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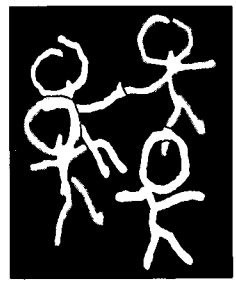
ABSTRACT

In 1986, the Ounce of Prevention Fund undertook an ambitious project: creating and operating a family support program for young families with infants and toddlers in the Robert Taylor Homes public housing development in Chicago. The program was the outreach function of the Center for Successful Child Development (CSCD). The CSCD, a comprehensive, community-based, early childhood development and family support center, was designed to help all service-area children from conception to age 5, emphasizing the critical first 3 years. The program became known as the Beethoven Project because all of the children were expected to later attend the nearby Beethoven Elementary School. This report describes the CDSC and the Beethoven project, as well as a fifth-year assessment of the effectiveness of the program. Chapters in the report are: (1) "Overview," discussing goals, the community role, and a description of CSCD's programs and services; (2) "The Retrospective Analysis: Assessing the First Five Years," focusing on participants, staff, professionals, paraprofessionals, community needs, and cultural and environmental influences on parenting behavior; (3) "Violence and Its Effects"; (4) "Important Lessons and Unresolved Issues," detailing seven "lessons" learned from aspects of the CSCD; and (5) "Summary and Conclusion," defining the Center's success. This section describes how the comprehensive services offered have had an important impact in a variety of areas, including economic self-sufficiency for many parents, improved health care for children, and improved relationships between parents and their children's school. (BGC)

The Beethoven Project

Summary and Retrospective Analysis of the First Five Years of the Center for Successful Child Development



The Ounce of Prevention Fund

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The Beethoven Project

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The Ounce of Prevention Fund

1995

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Acknowledgments

The Center for Successful Child Development has benefitted from the interest and involvement of so many people over the past seven years that it would be impossible to acknowledge each of them here. Home visitors, medical partners, development directors, teachers, maintenance staff, policy advocates, and community supporters all worked and worried with us every step of the way. We appreciate their incredible commitment. We will, however, mention a few key people.

First and foremost there is Irving B. Harris, founding chairman of the Ounce of Prevention Fund and the inspiration behind the Beethoven Project. Irving Harris is a visionary, a spokesman, and a great friend of our nation's youngest citizens. He believed in the program from the beginning and personally supported the work of the staff as they realized the dream. He continues to commit his financial and intellectual resources to the program and to hundreds of projects of committed individuals working in the field of early childhood education.

The Chicago Urban League President and Chief Executive Officer James W. Compton and former Urban League staff member and Ounce board member Gwen LaRoche provided us with direction and support as we worked through community issues. Former Chicago Housing Authority Director Brenda Gaines and current Director Vince Lane gave us the space for the project, labor to help with the renovation, and praise and help as we continue to advance the initiative.

The first CSCD home visitor would have never reached the first door without the guidance, patience, and support of two successive Ounce Executive Directors: Judith S. Musick and Judy Langford Carter. The original staff of the CSCD brought their personal vision and passion to the project under the thoughtful mentoring of Gina Barclay and Linda Bowen. The ongoing work is carried on by its current indefatigable staff under the leadership of Beverly Njuguna and Dorothy Coleman.

The project has enjoyed the generous support of many faithful individuals, foundations, and corporations who committed their time and understanding as well as their resources to further the mission of supporting families in the Robert Taylor Homes community. The Illinois Department of Children and Family Services has made a significant financial commitment to the CSCD. The Robert Wood Johnson Foundation helped us establish our Primary Care Health Center, which has provided health care to hundreds of poor women and children. Their original five-year grant, and recent five-year renewal, have allowed us to continue to serve people in great need while we attempt to navigate the uncharted waters of health care reform and managed care. Terrance Keenan of the Robert Wood Johnson Foundation deserves enormous praise for helping us achieve this worthy goal.

Finally, and most importantly, we thank the community and the participants who have allowed us to enter their lives. In the midst of great adversity, families do their best to raise their children out of harm's way. We hope our presence has helped.

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This report was written by current and former Ounce staff members. Principal authors were Susan Miller, Kai Jackson, Carolyn Johnson-Hoeks, and Rebecca Stone. Editing was done by Nancy Drew and Jeff Hackett. The Retrospective Analysis was the vision of Dr. Enora Brown. The Ounce staff provided ongoing oversight.

Does Beethoven Work?

"For a baby, those early weeks and months can never be brought back to do over again. This is not the rehearsal. This is the main show."

Irving B. Harris, Founder of the Ounce of Prevention Fund

In 1986, the Ounce of Prevention Fund undertook one of its most ambitious and ultimately most successful projects: to create and operate a family support program for young families with infants and toddlers in the Robert Taylor Homes public housing development in Chicago. We called our program the Center for Successful Child Development (CSCD). The CSCD was designed to help all service-area children from conception to the age of five years, with an emphasis on the critical first three years. It quickly became known as the Beethoven Project because all of the children were expected to later attend the nearby Beethoven Elementary School.

Why all of the children? We had a specific purpose. We knew that in many schools in low-income neighborhoods, 30 to 50 percent of the children arrive at school "not ready," unprepared cognitively or emotionally. Teachers in these schools told us that when one or two children in a class were "not ready," they were skilled enough to handle those children and still devote enough time to the rest of the class. But when 10 percent or more of the students have low attention spans, are hyperactive, or have obvious learning impairments, a teacher cannot devote the necessary time to them and to the untroubled children. As a result, the whole class is shortchanged. It was clear to the teachers and to us that unless *all* children were ready to learn, *all* children would suffer; a few "not ready" children would drain away the teacher's energy and the entire class would fall behind.

The pervasiveness of America's failure to prepare its children for school was confirmed by a 1991 Carnegie Foundation for the Advancement of Teaching survey of 7,000 kindergarten teachers. The teachers reported that 35 percent of American children were not ready for school when they entered kindergarten. American College Test scores of Chicago high school students demonstrate the long-term effects for Chicago's children. In 1987, the Illinois state legislature began requiring Chicago schools to compare the test scores of graduating high school students to national norms. In that year, of more than 5,400 schools in the ACT universe, thirty-five of Chicago's fifty-eight high schools fell into the bottom 1 percent in the nation. It was hard to believe, thirty-five of the fifty-four worst schools in the ACT universe were in Chicago. And, since ACT tests are administered only to seniors, the 50 percent of Chicago students who had already dropped out were not even tested.

In 1991, after five years of the program, we began the difficult process of taking stock of the CSCD. We wished to measure its progress and to reassess its potential. This report summarizes our findings based on a Retrospective Analysis of the first five years. It also discusses a variety of issues associated with designing, starting up, administering, and evaluating the program. We hope that our experience will be helpful to others interested in one program model and its implementation.

The CSCD was an attempt to copy--with some noteworthy modifications--successful smaller programs that had been carried out twenty years before in New Haven, Connecticut, and Syracuse, New York. The CSCD is designed to promote, from birth, the healthy development of children in intensely poor communities and thus improve everyone's chances for school success. The CSCD accomplishes this goal by offering comprehensive medical and counseling services to pregnant women, by offering intensive, continuous support services to parents, and by encouraging parents to interact with their babies and enjoy them.

To the question "Does the CSCD work?" we respond absolutely "yes." The CSCD nurtures many at-risk children from the womb to the school. It offers a comprehensive array of prevention-oriented services for families living in poverty, including prenatal care for pregnant mothers and family health care at a free, on-site clinic, parenting education, counseling, home visiting, a continuum of childcare for students and working parents, and developmental activities for infants and toddlers. At the CSCD, trained professionals and paraprofessionals from the community work together with Robert Taylor residents both at the facility and in the residents' homes.

The CSCD has clearly succeeded as a demonstration model. It has spawned more than forty replications across the country and it helps state and federal agencies plan for work with complicated and isolated populations. The CSCD is a program worthy of emulation. Its success has been achieved through the blood, sweat, and tears of dedicated staff and cooperation from resident participants. Fewer tears would have been shed if the CSCD had been set up as a demonstration in a university or hospital setting. But the CSCD broke new ground by situating itself in the real world of a drug- and violence-plagued urban, public housing development. And the CSCD has successfully trained community members as outreach workers.

Unlike pilot research programs that have emerged from universities, the CSCD was designed to be carried out on a continuing basis in the real world and was the conception of a businessman and philanthropist, Irving B. Harris. Harris is a longtime advocate for families and children and has written and spoken on the fundamental links between very early brain development, appropriate interaction of infants and caregivers, and later success in school. In 1982, he founded the Ounce of Prevention Fund. He helped establish the Erikson Institute in 1965 and is a longtime supporter of higher education programs in social work and public policy. These activities, Harris's substantial reputation as a businessman, and his willingness to make major philanthropic investments helped make legislators and the public more willing to listen to him on the need for practical early childhood programs to help children of our country be ready to learn.

Harris succinctly described the heart of the Beethoven Project agenda:

> In 1991 we spent $418 billion trying to educate children from the age of six years up through university, while, for the children at high risk of failure, we're missing the most important time for improving learning capacity, namely from the minute of conception until those children are three years of age.

Two months after the doors opened, the CSCD drew national attention with a page one story in the *New York Times*. The project had captured the imagination of *Times*

reporter Kathleen Teltsch, who persuaded her editors to send her to Chicago to write about it. The *Times* hailed the program in an editorial, calling it a "Head Start on Head Start." The following Congress appropriated funds to replicate the basic model of CSCD in twenty-five other locations around the country and has subsequently funded fifteen additional centers. Today there are forty-two federally funded CSCD replications.

In the larger historical context of early childhood education and care, the Beethoven Project has been an important force in policy development for children from birth to three years of age who live in poverty. By focusing public discussion on the critical importance of children's earliest years, the CSCD basic approach has inspired replication and helped lay the groundwork for expanded support of programs for children from birth to age three and for comprehensive family support programs. In May of 1994, President Clinton signed the Head Start authorization bill for the years 1995 through 1998. In that bill the Congress, for the first time, stipulated that 3 percent of all Head Start funds be allocated to programs for children aged zero to three years. That funding year began on October, 1, 1994. This 3 percent will rise to 4 percent after one year and to 5 percent by the fourth year. For the Ounce and for Harris, national support for this type of program represents our ultimate success. Our work in Chicago touches hundreds of lives. The expansion of Head Start and the implementation of the federal replications and their evaluations meant improving the lives of thousands of children well beyond Chicago.

The CSCD works, but it does not work in the same way a pilot program or university model works. Evaluation methodology appropriate for a controlled setting fails to reflect the real-world challenges of the Robert Taylor Homes. How do we "factor in" a backdrop of immediate and unremitting violence and fear of the guns that are everywhere and the shootouts that recur every few weeks? How do we measure the impact of pervasive drug abuse? What can the program do about making good jobs available for parents? How long can it take one well-run program to overcome years of mistrust among a population for whom too many promises have been broken? Is it a program success or failure when a participating family moves out of Robert Taylor? These questions quickly taught our professional staff that there is a gap between book-learning and reality, that training cannot always substitute for education, and that trial and error is often the best route to take when the experts don't know the answers.

