. 41-46.

APPENDIX I

Self-Organization Checklist
Adapted from the ERIN Program

Self-Organization Checklist
adapted from the ERIN Program

NAME_____ OBSERVER_____

BIRTHDAY/AGE_____/_____ DATE_____

LARGE GROUP
difficulty # of

1. Does not watch or listen carefully to teacher. _____
2. Attention is easily distracted. _____
3. Child fidgets and/or cannot wait easily during group unison. _____

INDEPENDENT WORK PLAY

1. Easily distracted by what others are doing. _____
2. Does not choose activities or get started well (wanders). _____
3. Does not complete project/task and moves on to another. _____

SMALL GROUP INDIVIDUAL

1. Does not pay sufficient attention to understand the activity.
2. Does not work step-by-step during the project. _____
3. Does not check his product or make corrections/ alterations as he progresses. _____

TRANSITIONS

1. Is distracted.
2. Is unable to concentrate on the situation. _____
3. Forgets where he is going, what he is doing, or what he is taking with him. _____
4. Cannot monitor his completion of transition _____

CIRCLE THE NUMBER OF DIFFICULTIES THEN TOTAL SCORE IN EACH SUB-CATEGORY

APPENDIX J

Infant and Parent Mental Health Concerns

INFANT AND PARENT MENTAL HEALTH CONCERNS

BABY	PARENT
Failure to thrive/grow	Depression.
Depression.	Heavy drug or alcohol use.
Behavior problems.	History of mental illness.
Physical handicaps	
Lack of any emotions.	
Lack of responsiveness.	
Physically turning away from human contact, back arching.	
Parent-Baby Interaction Problems.	
There is no talk or play between parent and baby.	
Parent is very rough with the baby.	
Discipline problems.	
Problems with basic child care issues, such as feeding or toileting.	
Parent has difficulty reading baby's cues.	
Parent gives baby characteristics which are impossible for the baby to have such as saying the baby is scratching her face on purpose, at one day of age.	
Overstimulating, understimulating, unavailable, aloof.	
Overly intrusive and controlling.	

Adapted from Dr. Susan Adubato's project B.A.B.I.E.S

APPENDIX K

Infant Development Program Screening and Intake Checklist

Infant Development Program Intake Checklist

1. Intake Packet--Client Record Access Form (Pg.1) _____
   --Intake Staffing Enrollment Record (Pg. 2) _____
   --Intake Application (Pgs. 3 - 8) _____
   --Releases (Pages 9 - 20) _____
2. Parent Handouts
   --Annual Notice of Confidentiality of Client Records _____
   --Your Right as a Parent _____
   --List of Employees Who have Access to Confidential Information _____
3. IDP Brochure _____
4. Instructor's Business Card _____
5. Weekly Home Visit Letter for Parents _____
6. Other Agency Referrals (information given on individual basis) _____

APPENDIX L

Selected Curriculum Model Programs 0 - 3

Selected Curriculum Model Programs 0 - 3

ACTT Curriculum

Authors: Patricia L. Hutinger, Lori Perry, Linda Robinson, Kathie Weaver, and Kate Whitake

Developmental Ages: Birth - 8 years

Adaptips

Authors: Judy A. Goodrich and Patricia G. Kinney

Date of Publication: 1985

Developmental Ages: 0-24 months

Carolina Curriculum for Handicapped Infants

Authors: Nancy M. Johnson, Ken G. Jens, and Susan M. Attemeier

Developmental Ages: 0-24 months

Developmental Programming for Infants and Young Children

Authors: D. Sue Schafer and Martha S. Moersch

Date of Publication: 1981

Developmental Ages: 0-36 months

Hawaii Early Learning Profile (HELP) and HELP Activity Guide

Authors: Setsu Furuno, Carol Hosaka, Barbara Zeisloft, Katherine O'Reilly, Takayo Inatuska, and Toney Allman