The success of the Beethoven Project is best measured in the small incremental changes that occur family by family, child by child. The CSCD families and staff set goals for each family that are particular to that family's circumstance. The measure that best captures the success of CSCD will consider a family's starting point and will also capture the life circumstances of being a Robert Taylor parent. For one parent, just getting to the CSCD regularly is a major accomplishment; for another, getting a general equivalency degree is not enough.

Within the world of the Robert Taylor Homes, the CSCD is a lifeline to infants and toddlers who will enter kindergarten when they are five or six years of age, either at Beethoven School or elsewhere. This report attempts to bring together the complete range of staff and participant perspectives. Because of that, and because we aim to produce a report valuable to a large number of persons who have varied interests and concerns, some readers will find insufficient detail on topics of great interest to them and an abundance of

detail on topics about which they have less interest. Each subject area we address in this report actually deserves a major investigation to help inform human services professionals. We hope that the information we provide in the following text will be helpful to those who also attempt to do similar work.

Harriet Meyer
Executive Director
Ounce of Prevention Fund

1. Overview

"Ready for school" is a phrase that conjures up images of eager and excited five-year-olds taking their first steps through school doors while smiling, anxious parents wave good-bye. For children living in Chicago's Robert Taylor Homes, life between birth and kindergarten is filled with challenges and pitfalls that distance that happy image from reality. The Robert Taylor Homes are the nation's largest high-rise public housing development. In the public mind the Robert Taylor Homes are characterized by extreme poverty, gang violence, substance abuse, and a crumbling infrastructure. Yet the Robert Taylor Homes are also home to a community of people. Here, families and individuals struggle to make a life in a harsh and unforgiving world.

Since 1986, the Robert Taylor Homes have also been home to the Center for Successful Child Development (CSCD). The CSCD is a comprehensive, community-based, early childhood development and family support program. The CSCD is dedicated to making school readiness a reality for this extremely high-risk population. Founded and administered by the Ounce of Prevention Fund and jointly sponsored by the Chicago Urban League, the program provided support services to more than 700 families in its first five years. The CSCD promotes the healthy growth of children from conception through five years of age in all areas of their development. To do this, the CSCD focuses on both parents and children. The CSCD helps parents build on their individual strengths as caregivers. The CSCD gives children an environment in which their natural instincts to explore and learn can be expressed and encouraged.

Like other Ounce programs, the CSCD built upon a growing body of research pointing to the critical role of the first three years of life for a child's healthy development and success in school. Other successful child development research projects had employed highly trained professional staffs to work with families in preparing disadvantaged children for school. For the CSCD, the Ounce of Prevention Fund, experienced with community-based family support programs and early child development, adapted the design of those research projects for an inner-city community. The CSCD hired and trained community residents as the primary support workers. By drawing both staff and participants from the area, the Ounce hoped to strengthen the community, assist individual families, and also provide a program staffing model that could be replicated in other similar communities.

The story of the CSCD's first five years is the story of what it took to translate our experience, assumptions, and principles into action. It is also the story of what we learned about enhancing families' capacities to raise healthy children within the most difficult and threatening of environments.

Opening The Doors

Goals and Realities

In July 1986, with a major grant from the Harris Foundation and matching funds from the U.S. Department of Health and Human Services, the CSCD was established to serve young families living in six adjacent high-rises among the twenty-eight buildings that

constitute the Robert Taylor Homes. Although years of experience had given the Ounce a sense of the size of the task at hand, what we could not fully appreciate until after our work had begun was the *intensity* of the difficulty, the *degree* of the complexity, and the reverberations of this complexity on everything we were to do: the goals we set, the program components we put in place, the people we served, and the outcomes we could expect.

The six target buildings formed the attendance area for the Beethoven Public Elementary School (giving the CSCD its nickname, "the Beethoven Project"). By recruiting families within those six buildings, the program hoped to work with enough families to prepare an entire kindergarten class to enter the Beethoven School ready to learn. Although early press coverage of the Project focused attention on this aim, the goals of the program more accurately describe CSCD's focus:

- To provide children from the earliest possible moment with the facilities and support to develop socially, emotionally, physically, and cognitively, so that they will be ready to take advantage of preschool and formal educational opportunities

- To improve family interactions and relationships between parents and children by encouraging parents to learn about their children and how to promote their healthy development, and by helping parents build on their strengths as individuals and as parents

- To promote health among women and children by providing quality primary health care and health education

During the planning year it became clear that recruiting an entire kindergarten class-to-be would be impossible. Families identified by the initial outreach visits had immediate needs. To begin building relationships the program had to respond to those needs. A high level of family mobility within the community made recruitment and retention of participants more difficult than expected. Developing each program component also took longer than we would have wished owing to the normal course of program development, licensing delays, and the time required for intensive staff development and training of community workers.

All of these factors meant that the CSCD could not simultaneously recruit an entire cohort of families who would promise to stay with the program and respond to the needs of all eligible mothers of young children. With families frequently moving out of or within the Robert Taylor complex, and new families deciding to participate, the CSCD had to be flexible and practical about participation. The CSCD allowed families to determine for themselves their level of need and involvement. Some of the participants included the relatives of lease-holding residents, people who probably would have been homeless had they not been sheltered by extended family.

Our experience indicates that the longer a family participates in the CSCD, the better its prospects. But families also make their own decisions. The CSCD supports families for as long as possible in their efforts to help their children be ready to learn, regardless of which school they will attend.

The Community

Chicago's Grand Boulevard neighborhood lies several miles south of the city's center. It is dominated on its western fringe by the Robert Taylor Homes. The Robert Taylor Homes are a two-mile-long stretch of high-rise apartment buildings. Adjacent to Robert Taylor is an expressway that isolates the community from neighborhoods further west. According to the Chicago Housing Authority (CHA), approximately 15,000 people live in Robert Taylor. Almost all residents are African-Americans. Those working and living within the community, however, know that the figure may be inaccurate because CHA cannot keep track of the many fluctuations in occupancy common to the housing development. Median annual family income in the development barely exceeds $5,000. Less than 5 percent of households report wage income, and nearly all receive public assistance. Families headed by single women make up approximately 75 percent of all households in the area. Completed in 1962 as part of a plan to provide decent housing to low-income families, the buildings today are decaying more rapidly than they can be repaired. They are concrete testimony to our society's neglect of the poor and disenfranchised. Today, with the clarity of vision that history provides, we acknowledge the racism inherent in the city's decision to cluster and isolate poor African-Americans.

Community poverty is reflected in the health and development of its children. Many Robert Taylor children enter kindergarten without needed immunizations or with other health problems. A substantial number of these children never complete their basic education. DuSable High School, which serves Robert Taylor, has a four-year drop-out rate of around 60 percent.

Crime and violence plague the area. With the increased drug activity of the late 1980s, Grand Boulevard experienced a rise in drug-related gang activity along with dramatic increases in gun-related violence. The police district within which the community lies had the highest overall crime rate in Chicago in 1990. It ranked highest for murder, criminal sexual assault, robbery, and aggravated assault. Like people in any other community, residents of Robert Taylor want a home in a safe neighborhood.

For mothers *and* fathers the welfare of their children is a primary concern. While many young and single mothers live in Robert Taylor, many fathers are also there and involved with their children. Some work and provide for their families. Others care for their children while mothers work or attend classes. Together with the Robert Taylor families, the CSCD staff had to negotiate the many difficulties and challenges of this ravaged community. And after the first five challenging years, the program that has evolved is truly a part of the community it serves.

The CSCD's Physical Presence

The CSCD occupies the second floor of one of the six target buildings. Locating, negotiating for, and renovating the facility took more than two years. Another service organization had once used part of this second floor, but it had been empty for five years before the CSCD moved in. The space was offered rent-free by the CHA because the CSCD was committed to improving and maintaining the facility. Locating the CSCD within Robert Taylor proved to have both advantages and disadvantages to the Ounce. The escalating

violence and drug use over the first five years meant that enormous resources had to be devoted to securing the premises, providing adequate physical and emotional support to staff working in a danger-ridden environment, and ensuring the safety of the participants.

But the location offers important benefits. Families praise the convenience of services located within easy walking distance. Because of its location, the CSCD is seen as a program willing to be part of the community. The program's longevity has underscored its commitment to stay when so many other programs and services have vanished. Attractively maintained, the facility is an oasis that conveys the respect we have for the participants.

The Center's Programs and Services

The CSCD draws on a number of programmatic traditions and academic disciplines. It has roots in a variety of approaches to community development, adult and early childhood education, and social service delivery. This interdisciplinary spirit of enterprise and vision helped form the CSCD's principal program components:

- Family support activities conducted through home visiting and center-based services
- Prenatal, child, and mother medical care provided at the Primary Care Health Center
- Drop-in and other parenting services provided at the Family Enrichment Center
- Developmental child care provided at the Infant/Toddler Center
- Full-day, year-round Head Start programs

For many reasons discussed throughout this report, some program components planned at the outset took longer to put in place than was anticipated. Staff have adapted procedures and services of other components as experience dictated. All CSCD services are subject to continuing adjustment as we learn more about how best to deliver services to the participating families. The CSCD continues to offer, as it has from the beginning, a rich environment for program innovation.

Getting Started at the Center

The protocol for welcoming new families to the CSCD was refined during those first five years. Today, after a new family is identified or makes an initial contact with the CSCD, an intake worker visits their home to tell them about the program. She conducts a home assessment that explores the family's needs, interests, and concerns, then develops a set of goals and objectives. The objectives and goals include the parents and the child or children's using the CSCD, along with the other household children as appropriate.

Following intake, each new family is assigned a Parent-Child Advocate (PCA) who visits the family in their home within one month. At that time, the PCA talks further with the family to assess needs and interests and performs developmental screening for the children or arranges appointments for screenings.

Program staff then discuss the assessments and develop an Individual Family Service Plan, outlining which of the CSCD components are most appropriate, as well as referring the family to other community services they might need. Every three months the clinical supervisor reviews family goals and objectives with each new participant. Every six months the whole team (staff from each component with which the family has been involved) assesses the family's progress on these goals and objectives and helps the family set its agenda for the coming half-year.

The following discussion details the conception, development, and function of each of the CSCD's components.

Home-Based Services--Parent-Child Advocates

> *I felt close to her, as if she was a part of my family. She talked to me in comfortable ways and she listened, she cared.*
>
> A CSCD Participant

When CSCD services began in 1986 they were composed solely of the efforts of six paraprofessional home visitors called Parent-Child Advocates (PCAs). (The original job title was "Family Advocate.") The six PCAs, all Robert Taylor residents, were hired from the 100 applicants who sought this employment opportunity. PCAs were selected for their personal warmth, concern for others in the community, and an ability to relay information and provide support to parents with young children. For the program's first few months, while the CSCD searched for a permanent home, the PCAs worked out of the nearby offices of the Chicago Urban League. The PCAs went from door to door in each of the six target buildings. They talked to anyone willing to listen about the new program. The PCAs told residents that the CSCD would help pregnant women get the prenatal care, provide a place where parents could come with their babies, answer questions about toddlers and older children, and would help parents return to school or find a job. In emergencies, the CSCD would provide food, diapers, or baby clothes. When a resident agreed to participate the PCAs continued to visit regularly and became supportive friends, role models, and confidantes.

Although the CSCD came to offer a full array of site-based services, these PCAs remain the front-line workers. Home visiting continues to be a crucial part of the CSCD's program. PCAs link the families and the CSCD together. They provide a first--and lasting--trust relationship that is key to the program's success. PCAs continue door-to-door canvasses and ongoing recruitment activities to identify and engage potential participants.

During their regular home visits, PCAs provide information about health, parenting and child development; work with families to identify specific needs; and make referrals for other services. The home visitors' continued presence in the lives of the families allows them to

spot potential problems in a child's development that might otherwise go unnoticed until the child enters school.

Benefits and challenges of community staffing. Employing community residents as home visitors (and eventually as site staff) brought many benefits to the program. Community residents enhanced the program's credibility, supplied insight into community issues and specific problems facing participants, and were already familiar with behaviors and environmental responses that might be new to professional staff. The program also encountered major challenges in building a home visiting team drawn from the community. For most of the PCAs, home visitor was their first job. As a result, the staff from the community needed intensive training to compensate for a lack of experience in child development, social service delivery, record-keeping, health care, and basic job skills. Although they were community members who shared many of the problems faced by everyone in Robert Taylor, PCAs had to learn how to separate their new work roles from their private lives. Responding to the needs of this special work force added some unanticipated dimensions to program management and took extra time and energy.

Despite the challenges, drawing staff from the local population proved to be one of the most important and positive aspects of the program design. The CSCD remains committed to employing community residents. Today, more than half of the CSCD's employees are current or former residents of Robert Taylor. Some current staff themselves began as participants in the program, creating an even stronger community bond within the program. It has been particularly rewarding to see some of these community workers enter and even graduate from college.

Family Enrichment Center

> *It was different, it was a change from the normal environment . . . . It provided a lot of things you don't ordinarily get, like arts and crafts, educational movies, food sessions and different types of music.*
>
> A CSCD Family Enrichment Center Participant

The Family Enrichment Center (FEC, initially called the "Drop-In Center") at the CSCD offered a welcoming place for parents to come with their young children. Staff used "teachable moments" to offer advice on childrearing. Parents were encouraged to foster early literacy and learning by sharing books, reading, coloring, telling stories, and listening to stories their children wanted to tell. Parents could also watch staff interact with their children and then use those models in their own interactions. Parenting skills were taught formally in parent support groups, as well. Through structured and informal activities, parents learned more about their children--how they grow, how they play, and what they need at different times and different ages.

With sofas, snacks, and reading material, the FEC also provided a place for parents to get a break from the everyday responsibilities of childrearing. While parents read the newspaper, talked with their PCA, or attended a class or support group, their children were involved in age-appropriate activities with staff. Children's areas included books, toys, games, and play equipment not always available at home.

Parenting groups run by professional staff provided information to parents about what to expect from children at different ages and how to enjoy and aid their child's growth. Parenting and peer support groups also provided a forum for parents to discuss parenting techniques and share concerns. Staff watched parents in these groups transform from silent onlookers to active leaders. Staff noted that the peer interaction provided real opportunities for parents to grow as individuals and to gain an appreciation for their own capabilities.

Overcoming barriers to participation. While the staff considered the FEC one of the strongest components for formal and informal parenting education, it had difficulty drawing a large number of participants. For some parents, the concept of a casual "drop-in" program was foreign. Other participants simply had different priorities or needed other services from the CSCD. Some younger participants felt they would not fit in with a core group of older parents who used the FEC regularly. But, parents who did use the FEC and its services were enthusiastic about its many opportunities. The drop-in activities at the FEC were eventually replaced with similar, but scheduled, activities. The parent support groups and other FEC programs continued, all focused on the particular needs of different groups of parents and children.

Primary Care Health Center

> *I found out a lot of stuff about my body I didn't really know, not only me but my kids too. I go to the doctor . . . more often now. I read the little pamphlets now, I didn't used to read them. I know the different symptoms about when babies are sick.*
>
> A CSCD Primary Care Health Center Participant

The Primary Care Health Center, an on-site clinic at the CSCD, provides early childhood medical services, including early and continuous prenatal care and well-baby care for infants and toddlers. The Health Center also has an education component focused on primary prevention, early intervention, and reproductive health. Scheduled appointments allow plenty of time to explain procedures, to answer questions, and to teach simple home health care tasks (such as how to use a thermometer, how to treat colds and sores, when to get immunizations, and what to look for between well-baby visits).

The Health Center has two examining rooms. Primary pediatric care for infants and toddlers and their siblings is provided by a pediatric physician, with the help of a licensed practical nurse, a registered nurse, and a medical assistant. A family practice physician provides routine prenatal and postpartum care for women. In addition, the medical director is always available to address any medical or clinical concerns. The Health Center staff are employees of Sinai Family Health Centers, a federally qualified health center. Referrals for specialized care are made to Sinai and other appropriate providers.

During routine medical visits, in particular pregnancy-related visits, participants may admit to drug use. Following an initial diagnosis by a staff physician, participants are referred to the appropriate community resources for counseling and treatment.

Making service delivery work for the community. Providing on-site health services allows the CSCD to respond to the health care needs of the participants. Other

health care available in the community cannot promise the same convenience, quality of service, or emphasis on health education. In an area where health services are typically used only when an illness or injury reaches a crisis point, regular preventive health care must be carefully explained and actively encouraged in order to overcome entrenched ideas. Utilization rates climbed slowly, in part because many participants were unaccustomed to the level of service provided. Many had never before had a comprehensive exam or talked with a physician who took time to explain procedures or medications. Slip-shod, poor quality care had been the previous experience of some participants. For example, some children had never been asked to undress for physical examinations conducted at other facilities.

Recruiting health professionals to work in the CSCD's clinic has been an ongoing challenge. A regional shortage of nurse-practitioners has exacerbated the already difficult issue of attracting experienced, trained staff to such a high-risk, stressful environment. The CSCD has been able to find highly qualified physicians and other health service providers, but never without time lost to lengthy searches. The CSCD also has had problems retaining veteran staff who have built important relationships with participants. Nevertheless, using a part-time staff of doctors, the clinic has achieved a high level of activity, reflecting the commitment of the staff to meet the particular needs of the community.

The Infant/Toddler Center

> *[My son] learned more, could play with children better. If he wasn't going there, he wouldn't be able to communicate with other children like he does. He wouldn't be able to know the names of things like he does . . . .*
>
> A CSCD Participant

The Infant/Toddler Center was always envisioned as a CSCD core component, but it was delayed until 1989 by a series of frustrating location and licensing problems. It now flourishes on the renovated first floor of the Robert Taylor high-rise building immediately south of the CSCD's main facility. Infant/toddler childcare provides an opportunity to observe children and families from the time the children are born. That means that we can detect problems that might cause developmental delays earlier than they might otherwise be detected. The earlier the intervention the greater likelihood that the child will be at an appropriate developmental level when he or she enters kindergarten.

The only infant childcare center in all of the Chicago Housing Authority, the Infant/Toddler Center can accommodate fourteen children up to the age of two years. It is open to parents of all ages who are employed, in school, or in full-time training programs. However, teenage parents tend to have a greater need for infant care and the facility is located directly across the street from the area's high school. When teens face the double responsibilities of childrearing and finishing school, they require childcare services specially adapted to their own developmental needs and the needs of younger babies. In creating the Infant/Toddler Center the CSCD is placing extra program emphasis where it is most needed.

The Infant/Toddler Center offers an inviting place for babies to spend the day--it is clean, bright, and colorful, with high-quality toys and equipment. Children can come to the

Center weekdays from 7:30 a.m. to 5:30 p.m. Under the guidance of early childhood educators and community staff (a number of whom are CSCD participants who were hired and trained to work in the Center), babies receive quality care. A Parent-Infant Consultant administers developmental screening for each infant and toddler and conducts ongoing staff training.

Full-Day Head Start and Two-Year-Old Childcare Program

In the fall of 1991, the CSCD obtained funding to set up two full-day Head Start classrooms for thirty-three children of participant families, as well as full-day developmental childcare for nine two-year-olds. With this program expansion, the CSCD offers a full continuum of year-round quality childcare services for children from three months to five years of age.

The full-day Head Start and childcare programs at the CSCD differ from what is available in existing Head Start programs in important ways. First, most Head Start programs provide only half-day care for children nine months of the year. Second, regular Head Start programs serve only children three to five years old. Thus, before the CSCD expanded its services, children who graduated from the CSCD's Infant/Toddler Center by turning two and some older children (three to five years of age) had no childcare available that would allow parents to attend school or work full-time.

Although still not sufficient to meet the community need, these programs at the CSCD allow families to move from part-time to full-time schooling or employment while their children remain in a familiar childcare setting cared for by trusted caregivers. This continuity of care--throughout the day and over the years--is an important aspect of healthy child development and is one more support to families as they move out into the work world.

Childcare programs are the only CSCD services for which there is a fee. Parents pay on a sliding scale based on their incomes. The typical payment is $1 per month. All fees paid taken together do not begin to approach the cost of these programs. But most parents are fiercely proud of providing support. Those single dollar bills paid month after month symbolize the parents' determination to secure the best for their children.

2. The Retrospective Analysis: Assessing the First Five Years

Introduction

The CSCD Retrospective Analysis was designed as a qualitative history of the first five years. It is based on extensive interviews with ninety-five participants and forty-five staff members. Our original intention was to interview participants in three categories: currently active in the program, formerly active, and not yet or never active. The constraints of interviewing at the CSCD, problems associated with the continuous development of programming, and self-selection of participant interviewees all conspired to make our original design unworkable. Because of this sample selection difficulty, and because we felt that quantitative methods would not by themselves adequately reflect the CSCD experience, we chose to ground the methodology for the Retrospective Analysis in ethnographic research methods.

Ethnographic methods are particularly well suited for researchers seeking to understand the processes of a living, evolving society. The ethnographic interview, because it uses open-ended questions and allows for the possibility of different but equivalent phrasing of questions and answers, offered a significant advantage for the Retrospective. It allowed us to raise important empathic questions, describe processes, and give voice to the people living out the issues under investigation. The resulting interviews yielded an extremely rich history of an evolving program.

The collective memory of this self-selected, somewhat eclectic cohort yielded deep but narrow data. Using these data we were able to capture some measure of the collective experience of the CSCD participants and staff. Also, these data allow us to better understand the real life of families living in the Robert Taylor Homes and how our program fits into that reality. Overall, they provide signposts and reveal patterns that give us a richer understanding of the program's evolution than we would have been able to glean from quantitative analyses or from an administrative history. The Retrospective Analysis elaborates on some of the critical aspects of the CSCD experience, such as the role of violence in the life of the community and the life of the program.