Date of Publication: 1979

Developmental Ages: 0-36 months

Infant Learning: A Cognitive Linguistic Intervention Strategy

Author: Carl J. Dunst

Date of Publication: 1981

Developmental Ages: 0-24 months

HICOMP Curriculum Guide

Authors: Sara J. Willoughby-Herb and John T. Neisworth

Date of Publication: 1983

Developmental Ages: 0-60 months

Macomb 0-3 Regional Project Core Curriculum (3rd Edition)

Authors: Patricia L. Hutinger, Sue Marshall, and Kathleen McCartan

Date of Publication: 1983

Developmental Ages: 0-36 months

Small Wonder (Level 1 and Level 2)

Author: Merle B. Kames

Date of Publication: 1979, 1981

Developmental Ages: 0-36 months

Jordan, Gallagher, Hutinger & Karnes, 1990, pp. 61-62.

APPENDIX M

Selected Screening, Identification, and Assessment Measures 0-3

SELECTED ASSESSMENT INSTRUMENTS

Developmental Measures

Bayley Scales of Infant Development

Author: Nancy Bayley

Date of Publication: 1969

Age Range: 2-30 months

Battelle Developmental Inventory

Authors: J. Newborg, J. Stock, L. Wnek, J. Guidabaldi, and J. Svinicki

Date of Publication: 1984

Age Range: 0-8 years

The Callier-Azusa Scale

Editor: Robert Stillman

Date of Publication: 1977 (F. Edition) and 1978 (G. Edition)

Age Range: 0-9 years

The Evaluation and Programming System for Infants and Young Children (EPS)

Authors: D. Bricker, E. Bailey, and D. Gentry

Date of Publication: 1985

Age Range: 0-5 years

The Revised Gesell Developmental Schedules

Authors: H. Knoblack, F. Stevens, and A. Malone

Date of Publication: 1980

Age Range: 1-36 months

Sensorimotor Measure

Ordinal Scales of Psychological Development

Authors: I. Uzgiris and J. Hunt

Date of Publication: 1975

Age Range: 1-24 months

Parent-Child Interaction Measures

Human Interaction Scale

Authors: Burton White and Jean Watts

Date of Publication: 1973

Age Range: birth-6 years

The Nursing Child Assessment Teaching Scale

Author: L. Barnard

Date of Publication: 1979

Social Measures

A Social Maturity Scale for Blind Children

Authors: Kathryn Maxfield and Sandra Buckholz

Date of Publication: 1957

Age Range: 0-6 years

Vineland Social Maturity Scale (Revised)

Author: Edgar A. Doll

Date of Publication: 1985

Age Range: Birth-Adult

Curriculum Referenced Measures

Peabody Developmental Motor Scales

Authors: Rebecca Fewell and Rhonda Folio

Date of Publication: Revised Experimental Edition 1974

Age Range: Birth-7 years

Skills Inventory (The Oregon Project for Visually Impaired and Blind Preschool Children)

Authors: Donnise Brown, Vickie Simmons, and Judy Methvin

Date of Publication: 1979

Age Range: Birth-6 years

Language and Communication Measures
Protocols for Language Samples and Mean-Length Utterance

Authors: Jon Miller, Thomas Klee, Reha Paul, and Robin Chapman

Age Range: Infants, toddlers and older children

Receptive-Expressive Emergent Language Scale (REEL)

Authors: K.R. Bzoch and R. League

Date of Publication: 1971

Age Range: Birth-3 years

Sequenced Inventory of Communication Development

Authors: Dona Lea Hedrick, Elizabeth Prather, and Annette R. Tobin

Date of Publication: 1978

Age Range: 4-48 months

Screening Measures
Administered by Medical Personnel

Apgar Scales

Author: Virginia Apgar

Date of Publication: 1953

Developmental Age: Neonates

Brazelton's Neonatal Behavior Assessment Scale

Author: T. Berry Brazelton

Date of Publication: 1974

Developmental Age: Birth through first month of life

Developmental Screening Measures Administered by Early Intervention Staff

Battelle Developmental Inventory Screening Test

Authors: J. Newborg, J. Stock, L. Wnek, J. Guidabaldi, and J. Svinicki

Date of Publication: 1984

Developmental Range: 0-8 years

Denver Developmental Screening Test (DDST)

Authors: W. Frankenburg, J. Dodds

Date of Publication: 1970

Developmental Age: 0-6 years

Denver Prescreening Development Questionnaire (DPDQ)

Authors: W.K. Frankenburg, W.J. van Doorninck, T.N. Liddell, and N.P. Dick

Developmental Ages: 3-6 years

Developmental Activities Screening Inventory (DASI)

Authors: R. Dubose and M. Langley

Date of Publication: 1977

Developmental Age: 6 months - 6 years

Jordan, Gallagher, Hutinger & Karnes, 1990, p. 63-66.