Program Participants and Their Use of Services

Seven hundred families used the CSCD's services during its first five years. The ninety-five interviewees were recruited from a list of active and inactive participants, and by advertising for respondents in the community. Each woman participated in a two-to-three hour interview that collected data on her program experiences, school and employment history, family background, aspirations for herself and her children, and community experiences. The participant interviewing instrument combined both closed-ended ("Yes" or "No") and open-ended ("Why?" "Can you describe?") response categories.

Interviewing was conducted over a six-month period by three paraprofessionals who had been employed at the CSCD, had prior work experience in the community, and were sensitive to participants' personal needs and concerns. The community experience that the interviewers brought with them was beneficial to the data collection process. Because the

interviewers already knew many participants personally, they proved key to locating, recruiting, and interviewing the participants during the six-month period.

Specifically, each participant provided the following information:

- **Description of program participants**. Interviewees provided information about past and current household composition; their age when they moved into the Robert Taylor Homes; personal and parental education and employment histories; future goals; family sources of income (past and current); marital status; age at the birth of their first child; and age at intake into the program.

- **Service utilization**. Parents who responded also provided information about how they were recruited or referred to the CSCD; the nature of their participation in CSCD components (i.e., Parent-Child Advocates, Family Enrichment Center, Primary Care Health Center, Infant/Toddler childcare) and other activities; the frequency and level of their initial and current involvement in the program; how their involvement in the program changed and how much involvement they would like to have; and the duration of their involvement in each component. Information was also collected about the areas of need (e.g., children's health care, parenting skills, family planning, material aid) with which the CSCD assisted participants.

- **Participants' program experiences**. Participants were given the opportunity to describe their feelings about their experiences at the CSCD and the services they received. They were asked to describe their experience with each of the components; their comfort using these components for themselves and their children; how helpful each component was; the services received; and the changes they perceived in their lives as a result of participating in each component. Participants were asked to describe their relationships with CSCD staff and explain what (if any) impact the staff and/or each program component had on their lives and the lives of their children.

A Look at Program Participants

Biographical information provided from the interviews presents an interesting, and in some ways, unexpected portrait of the CSCD participant. An "average" participant is twenty-two years old, has between one and two children, has been living in Robert Taylor Homes since childhood, and grew up in a two-parent home with parents who worked at least part time and received some public assistance. Although her parents were unlikely to have finished high school, the participant herself probably graduated from high school, had her first child while still a teenager, and wants to extend her education. Although likely to be a single parent receiving public assistance, the average participant relies on her own mother or her male partner for extra emotional or financial support and for help caring for her children. She is likely to use the CSCD's services for two or three years, with a hiatus or two lasting several months.

Early family life and education. Nearly half of the participants interviewed grew up in two-parent homes. Most others grew up living with their mothers or with one or both grandparents (see Table 1). Many participants were unaware of their parents' level of education. More than one-third could not name the highest grade completed by their mothers and more than half could not name the highest grade completed by their fathers. Among those who knew their parents' educational history, only a few came from homes where either parent had acquired any postsecondary education. Overall, 24 percent of participants reported that their mothers had completed high school or obtained a general equivalency degree and 17 percent said that their fathers were high school graduates or GED recipients. Slightly fewer than 10 percent said their fathers had some college education. Slightly more than 10 percent said that their mothers had attended college and 2.4 percent said that their mothers were college graduates. The majority of participants reported that their parents supported their families through employment and/or some form of public assistance (see Table 2).

Participants' own educational attainment exceeded that of their parents. Forty percent completed the twelfth grade. Fully 90 percent reported wanting to further their education. In fact, when participants were asked to list their top five goals, attending or finishing school was the second most frequent response.

Current family life. While most CSCD participants interviewed were single mothers receiving some form of public assistance, a few were employed either full- or part-time when interviewed (Table 2). Most told us that when they needed financial or emotional support, they most often turned to their mothers (42 percent). Other sources of support were the father of the baby (14.7 percent) or the husband or significant male in their lives (9.5 percent). Male partners and mothers were also the individuals who most often helped care for the participant's children. Thirteen percent said they turned to themselves or to no one for financial and emotional support and 41 percent said that they turned to themselves or no one to help them with their children.

Age. At entry into the CSCD, participants' ages ranged from twelve to thirty-five years, with an average age of twenty-two years. More than a third of the participants, however, began coming to the CSCD between the ages of twelve and seventeen years and 87 percent of the participants were mothers before reaching age twenty. Nearly half (48.4 percent) were mothers by age sixteen.

Total length of involvement at the CSCD. Participation in CSCD programs averaged about twenty-nine months. Fourteen percent of the participants were involved in the program for more than four years, 21 percent for three to four years, 24 percent for two to three years, and the remaining 41 percent for one to two years. Almost half of those we interviewed reported that they had stopped participating in the program at least once or twice, most for a period of less than a year.

Table 1: Primary Caregiver to Participant Mother During Her Childhood	
Mother	40.4%
Father	2.1
Both parents	43.6
Grandparent(s)	10.6
Foster home	3.2
Total [N = 95]	100

Table 2: Income Sources		
	Household in Which the Participant Grew Up[1]	**Participant's Current Household[1]**
Employment	64.2%	5%
Public Assistance	51.6	97
Social Security	6.3	(All other sources total 6%)
Veterans Benefits	1	
Child Support	1	

[1]Because households have multiple sources of income the percentages will not total to 100 percent.

Participants' Use of Services

Parent-Child Advocate (PCA) component. More than one-third of those interviewed first heard of the CSCD from a Parent-Child Advocate. Many participants told us that PCAs were instrumental in helping with financial, housing, education, childcare, and employment problems. PCAs also helped participants deal with the Illinois Department of Children and Family Services, the courts, and the foster care system; provided emotional support during personal relationship and other problems; helped participants sharpen their parenting skills; and assisted in obtaining health care and family planning services.

At some point during their CSCD involvement, every participant used the PCA component. Most participants worked consistently with only one or two PCAs, but some had contact with up to five. The amount of contact between participants and PCAs decreased over time. Seventy-six percent of the participants reported that the total number of PCA home visits had decreased over time (Table 3), but the length of time that PCAs spent with participants during home visits remained constant.

Contact with PCAs during visits to the CSCD also decreased for most participants (Table 3). A sizable number reported wanting more contact with their PCAs in their homes

and at the CSCD, even though over half of the participants reported receiving telephone calls from their PCAs monthly or weekly.

Table 3: Change in Participant Use of Services over Time

	PCA Home Visits [92 Responding]	PCA Center Visits [89 Responding]	Family Enrichment Center [74 Responding]	Primary Care Center (for child) [86 Responding]
Increase	3.3%	7.9%	12.2%	9.3%
Decrease	76.1	73	79.7	63.9
Same	20.6	19.1	8.1	26.7

Participants often compared their PCAs to mothers, sisters, and aunts. Some credited their PCAs with changing aspects of their lives, particularly their relationships with their children. One participant reported, "[There were] changes in me because my Parent-Child Advocate lifted my spirits, and changes coming from me is why kids change." Another commented, "I became more patient with my children. I don't walk off and turn my back to them any more. We really talk like people are supposed to." One woman told us about the attention she received from her PCA. "She helps me with whatever she can . . .She lets me know . . . how important it is for me to keep clinic appointments for myself and my children." Another mentioned the personal bond she shared with her Advocate. "We had a good relationship . . . she would always make me smile . . . . I could talk to her about all my problems." Still another talked about issues PCAs frequently need to confront. "She helped me focus on myself and my children. I was going through some rough times with my husband. She helped me to get control of my life."

Each PCA had to earn the trust of the families with whom they worked. Most participants trusted their PCAs. In a community where trust is rare, PCAs had to establish early on that interactions and discussions would remain private. A small number of participants suggested that they had been unable to trust their PCAs because their confidentiality had been breached. We heard complaints such as "I heard things that people said about me. [A PCA] would repeat your business to her clients. That happened to me a few times and I didn't like it." Such experiences might cause a participant to stop using a particular PCA or to quit the CSCD altogether.

Family Enrichment Center (FEC). The FEC underwent many changes over five years as we tried to find the right blend of casual time, focused programming, and staffing. It never attained the high level of regular, ongoing participation that had been initially envisioned for it. The frequent changes in staffing and programming may have contributed to the mixed feelings some participants voiced about their FEC experiences. Eighty percent of all participant interviewees used the FEC at some time. Most came in weekly for several hours at a time. Participants' use of the FEC decreased with time. At the time of the interview, half of the participants were not using the FEC at all and many who did used it sporadically. In part, this was because some families who had been involved for some time began to seek other activities, such as preschool, for their children. Others said their

involvement dropped because the CSCD halved hours the FEC was open. Limiting hours confused some participants and made others feel unwelcome. A few participants complained that staff and activities within the FEC changed too rapidly.

For the most part, participants were unhappy when the FEC hours became more limited. They told us they liked being able to interact in meetings and talk to other parents in the parenting classes; that their children "really like" the FEC; that they wanted their children to be in other kinds of surroundings, saying things like "I don't get a chance to take them out much"; and that the FEC had fun activities. Participants said the FEC helped them learn about child development and obtain parenting skills. Sixty-four percent of the participants took part in the parenting groups at some time during their involvement. A substantial number also took advantage of the opportunity to consult with staff.

Some participants disliked the FEC. These complained that the activities were boring and were designed for children or that the children were too noisy. Others liked the focus of parents *with* their children. "It gives you a chance to communicate with your child and friends," said one mother.

Many of the participants who used the FEC said they learned to communicate with their children through touching and holding them, and acquired alternative ways of disciplining from striking or yelling at their children. Individual participants reported spending more time helping children with homework, being more patient with their children, and communicating better.

Infant/Toddler childcare. The CSCD's Infant/Toddler Center opened in December of 1989, with space for fourteen children aged between three months and two years. Eighteen percent of the interviewees participated in the day care component at some time during their involvement in the program and the vast majority expressed satisfaction with its services.

Those who used the Infant/Toddler Center appreciated the high quality of care their children received and felt safe leaving them with the staff. Parents commented that, while ordinarily they might not have been comfortable with the idea of childcare, they were more willing to try the Infant/Toddler Center because of its connection to other CSCD programs, specifically the FEC and the Primary Care Health Center. Some of the participants reported, "I like it because it helped me finish school," or "I felt good knowing people are able to take care of her like I do." For the most part, its popularity reflected its mission: it allowed participants to attend school and/or to maintain employment.

Participants reported feeling good about the changes in and accomplishments of their children. One participant told us, "I liked them 'cause they taught him a lot. They taught him how to drink from a cup, how to use the path, and helped him learn how to walk around." Another mother also liked seeing her child learn: "They taught [my] child to eat by herself. Every time she came home it seemed like she knew new words and sounds." The interaction with other children was also important. One mother said, "[My] child learned more, could play with children better. He is easier to talk to." Even those who regretted not being the person at home with their children gave the Infant/Toddler Center good reviews. One young mom said, "It was a good thing for my child and I like all the things that they

would do. They had everything, the care was good. The experience was new, but good for both of us."

Primary Care Health Center. The Primary Care Health Center opened in March of 1988. It served 90 percent of participants questioned and/or their children at some point in their CSCD involvement. More than half of those interviewed had used the Health Center for preventive visits, which include check-ups, family planning, gynecological examinations, and prenatal examinations. Other reasons given for clinic use were sick visits (appendicitis, gynecological problems, migraine headaches, chest pains, and hypertension) and pregnancy-related care. Participants' children, too, used the clinic most often for well visits, including check-ups, immunizations, school physical examinations, and vision or hearing screening. Thirty-eight percent of children's visits were considered sick visits, which would include treatment for colds, asthma, ear infections, rashes, first aid (e.g., insect bites, bruises, cuts), fever, and stomach-aches (Table 4).

Participants reported using the clinic mostly for their children's health care. While more than half stated that the clinic was the primary health care provider for their children, only 19 percent of adult participants used the clinic as their own principal provider. Many participants may have already had established relationships with other community medical clinics.

For a variety of reasons, the frequency of visits by both the participants we interviewed and their children decreased after their initial involvement in the program. Some of the reasons given for these changes indicate good news. Some participants told us that their visits dropped off because their children got sick less often. Some other participants believed (erroneously) that the clinic would not be available to them if they went off Medicaid because of a job, or they believed there was no longer a reason to come in after a child's immunizations were up-to-date. Still others admitted they "would forget [a child's] appointments." Low clinic usage by adults might also have resulted in part from the lack of consistent staffing by an obstetrician and gynecologist before January, 1991. Under those temporary circumstances, many participants preferred to remain with providers with whom they were already familiar.

Although not many participants interviewed used the Primary Care Health Clinic as their *primary* health facility, those who did use the component felt that both their health behavior (e.g., keeping appointments, bringing children in for check-ups) and their children's physical health had improved. Some participants told us they had learned how to identify and respond to problems. One mother said, "I know when they're sick I bring them here first and ask what should I do." Another said it was "helpful to learn about symptoms and signs to make sure my kids were healthy. It made me aware of health."

Staff found particularly gratifying the comments about the quality of the CSCD's health clinic. One of the goals of the clinic is to teach participants how to be good consumers of health care; that is, what to expect from a doctor, and how to ask questions about the care they or their children receive.

Some participants underscored how essential their relationship with a PCA had been to improving their attitude toward health and health care. One woman told us her Advocate

"made sure I kept kids' appointments. If my kids were sick [my PCA] made a way for them to see the doctor." Another mother credited the clinic and her PCA with helping her improve her focus on health care and, consequently, her relationship with her child. "I take better care of [my] child," she told us. "I keep his appointments. He's not sick all the time, so I spend more time now giving him a hug."

Table 4: Reasons for Using Primary Care Health Center

	Participants		Participants' Children	
Services	**[N]**	**Percentage[1]**	**[N]**	**Percentage**
Well visit	[31]	53.4%	[108]	56%
Sick visit	[20]	34.5	[74]	38.3
Pregnancy-related visit	[16]	27.6	[0]	0
Other	[01]	1.7	[11]	5.7
Total	[68]		[193]	

[1]Percentages may not add to 100 because participants identified more than one reason for visiting the Health Center.

Overall Helpfulness to Participants

The Retrospective Analysis attempted to gauge the CSCD's overall helpfulness. The degree to which participants found CSCD helpful with their own educational goals, employment, family planning, involvement with the Illinois Department of Children and Family Services, their children's readiness for kindergarten, and issues involving drugs, alcohol, and community violence is detailed below. (Also see Table 5.)

Education and employment. Forty-two percent of the participants reported that the CSCD, and particularly the PCAs, helped with their education needs (Table 5). Some described direct help, such as the PCA who "helped make phone calls, and talked to the counselor to get me back in school." Another "went to the school, tried to get me back in and referred me for computer training." Half of the participants said that the CSCD was helpful with employment, citing "help writing my resume for this job," "providing information and referral," and "encourag[ing] me to volunteer."

Family planning. The vast majority of participants reported receiving birth control information (Table 5). Sixty-four percent reported actually using a method of birth control, most often oral contraceptives. Here again, PCAs played a major role along with the health clinic. Many participants told us they had discussed family planning. One told us that her PCA "talked with me about birth control and gave me information before I had my baby so I knew what I was going to use." Another described the clinic as "really helpful because they had a doctor who talked about different stuff concerning birth control." A third told us how her PCA "explained how different things worked like the IUD, diaphragm, and pills. [The information] made me look at it in other ways because I didn't know how to use it before."

Department of Children and Family Services. We were initially concerned that, of the 43 percent of participants who reported having contact with the Department of Children and Family Services (DCFS), 61 percent reported that the CSCD was not helpful in this regard (Table 5). A closer look at follow-up questions, however, revealed that, of those who said the CSCD had not helped, most either had not informed the CSCD about their involvement with DCFS or their involvement with DCFS occurred prior to CSCD enrollment. For the 39 percent of participants who reported that the CSCD *had* been helpful with DCFS, some credited the CSCD with "assisting us in getting beds," "getting me parenting classes," "supporting me; [the PCA] talked to my DCFS worker," and "making sure I met DCFS requirements through CSCD follow-up programs as needed."

Table 5: Participant Evaluation of CSCD Effectiveness

	All Participants [95]
Birth Control [Responding]	[94]
Participant received information	89.4%
Participant did not receive information	10.6
Child's School Readiness [Responding]	[89]
Helpful	90%
Not helpful	4
Don't know	6
Employment [Responding]	[62]
Helpful	50%
Not helpful	14.5
Don't know	35.5
Parents Education [Responding]	[83]
Helpful	42.2%
Not helpful	54.2
Don't know	3.6
In dealing with DCFS [Responding are 41 participants who had contact with DCFS]	[41]
Helpful	38.9%
Not helpful	61.1

School readiness. The question that elicited the widest range of comments was whether the CSCD helped prepare participants' children to be ready for formal schooling (i.e. kindergarten or Head Start). The participants' answers reflected wonderfully the CSCD's definition of "school readiness," a definition that spans cognitive, social, emotional, and physical achievement. For example, one participant told us that, "[the CSCD] gave books, ABCs, numbers. They have blocks for [children] to spell with; they let them write ABCs." Others said the CSCD "helped [my daughter] communicate with others"; "showed me different ways to teach children at home"; "exposed [my child] to activities and other children;" and "taught [my son] to sit still and listen better. Now he completes what he starts." The CSCD also helped parents become better advocates for their children in a variety of ways. One said, "They let me know what to look for in a school." Another told us the CSCD "helps make sure shot records and other necessary papers are ready."

Violence. The majority of participants interviewed said that they did not talk with CSCD staff about violence in the community or their experiences with violence, and that they did not believe the CSCD could really help with drug-related issues. Nonetheless, these aspects of life continue to have a major impact on participants, their children, and the whole Robert Taylor community. Because the CSCD and its families cannot help but be affected by the pervasive atmosphere of danger created by the drug trade, this report includes a special section focusing on the effects of violence in the community and in the CSCD's day-to-day operations. Participant responses to specific questions in these areas will be discussed in that later section.

Better parenting. Even those participants who had reservations about individual aspects of the program expressed either satisfaction or enthusiasm for the CSCD overall. Particularly interesting in light of staff concern over criticizing parenting techniques (see Race, Culture, and Class, below), were comments on how the CSCD helped participants become better parents. Parents said that their relationships with their children improved, that they were able to cope with conflicts calmly, and that they learned about their children's development and its influence on family interactions. One parent said:

> I have enjoyed being a part of the program. I have learned a lot more about being a parent. My child doesn't run away from me anymore. It's been a good experience for me having a Parent-Child Advocate.

Another talked about a program in the FEC.

> The Knowing Your Child sessions really have helped me a lot. It brought me back to the program. I want what's best for my child. At first I didn't agree with what [the staff leader] said, but I found out that if you really try, those things really work. It helped me a lot with [my] child. She helped me realize that my son was a person, too.

Other participants echoed the enthusiasm for both the Knowing Your Child and parenting sessions. One said, "We learned a lot from staff: how to discipline with talk and not whip." Another said:

> The [parent sessions] talked about how to develop relationships with your child. [The staff leader] talks about things you don't know about, like good health and spending

> time. The sessions help you deal with yourself and what you want to get out of life, and focused on you and your children. It taught me a lot. I'm communicating better with my kids.

Another said the staff member "tells you to go and check on your kids to see how they're doing in school and get to know their teacher's name. I go to their schools and [my children and I] are closer."

Participants gave a general thumbs-up for the array of services the CSCD offered. One said,"I was glad to get in the program. I met a lot of parents and staff, and the kids like the activities." Another parent singled out the health education aspects of the CSCD when she said:

> I learned how to take care of a child, what to fix for him and how to make him stay healthy, like [keeping] clinic appointments, [giving him] vitamins, how to help a child with asthma. It was a good experience because they taught me all these things.

One participant summed up the CSCD experience at its best, and ended with the lament most common to participants and staff alike:

> CSCD benefitted me in a way nobody ever did. They saved me a lot of money for babysitting . . . . When the [Infant/Toddler Center] opened I was able to save money. The clinic helped me a lot with my baby. He kept getting ear infections, and they helped me to be able to take care of him better. If it wasn't for the people at the Center I could never have gotten a lot of the good jobs that I've been able to get. The sessions with [staff] are great. We just don't have enough time. I wish we could get more time.

Inside the Center: The Staff's View

The Ounce of Prevention Fund addressed program problems and identified successful program components by examining the use of services, by interviewing participants, and by capturing the views of the staff. This section draws on staff and participant answers to open-ended questions from the Retrospective Analysis. It attempts to paint a detailed picture of the CSCD's development and to evoke some of the behind-the-scenes character and personality of the program through the first five years.

The Retrospective Analysis included extensive interviews with forty-five CSCD professionals, including current and former staff and consultants. Like the participant interviews, staff interviews examined the content of the program components, the strengths and weaknesses of the program, and the staff members' experiences with the program's development and operation. The staff interviews elicited some fascinating insights into the program and the community. They provide perspective on some of the conflicts with which the CSCD has had to grapple over the years. Some of the staff's comments reflect well on the CSCD's growth and response to extraordinary challenges. Other comments point to weaknesses in planning or to the continuing tensions within the endeavor. In both cases, the perspectives of the staff members are invaluable in raising fundamental program development issues that do not generally receive the scrutiny they deserve. In this section,

we try to bring some of those issues to light.

A Diversity of Approaches

The CSCD brought together an interdisciplinary professional staff, community members who conducted home visits and other outreach activities, and parents who worked as volunteers and served on advisory committees. Staff members, consultants, or volunteers brought their own sets of beliefs about what was needed in the community. To some degree, everyone who came to the CSCD had made a life choice. The unifying element among all the staff was a passion for the program and the community, as well as a belief that through their personal contributions the lives of the residents could change.

Along with zeal, however, came conflict. Staff members with clinical social work backgrounds sometimes had different priorities from those with a child development focus or a public health orientation. Some staff wanted to adopt a model of intervention oriented to treating problems or illness, while others believed in a model that built on strengths and promoted "wellness." Some staff believed the CSCD should provide different services than originally envisioned because families were asking for things the needs assessment had not identified.