APPENDIX N
Strategies for Working with Young Children Prenatally Exposed to Drugs

Strategies for Working with Young Children Prenatally Exposed to Drugs

Transitions

Many children have difficulty making transitions from the home situation to the day care or preschool. As children move from one activity to the next, they can lose control of themselves if they do not know what to expect and what is expected of them. The following are suggested strategies to working with substance exposed toddlers.

1. The daily routine should have as few transitions as possible.
2. Plan the routine so that active times alternate with quieter times and there is a gradual increase or decrease of the tempo of activity.
3. Provide warnings before activity changes--one at ten minutes, then five minutes, then one minute. These warnings can be a signal such as a bell or lights dimming.
4. Centers, such as blocks, should begin first.
5. Clearly signal the end of work time or the end of outside play time so that everyone is aware.
6. Tell the children what will happen during the transition time before the youngsters start to move.
7. Once the children have gathered and organized, help them make up special ways to move to the next activity, such as sing a song, hands up in the air, touch ears, etc.
8. Start the next activity right away, even if all the children have not gotten there yet. This lets them known that something fun is going to happen next, so it pays to get there quickly.
9. It is sometimes helpful to do "dry-runs." Let's practice it.
10. Give positive reinforcement when things go well.
11. When dismissing children, be sure to select small numbers of children at a time. "All boys wearing blue" or "girls with long hair, or the "the red table" may line up.

Adapted from Drug Exposed Children's Committee, Hillsborough Co. Public Schools

APPENDIX O

Agency Referral Guide

Infant Development Program
221-4050
AGENCY REFERRAL GUIDE

PUBLIC ASSISTANCE

Health and Rehabilitative Services/Developmental Services
HRS
221-4007, 468-4080

Aide for Families with Dependent Children
AFDC
287-8585

Supplemental Security Income
SSI
1-800-234-5772

Women Infants and Children
WIC
221-4000

Food Stamps
283-2300

MEDICAL SERVICES

Memorial Hospital
Occupational Therapy Dept.
223-5936

Memorial Hosptial
Speech Therapy Dept.
288-5884

Childrens Medical Services
CMS
881-5040

Medicaid
287-8585

Medi Wheels
(Medicaid Taxi for Handicapped)
288-0799

Community Health Center
597-3596

Memorial Hospital Emergency Room
223-5995

County Public Health Unit -
221-4030

County Public Health Unit -
597-3687

COUNSELING/SUPPORT SERVICES

Parent to Parent
288-7278

Association for Retarded Citizens Respite Program
ARC
283-2525

Catholic Charities
283-0541

Childrens Home Society
Playgroup
CHS
287-8009; 1-800-433-0010

Florida Diagnostic Learning Resource System
FDLRS
468-5385

Childrens Case Management Organization (CCMO)
1-800-273-3811; -881-5572

Developmental Evaluation and Intervention (DEI)
-881-2822

AGENCY REFERRAL GUIDE
PAGE 2

Abuse Registry
1-800-96ABUSE

Deaf Services Center of the
Treasure Coast
335-5546

Division of Blind Services
DBS
1-800-342-1828

DRUG TREATMENT

New Horizons
221-4084

Alpha
595-9495; 465-4050

APPENDIX P

Summary of Referral Agencies

Alpha Health Services, Inc. is a substance-abuse treatment facility for patients recovering from drug-related problems. Alpha has rehabilitative day treatment, adult out-patient, as well as individual group, family, vocational, and social services including specialized counseling and testing services, pregnant/postpartum women and daycare.

New Horizons of the Treasure Coast is an intensive residential program for drug- or alcohol-dependent pregnant women.