While the richness and diversity of the CSCD's programs stem from the many different perspectives of those who formed and nurtured it, some of the greatest hurdles the program faced derived from this same diversity of views and values. While staff realized early on that an interdisciplinary "whole" was needed to respond to participants' multiple needs, there were few historical examples of varied disciplines working together on such a project outside of the academic community.

Academic and professional diversity. The CSCD professional staff was of the highest caliber. Their commitment to the work and the community was undeniable. But, as they came from different academic backgrounds, each had a different theoretical framework which he or she brought to the job. Their different professional orientations, career experiences, and personal and cultural values had a tremendous impact on how the program's goals were pursued and the mission was carried out. Each professional felt the CSCD goals should reflect his or her own philosophy and experience.

It was not always easy to achieve consensus. The first CSCD Director had formal training in the field of early childhood education. Another manager had a doctorate in developmental/organizational psychology with years of experience directing programs. A clinical social worker with a masters degree in social work viewed families as total units and preferred to work on an adult-focused model. The research director had worked for many years in an academic setting, but had worked with populations similar to the CSCD participants. Other staff included an early childhood expert and an infant specialist who were primarily child-focused and believed in focusing on parent-child interactions and child development concerns, and a pediatrician who had been trained by the child development expert Dr. T. Berry Brazelton.

While sufficient time is a critical element in building successful collaborations, at the CSCD the overriding priority was getting services in place. Consequently, in the early

stages of the program, different components developed in isolation from each other. Differing academic and professional perspectives fostered decentralization. The isolation of components contributed to a lack of consensus and cohesion. Few staff members felt they received the necessary support for their efforts. And because families choose which components they want to use and how and when they want to use them, the utilization rates across the various components were uneven.

One solution was to stress to staff how the services at the CSCD formed a network of support. Addressing the problems stemming from staff diversity took time and detracted from the focus on helping families. But these discussions allowed staff to forge a common understanding. These talks strengthened the internal structure of the CSCD and encouraged integration of the services that now make up the whole program. Today, the team is still interdisciplinary. For example, medical and early childhood professionals travel together in the community on home visits. This allows them to bring different observation skills to their work with families. Staff from each discipline meet to share information, agree upon an intervention plan, and work to provide the services from each CSCD component or outside resource that will best help the family in a comprehensive way.

Race, Culture, and Class

In addition to a variety of academic agendas, the CSCD brings together professionals, consultants, and other support staff of different races and economic backgrounds. Most of the academic consultants employed early in the CSCD's operations were white, middle-class professionals. Their personal experiences and values were perceived as different from the primarily African-American CSCD permanent staff. Many early staff members expressed concerns about consultants' assumptions and statements that they saw as judgmental about the community and its residents.

In turn, consultants felt constrained by sensitivities to racism and bias and reported being very careful and conservative in their assessments of children, possibly to the detriment of the program and the families. The white staff felt that they could not speak of the negative situations they observed or talk openly about weaknesses they perceived in the children or the community. That some things were not said suggests a serious lack of trust among the staff members at the time and calls into question the honesty of the risk assessments central to the CSCD's program design.

In addition, questions concerning cultural bias and racial sensitivity were raised when differences of opinion arose between the predominantly African-American CSCD staff and white administrators. In the interviews, for example, some CSCD staff complained that off-site, white funders and program administrators focused too heavily on statistical indicators from the program without enough understanding of the real lives, culture, and life issues of the people being served by the CSCD.

Cultural responsiveness. Staff were particularly concerned with cultural responsiveness, that is, the process of understanding how the experience of being African-American and poor creates different norms and standards for life within the community. Staff worried that those coming in to work with CSCD participants would not be able to see beyond mainstream beliefs; to know, for example, that traditional measures of development

such as "age-appropriate behavior" might have little practical application in the Robert Taylor Homes community. The children of Robert Taylor and other similar settings have been described as living in a bicultural society without the benefits of having this bicultural status recognized or supported by others. Children must adapt to their own home culture as well as the "mainstream" culture--an emotionally challenging and exhausting effort for any child, but a particularly harsh reality for those whose efforts garner neither the recognition nor the respect they deserve. Thus, what might be "appropriate behavior" on a typically-used developmental scale could in fact be maladaptive for certain children. Staff were concerned that children (and parents) could be further stigmatized by a negative assessment when in fact their behavior might be perfectly appropriate for their environment.

For example, a baby developing normally learns to crawl in order to investigate her surroundings or pursue an object of interest. Staff noted that parents in Robert Taylor frequently limit a baby's movements by holding or restricting the child. Although such behavior might stem from a mother not knowing that her baby needs to crawl, the mother may also be protecting her child from insecticide or rodent poison on the floor or from other hazards to a free-roaming baby. The baby's developmental needs, in that case, are in conflict with the parent's need and desire to protect her child. (In some such cases the loan of a playpen from the CSCD offered the child a chance to develop motor skills in relative safety.) At the CSCD, as in any multiracial, multicultural organization, the issue of cultural responsiveness demands careful attention and patience from everyone.

Professionals and Paraprofessionals

The commitment to take an established and well-researched intervention model and replicate it using paraprofessionals in lieu of highly-trained professionals was the centerpiece of the CSCD experiment. In separate research projects, Dr. Ron Lally and Dr. Sally Provence had both shown that the comprehensive family support model based on improving parent-child relationships could improve children's readiness for school and for life. But they had demonstrated its effectiveness twenty years earlier in very controlled settings with a staff of professionals trained and prepared to implement the intervention. The scope of the CSCD's challenge at Robert Taylor Homes in the 1980s was put in perspective by Lally himself, who judged it ten times more difficult than what he faced in the 1970s with his Syracuse family support program.

The CSCD set out to show that the model could work in the dynamic setting of a public housing development, with a major piece of the service component being provided by paraprofessional Parent-Child Advocates--individuals from the target community itself for whom this might be a first opportunity to work full time. Although the PCAs were community residents with limited employment experience, they were dedicated risk-takers. Because many of the Advocates' experiences were similar to the participants' own experiences, they were able to understand and communicate with the families. A job at the CSCD presented them an opportunity to become financially self-sufficient and to be resources and role models to their community.

The Advocates themselves, however, had differing views about how to achieve the goals of the program. Job training for PCAs at the CSCD included workshops on parenting, child development, nutrition, and health care. The training forced them to question some of

the ways they handled problems. For example, some PCAs had before never had their own parenting methods challenged. To work effectively with participant families, they found they first had to accept new perspectives and deal with their own feelings and values. Also, some PCAs felt they were rejecting their backgrounds by embracing this new world.

Because, for many, the position of PCA was their first job, they had to learn to be effective home visitors while also learning the basics of employment, such as being on time for appointments, following through on tasks, and record-keeping. For some PCAs, the lines between work and friendship became blurred. They saw themselves as self-appointed teachers to their friends, families, and neighbors. As a result, they sometimes encountered resentment and envy before being allowed to help.

Supporting the PCAs and devoting the necessary effort to their training took more time than originally anticipated, and remains a challenge to the program as experienced Advocates leave and are replaced by new staff. Approaches have included addressing more issues in the trainings and pairing paraprofessionals with professional staff in home visiting teams. Pairing professionals and paraprofessionals builds bridges across cultural divides.

Defining and Responding to Community Needs

A common conflict between social service providers and the community targeted for help stems from different perceptions of the kind of help needed. The vehicle for solving these conflicts before they arise is the "needs assessment." At the CSCD, the needs assessment itself came under staff criticism after the program had begun. Families in the community had answered the questions we asked in the needs assessment, but once the program was operational, participating families began asking for assistance in areas the CSCD was unprepared to address, except through referral. When faced with such requests, some staff understandably concluded that the CSCD should accept a family's definition of their own needs and shift its focus. Social workers, in particular, argued that "higher order" psychoemotional needs could not begin to be addressed while families struggled with basic needs for food, safe shelter, and love. Other professionals argued that early parent-child interaction was key to healthy child development and that the CSCD model, based as it was on that agenda, should not try to respond to every family need in this radically depleted community. Said one former consultant, "The program isn't in a position to provide concrete things, but it can do something to increase parent-child interaction."

Advocates on the front lines. Parent-Child Advocates were caught between these competing definitions. Because the PCAs were the first outreach workers and recruiters for the program, they felt they had no choice but to cope with what families presented to them. PCAs reported that participants came for concrete needs such as diapers, milk, and transit tokens, as well other needs, such as well-child care, family planning assistance, and advice on problems with children. PCAs responded as best they could to each new family's situation and needs. Many staff believed this was an appropriate way to respond. They felt strongly that parents and families needed to feel empowered, respected, and valued in order to raise healthy children and to be able to pass this positive and healthy attitude on to their children. They also believed that once parents felt good about themselves they would be good parents, providing the nurturing and support that is necessary for positive child development.

After basic needs were met, PCAs said, participants came for emotional support. Some turned to the CSCD to help them find employment and move toward self-sufficiency. This was especially true of the men in the community. But many of the families desiring jobs needed more help to achieve employment than the CSCD alone could offer. The skills necessary for employment had never been developed. Many of the participants had not finished high school nor completed requirements for a general equivalency degree (GED). Their mental health needs were also beyond the limited counseling available through the CSCD's clinical social worker. It wasn't possible to meet the long-term counseling needs at the CSCD.

PCAs initially responded more to participants' needs for concrete items such as food or transit tokens than to their pressing emotional support needs. And Advocates continue to believe that some participants will never use the CSCD for more than those concrete items. As members of the community themselves, Advocates understand the need for these tangible goods, but they also know that it's easier for participants to express a need for concrete items than to try to cope with the range of extreme psychological and emotional pressures common to life in the community. They also understand that a breakthrough can occur at any time, and therefore it is critical to maintain the relationship. Moreover, the more the PCAs gained experience in identifying the intangible requirements of a family, such as the need for information or simply for encouragement, the more likely they were to address them.

Filling the service gaps. While attempting to respond somewhat through referrals, the CSCD also tried to build its capacity to fill service gaps in the community. It was an effort that sometimes took us in unplanned directions and caused some staff to feel less certain of the central purpose of the project. Participants presented problems that were not part of the original vision for CSCD programming. Staff members reported a growing problem with drug use in the community. PCAs said it was difficult to work with drug-using parents, who were unlikely to use CSCD services or take suggestions. Staff members understand that the CSCD cannot solve the community drug problem. But they say that because there is no CSCD drug program and because there are insufficient opportunities to get help with drug problems elsewhere in the community, many of the family problems will never be solved. Responding to drug-user needs through referrals runs up against a difficult reality: needed services are diminishing or unavailable.

Cultural and Environmental Influences on Parenting Behavior

No issue more clearly underscored the tension between the CSCD's vision and participants' own perceptions of need than the issue of what constitutes good parenting behavior. In the Robert Taylor Homes community, how the CSCD presented its parenting education services also became a litmus test for cultural responsiveness. In general, African-American staff believed that the CSCD approach embodied mainstream definitions of good parenting and while participants' parenting styles might differ from that norm, this did not automatically mean that they were bad parents or that their behavior was inappropriate within their environment.

As discussed earlier, parents in low-income, high-risk neighborhoods tend to be more restrictive with their children in an effort to protect them. The reality in public housing like

Robert Taylor is that children need to be protected from hazards within their homes as well as outside on the playground and on the balcony or breezeway. In the real world of drugs and gangs, both random violence and recruitment activities threaten children from a very early age.

Differing views on good parenting. Restrictive parenting is a matter of survival for many families. Parents fear that their children will not learn the toughness needed for survival in their environment. When children are shy or quiet, they are easy prey for the more powerful or aggressive. Although outsiders might balk at what they see in families under these circumstances, staff insisted that we don't know enough about childrearing in violent communities to condemn participants' approaches. One staff member referred to the Robert Taylor Homes as "a different culture." While children might need to behave one way in order to fit into the mainstream later, she explained, they need to be very different people to survive at home.

Paraprofessional staff, in particular, resented what they perceived as the implication that parents in Robert Taylor were bad parents. They believed the degree and regularity of any behavior had to be considered in context before judgements were passed. Criticizing culturally accepted behavior such as spanking or yelling at children was considered insensitive to the local culture. Children, many believed, adjust to the manner in which they are treated at home and know they are loved by their parents in spite of the harshness with which they are addressed.

Learning new approaches. In response, professional staff introduced different methods of parenting for participants through parent discussion groups and parent-child interaction activities. As different parenting techniques were introduced, parents were able to use the CSCD to test what felt comfortable and discuss issues with the infant specialist or early childhood development staff. Gradually, in spite of their ambivalence, PCAs said they began to notice changes in the families they worked with. One PCA said she noticed parents controlling their tempers better. Family stress was reduced, many said, attitudes changed, and children seemed calmer. Parents provided more structure for the children and talked less harshly, and kids who had arrived hitting or fighting before behaved better, and even asked for hugs.

3. Violence and its Effects

I have seen more violence here than ever in my life.

A CSCD staff member

To communicate the profound impact of violence on the families in the Robert Taylor Homes, we could discuss official statistics that reveal Grand Boulevard's high rates of murder and violent crime. Or we could recount in detail how violence has affected the CSCD program itself. The CSCD staff had to install bullet-proof glass in Center windows to reduce the risk of injuries from nearby shootings. The Infant/Toddler Center entrance was moved so that parents and children could avoid walking through a high drug-traffic area. A staff member from the Ounce's nearby St. Paul Head Start program was shot during a routine home visit. All of that is true, but none of it gets to the heart of why violence matters.

While the CSCD has had its share of disruptions due to violent events, and certainly has taken measures to protect its staff members, the role of violence in the life of the program and the lives of the participants is much more pervasive, subtle, and pernicious. This section is devoted to the issue of violence because, tragically, no other issue has by itself affected so many aspects of the CSCD experience so profoundly. No discussion of the first five years of the CSCD's development can be complete without a full and honest treatment of how violence has irreparably changed life and lives in the Robert Taylor Homes community.

Crossing Paths with Violence: Participants' Experiences

As part of the Retrospective Analysis interviews, participants were asked if they, their child, or a family member had been a victim of violence. Twenty-four percent of the participants themselves had been victims of a violent act such as being hit or beaten, being robbed, or being shot; 63 percent reported that a member of their family had been a victim, and nearly 13 percent said their child or children had been victimized. As bystanders, 40 percent of participants had witnessed physical violence, 29 percent had seen theft or robbery, and 25 percent had watched a shooting.

Participants believed that the increased presence of gangs and violence corresponded to the growing drug trade in the Grand Boulevard area. Almost all of the participants reported witnessing drug sales, and most said they saw drugs being bought and sold on a daily basis. Drug use also affected many participants. Nearly half those we interviewed told us they witnessed drug use every day, and many believed drugs could be responsible for what they perceived as the major problems of child neglect and abuse. As with violence, most participants considered the issue of drugs to exist in a separate sphere of their lives from the CSCD. The majority said that the CSCD could not help with drug-related issues.

Not surprisingly, many of the staff interviewed for the Retrospective Analysis agreed with participants that the CSCD could not help with drug-related issues. Staff, however, believed that the program should be moving aggressively to address the issue of drug use. Almost every staff member interviewed cited drug treatment and counseling as *the* key service missing from the CSCD, hindering its ability to serve the community fully. In fact, the CSCD has been moving toward offering more and better training for staff to begin

addressing this issue. The CSCD also employs a psychologist part-time who is trained to do drug counseling.

An Atmosphere of Violence

Impact on participants. The CSCD participants eloquently described what violence does to them and their children, especially the unyielding sense of fear that permeates their everyday lives. "I'm scared to send kids out of house because I think they might have a shoot-out," said one mom. "And [my children] are scared; they can't go downstairs and play like they want."

The events that make the news do not begin to reflect the reality for Robert Taylor residents. The Robert Taylor Homes are an isolated concentration of extreme poverty. Other housing developments, though sharing many of the drug and violence problems, are situated within or close to more prosperous neighborhoods. Robert Taylor, however, occupies a lonely stretch on Chicago's south side that is cut off from other neighborhoods by one of the busiest interstate highways in the nation. This contributes to the sense of powerlessness that many residents feel. Because they are cut off, no one else complains of the violence, and problems can go unattended for long stretches of time.

Children look to their parents to make them feel safe and secure. In the Robert Taylor Homes, parents often cannot reassure themselves or their children, even inside their own homes. "It scares them, they're scared to sleep in their own rooms," one woman said. Fear also further isolates families who believe that every venture outdoors carries a great risk. "I'm afraid to go out to the store, shopping, elevators--think they're going to stick me up. Two oldest [children] don't like it, it scares them, they're afraid," said one participant. Echoing that, others told us, "It makes [the kids] scared to go out. They always think if they go out they're going to get shot, or somebody will beat them up." "It has me scared sometimes to even come out. You can't even take your children for walks." "It has me scared to go out my door or carry my kids to the playground." And, "Living here makes me afraid because I can't let my children go outside to play."

The harshest reality of all is that no one can see a way to stop the violence, leaving parents without the confidence to say what every parent wants to say: that everything will be all right. "I'm afraid for my children who go outside to school everyday," said one participant. "I think that they will be hurt. And they are afraid to play outside. They won't walk to the store. They want to know if it'll ever stop."

Impact of environment on staff. Even though many of the CSCD staff spend their evenings away from the Robert Taylor Homes, the violent atmosphere and the random threat of harm make it an emotionally debilitating environment in which to work. Even if physical violence were not an issue, the state of neglect and decay that defines much of the Robert Taylor Homes is a constant assault on the senses and on one's nerves. Every staff member interviewed offered her or his perspective on the violence and on the general

environment. When asked what the largest environmental problems were for the CSCD one staff member described it in vivid detail:

> At Robert Taylor, there's violence: bullets in windows, rats, roaches, filth, stench, vandalism, graffiti in the hallway. Even our area itself gets dirty--we can't keep computers clean. [There's] no control over the environment. We may get water all day [through the ceiling]--in one day 150 to 200 gallons of water will have to be mopped up. It's difficult on a person's morale.

Virtually every staff member interviewed had witnessed physical violence outside the building. More than a few have been witnesses to brutal violence and shootings. One staff member, obviously still very shaken by the memory, described a day when she was visiting a mother:

> Gangs ganged up and a man pulled out a gun and shot a boy at point blank range. It was tea time. We heard a gunshot and went downstairs. The boy was lying down on the ground with half of his face shot off. He laid there about two hours because the coroner had to come for him. [The participant] put a blanket over him.

Another said she has "seen people shot lying on the ground, and experienced violence by seeing a boy beat up. Boys run up the steps pushing the CSCD staff, and I've heard bullets coming through the windows."

It isn't possible to live or work within an environment like Robert Taylor and remain unaffected. Some staff believed that participants seemed unbothered by the violence, saying that participants "are able to cope with it; they learn to accept it as a way of living." But most staff were quick to acknowledge its debilitating effect in their own lives and assumed participants were also scared. One staff member said:

> I saw guys shooting. Personally it made me sick, it stresses me out. I'm tired of coming to work here. Mentally it gives me headaches, high anxiety levels. I'm anxious to get out of here. It's draining.

Another reported that she suffers from "depression, low motivation, and a constant battle not to be overwhelmed. Physically I have an ulcer, my hair came out, and I've gained 20 pounds since I began working here."

PCAs have had their jobs interrupted by the violence, either because it becomes too dangerous on any given day to be out, or because participants also stay home (and, consequently, away from the CSCD) in order to stay safe. "There is more violence and more shootings, " said one. "We don't know if we will live through home visits." Another told us that when there is gang activity:

> . . . home visits cannot be made and the participants do not come downstairs [to the CSCD]. There is concern about day care because the bullets come through the door. Staff cannot go out and the children can't get back home safely.

One staff member, a former Robert Taylor resident, said:

> . . . men come out and start shooting in the playground. My own apartment windows were shot out. I moved because of this. I couldn't go out once I was in my home. I have known people who have been killed. I have had to fall on the floor at the CSCD [to escape stray shots]. People get robbed for money for drugs. Neighbors fight because of taking from the other. I am scared. We have had police escorts out, and also the participants tell us what is happening and [when] not to come. You have to speak to everybody and know how to dress. Always have to come [to work] with your eyes open at all times.

Although the subject of violence and how to address it is repeatedly discussed by the CSCD and other Ounce staff, persons interviewed reported differing views on the extent of the problem for the Center and the amount of support given them at work. One staff member reported that she:

> . . . does not have any support around violence. I support my staff by letting them vent, but still work has to be done even though there is violence. There is nothing at the Center to address the violence.

Another sounded resigned, saying she doesn't think about it. "Violence is a part of the daily routine. When it's warm, it flourishes."

We found it odd that participants and staff would be so forthcoming in their own descriptions of the violence and the fear it instills, yet--as both groups acknowledged--the subject does not come up in the otherwise supportive, family atmosphere of the CSCD. It seems that the subject is avoided because everyone must face it and no one seems to know how to stop it. "People become numb or immune to violence," said one staff member. "Families have taken the hush-hush approach. They have stopped talking about it. They are scared too, but they do not acknowledge violence with me." Other staff, because the families rarely talk about violence, assumed that participants have "learned to live with it."

But the literature on persistent exposure to violent threat strongly suggests otherwise. Just as staff have developed nervous conditions, gained weight, and worry constantly, so do parents and children absorb fear and experiences of violence into their bodies and minds. This kind of stress can lead to the chronic, debilitating depression. It can also lead to physical symptoms of stress such as headaches, stomach-aches, or even acne. Extreme stress and persistent exposure to violence can also cause anger, depression, violent behavior, lassitude, short attention spans, hyperactivity, and acting-out among children. Some psychologists have begun to suspect that children (and adults) who must live with that level of tension and threat can suffer from Post-Traumatic Stress Disorder just as a combat veteran might. What no one seems to know yet is why some children can "survive" the stress emotionally intact while others become unable to cope with everyday decisions.