Florida First Start Program located in Indiantown is designed to give children the best possible start in life and to support parents in their role as the child's first teacher. They provide once-a-month parenting education groups and once-a-month home visits to families with at-risk children from birth to three in Indiantown.

Lifeline is a group that will provide free baby equipment.

Medicaid helps low-income families get public medical assistance from various programs.

Women, Infants, and Children (WIC) to be eligible, woman must be pregnant or breast-feeding, a new mother, or have a child up to the age of 5. We may have coupons to purchase certain foods.

Children's Medical Services is a program to provide medical services for needy children with chronic, handicapping, or potential handicapping diseases or conditions to assist the child to develop to his/her full potential.

Supplemental Security Income (SSI) Income that can go to assist people over 65, disabled, or blind adults or children. Usually those who qualify are eligible for food stamps and Medicaid.

Aid to Families with Dependent Children (AFDC) helps families stay together while they learn how to support themselves. It provides financial assistance and medicaid.

Division of Blind Services provides services for those who are visually handicapped; blind, or threatened with blindness are eligible. The services include assessment, counseling, medical services, supportive services, vocational training, and job placement.

HRS Developmental Services provides case management and referral to assistance programs for individuals who are at risk of having a developmental disability. The goal of the Developmental Service Program (DSP) is to assist the developmentally disabled individuals in living as normally and as independently as possible.

S.T.O.P. Substance Treatment Outpatient Program 6 week highly structured treatment program for 2 groups, Adult 18 and over, and Adolescent 13-17. Clients meet once, followed by a once-a-week evening meeting for 6 months. Insurance and third-party payments are accepted.

Florida Diagnostic and Learning Resources System (FDLRS) provides screening, evaluation, and training to professionals, parents, agencies, and other persons involved in the education of exceptional children, birth to twenty-one. Screens children for referral to Exceptional Student Education.

Deaf Service Center of the Treasure Coast provides service for the hearing impaired and collects local data. Supplies intrepretors to work with use of TDD (telephone device for the deaf); assists hearing impaired in making opportunities, and has sign language classes.

Catholic Charities provides services for all on a sliding scale. Services include counseling, adoption, foster home care for infants, and emergency assistance for families in distress.

Association for Retarded Citizens (ARC) Respite Program provides an after-school respite program for handicapped children. Respite care for mentally or physically involved children.

Children's Home Society assists in prevention of abuse and neglect and provides assistance to teen parents as well as having a play group.

Developmental Evaluation and Intervention Program provides service to infants prenatal/perinatal or port-trauma who have been identified as at risk. The child is evaluated initially and assessed at regular intervals. Parents are encouraged to participate.

Children's Case Management Organization, Inc. This social service agency provides comprehensive case coordination for families with babies who are in the newborn intensive care center at St. Mary's Hospital. The assistance will last for the first three years.

Parent to Parent is a support group for parents who need assistance in accepting the special needs of their disabled child. The group holds regular monthly meetings.

Private Industry Council operates a federally funded job training center in the County. Provides employment, training programs, and support services for the economically disadvantaged and handicapped.

APPENDIX Q

S.P.O.K.E. Information

S P O K E

SUPPORT FOR PARENTS OF KIDS EXPOSED

JOIN THE MEETING (SITE A)

1ST TUESDAY OF EACH MONTH, 3-5 P.M.

FEBRUARY 4TH

MARCH 3RD

APRIL 7TH

MAY 5TH

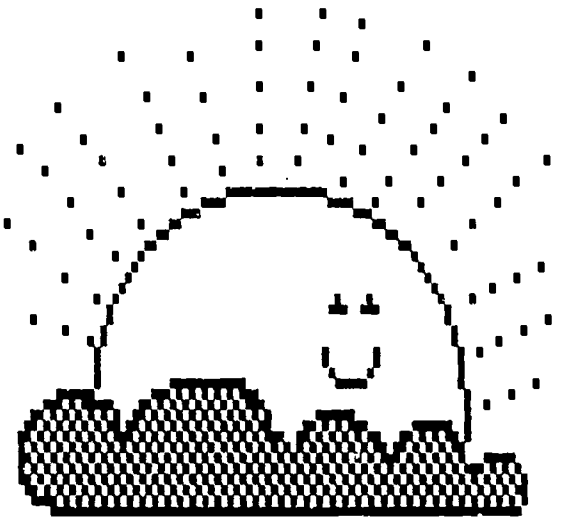
JUNE 2ND

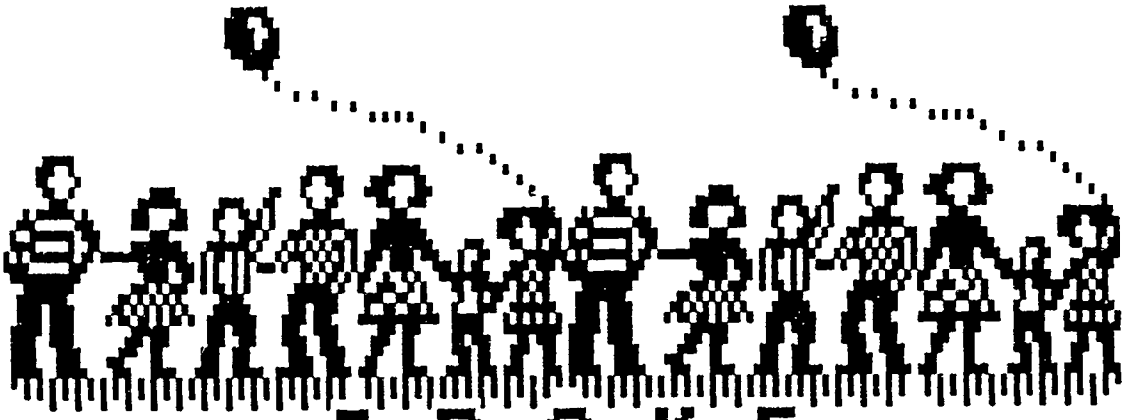
JULY 7TH

*FREE CHILD CARE *REFRESHMENTS

*PRIZES *SPEAKERS

*CONVERSATION





S P O K E

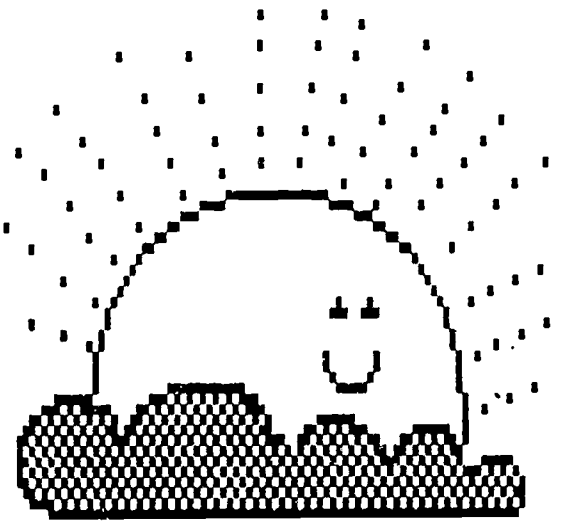
SUPPORT FOR PARENTS OF KIDS EXPOSED

JOIN THE MEETING (SITE B)

1ST THURSDAY OF EACH MONTH, 3-5 P.M.

FEBRUARY 6TH
MARCH 5TH
APRIL 2ND
MAY 7TH
JUNE 4TH
JULY 2ND

*FREE CHILD CARE *REFRESHMENTS
*PRIZES *SPEAKERS
*CONVERSATION



APPENDIX R

Presentation Techniques, Management and Activities

Task Force of Martin County

- PRESENTS -

Techniques, Management and Activities for enhancing the quality of education for substance exposed children entering the school system

Facilitators:

Janice Cashell and **Della Vodenicker**

May 27, 1992

Presentation: 1-3 PM • Discussion 3-4 PM

J.D. P. Elementary School

Please contact **Susan Klingler** or **Kathy Derringer**

at 221-4050

for Registration or Additional Information

FUNDED BY:

Children's Services Council
OF MARTIN COUNTY