Although the CSCD has a clinical psychologist who evaluates and counsels families at the Center, the demand for these services far outstrips what is possible for one therapist to do and other local services do not begin to fill the gap. Moreover, everyone at the CSCD who

interacts with families must deal each day with the atmosphere of threat and the impact of the environment on participants and children. That impact can range from families dropping out of the program for periods of time, to physical and emotional problems, and to developmental problems in children. The decaying infrastructure and minimal, sporadic maintenance efforts merely exacerbate the tension of everyday life in the Robert Taylor Homes.

The unthinkable has become commonplace in the Robert Taylor Homes. That may explain, in part, why participants do not talk about violence and why staff assume they have become accustomed to it. Participant interviews clearly show that Robert Taylor parents know that fear governs their actions, makes them more protective of their children, and makes children less able to cope with life. Daily schedules are altered based on avoidance of dark elevators, rumors of a gang war, and occasional sweeps by police. Many may be resigned to the violence, but none are unaffected. And what they want to know is what no one can tell them. When will it stop?

4. Important Lessons and Unresolved Issues

The CSCD's first five years taught us many lessons. We learned lessons about the nature of family and community life in a poverty-stricken inner city, lessons about bringing unfamiliar services into an area where the need for basic supports is so high, lessons about the impact on families of dysfunctional public welfare systems, and lessons about what questions to ask in order to strengthen the program and its role in the community. Each lesson has helped make the CSCD more responsive to the community and better able to make a difference in participants' lives, and each is instructive for others who may want to replicate various parts of the CSCD model.

At the same time, not every issue has been resolved. As was pointed out many times in this report, certain difficulties may be built into the program. These include problems brought on by the CSCD's location, conflicts related to race and culture, and enduring debates over program emphasis and direction. This section is devoted to a more complete explanation of the lessons from the CSCD experience and to a discussion of some of the issues with which we continue to grapple.

Lesson One: Successful Programs Must Earn Participants' Trust

The physical and emotional stresses faced by residents of the community--and the impediments to earning their trust--have proved staggering.

Education Week, February 1989

Five years into its operation, the Center for Successful Child Development occupied, as it does now, an established place in the community. It recruits as many new families from the positive referrals participants give to friends as it does from the ongoing door-to-door outreach efforts of the program's home visiting staff. Each new family must be treated individually and encouraged to use CSCD programs. PCAs devote much of their energy to gaining the trust of each new family recruited to the program.

We have learned how essential one central relationship can be to a family's success. We have tried to foster that relationship between the family and a CSCD staff member. We have also learned that trust must be earned over time, and that the participant is likely to be very selective in choosing who to trust. When she begins to engage a family, a PCA might try home visits for weeks before she is even allowed inside the door. And once inside, it may take weeks more for the participant to trust the Advocate enough to talk about life issues such as her goals for herself and her children. A participant might feel closer to another staff member at the CSCD, such as the nurse-practitioner in the health clinic or a developmental specialist in the Family Enrichment Center, than she does to her Advocate. Whatever the key relationship becomes for that participant, the CSCD strives to encourage and nurture it, because we know a genuine relationship is the prime organizer for all learning.

Even when trust has been established, parents have other difficulties that may prevent them from using all the CSCD services on a regular basis. Such difficulties might

include other family members who require care from a young mother, or a learning disability that has kept her from achieving in school. Problems with a close friendship or an intimate relationship, violence in the community, or depression may cause a participant to drop out of sight for a while. Or, having used some services, a participant may feel that her needs have been addressed and there is no reason to come to the Center until a new problem arises. What will bring participants back in these instances is the strength of the personal attachments to the CSCD staff and the knowledge that the CSCD will respect the participant's choices. Those connections can be built only through repeated, individual attention over a long period of time. This is why it is so important that we succeed in establishing those connections whenever we can.

Lesson Two: The Environment Challenges Families and Programs

It scares me to go out my door or carry my kids to the playground.

A CSCD Participant

As we have noted, the environment of Robert Taylor Homes is by far the most unrelenting of obstacles to smooth program operation. Families must overcome daily physical and practical obstacles in their efforts to gain control of their lives and to raise healthy children. The program itself must find ways to deal with the constant threat of violence and atmosphere of neglect as it strives to support families in their efforts.

Even the strongest families have problems negotiating this environment. The impact of multiple stresses on families with little income and few community resources can be immense. An "abrasive place to live," as one person described it, the Robert Taylor complex lacks sufficient numbers of telephones, laundry facilities, newspaper delivery, grocery stores, and drugstores--all the common elements of a functioning community. The few existing basic services fall short of the community's needs. Often they are beyond walking distance or too expensive.

Families laboriously negotiate tasks that would be much more easily accomplished in a family-friendly, well-maintained community. At Robert Taylor, just doing the laundry can be an ordeal. Broken elevators and failed stairway lighting can leave mothers wrestling bags of laundry and maneuvering small children down a dozen flights of dark stairs. They must then walk two or more blocks, and wait for the use of the few expensive coin-operated machines working and available. For many residents, the bathtub provides the only affordable option if clothes are to be washed.

There are no large grocery stores convenient to the Robert Taylor Homes and the handful of small grocery stores within walking distance often charge three to four times as much as larger stores. The closest chain stores are at least a bus ride away and this means paying the fare and finding help to carry groceries back or paying for delivery service. Few store delivery services will bring groceries into a Robert Taylor building and up to an apartment. Mother and children must take the bus back and wait downstairs for the groceries to arrive, then haul them upstairs.

Crime, especially drug- and gang-related problems, flourish in the neighborhood despite the presence of Chicago Housing Authority security and Chicago police. Participants and staff testify that police do not appear to try to stop violence, although the police station is directly across the parking lot from the CSCD. Furthermore, there are few ongoing recreational programs or employment opportunities for youths that can serve as real alternatives to the pressures of gang membership.

Intensive mental health services are quick to arrive in more affluent communities when a tragedy such as a shooting or the death of a child occurs. But they are not available or easily accessible at the Robert Taylor Homes, even though severe everyday stress levels subject residents to short- and long-term psychological problems that would be considered debilitating in any middle-class community. Participants speak of their fears in interviews, but do not talk much about the violence with the CSCD staff. As a result, much of the impact of the violent environment is hidden.

In light of such hazards as unpredictable gunfire, landings and concrete yards strewn with shards of glass, and roach and rat poison lining the baseboards of many apartments, parents express legitimate concern over certain normal childhood behaviors like crawling, exploring spaces, and putting objects in the mouth. The CSCD professional staff had to rethink their views on child-rearing practices and reorient parenting education to be appropriate for the context and culture. To work with families at the CSCD, staff had to learn how to distinguish what parents did with their children in response to the environment and what they did or didn't do for lack of information or skills.

Unfortunately, the CSCD cannot solve all of the environmental problems. Since the establishment of the CSCD, the Chicago Housing Authority has established tighter security procedures for CHA buildings and this has included limited access to the building housing the CSCD to a single entrance where a security guard is posted. But occasional security guards, a clean environment at the Center, and bullet-proof glass will go only so far. Because neither the violence nor the intense poverty and environmental neglect are likely to abate, the CSCD must continue to address these issues on a daily basis.

Lesson Three: Programs Must Respond to Basic Needs

Because Grand Boulevard lacks basic family support services, the CSCD must divide resources between its child development objectives and helping to meet immediate family needs. Issues of housing safety and disrepair; lack of food, milk, clothing, and furniture; inability to find or afford limited laundry facilities; and transportation cost influence everyday decisions and often overwhelm even the most resilient families. The CSCD staff recognized early on that they needed to help families obtain essential services, even when that meant deferring work prescribed by the developmental program. While these extra support activities may have delayed some of the CSCD's program development, willingness to help families with their concerns played a large role in building the strong relationships the staff enjoy with participants. It helped convince residents of our commitment to the community.

To help meet the daily demands for basic assistance and draw participants into the program's child development focus, the CSCD has developed a team approach to home

visiting. This meant sending a child development specialist with the PCA on visits to participants' homes. The team approach ties together the home-based program work and the center-based work, giving each family a long-range plan that meets both basic needs and child development goals.

Certain intractable issues can slow family progress. The CSCD staff suspect that more than half the children in the program live in homes in which drug use occurs or where family members are involved in drug-related activity. "It's hard to work with drug-using participants," PCAs report, with classic understatement. Domestic violence affects many families and community violence surrounds everyone.

Lesson Four: Valuing Personal Expressions of Change

From the beginning we have recognized that the parent is the key to improving children's lives. Although the CSCD childcare and early education programs are important components in preparing a child for school, support for a child's education and development of a child's ability to learn are strongly influenced by parents and other primary caregivers. Supporting parents in advocating for themselves and their families has been an important part of the program. When parents feel more in control and capable, children are better off. But every family expresses success in different ways, and what may seem like small improvements to some may be great strides for others. The CSCD tries to support all families in their efforts, recognizing even small changes as positive, important steps.

It is in small, hard-to-measure gains that we see the CSCD's most profound impact. As parents use the various services offered, their confidence in themselves and their ability to take charge of their lives--as individuals and as parents--increases. Mothers pay more attention to their children's nutritional needs; they talk of how they cook more often and eat with their children. Home visiting staff note changes in how some mothers maintain their homes and budget their money. They point out that some mothers begin to take greater care with their appearance and their children's. As parents open up and take pleasure in new parenting skills, the children respond. New family rituals begun at the CSCD become established in the home.

Moving out of the Robert Taylor Homes was an expression of personal success we weren't initially equipped to measure. Because the CSCD staff were focused on child health and development outcomes, there was no ready mechanism to track the families that moved away from the community. In one sense, this was simply a problem created by the transient nature of the community. But, in some cases, it meant that we sometimes missed recording as successes those families that became stronger because of their CSCD experience and moved out of public housing and into safer neighborhoods. No longer available for tracking, some families were classified as program drop-outs, rather than program successes.

Lesson Five: The Complicated Nature of Program Evaluation

A number of complicating factors influenced our ability to measure the effectiveness of the CSCD services. The population served was quite fluid in nature; families with young children moved in and out of the neighborhood. Participant families had different needs and had the freedom to choose which services they wished to use. These circumstances inhibit

direct comparison of outcomes. In addition, the CSCD was changing throughout the period. Staff members became more experienced, experienced staff left and were replaced, programs were adjusted to respond to community needs, and new components were added to the mix of services available. All of these conditions undermine the usefulness of before-and-after or participant-and-control comparisons.

Not only were comparisons difficult, PCAs were not ideally suited as record-keepers. Participants were not always willing to be completely open to PCAs, whom they knew as friends and neighbors. The demand on PCAs' time was often overwhelming and this reduced the time available to devote to records. PCAs were relatively inexperienced in record-keeping procedures and this inexperience meant that certain records are incomplete. Some of the categories initially thought to be likely measures of participant success were created before the CSCD was opened, before some services were available, or before appropriate interventions for particular problems had been identified. As a result they failed to measure either the baseline situation or any progress. Taken together, all of these factors meant that there was no common pool of information about the community and participants that could be used to characterize the population served.

In a perfect world, the need to evaluate is understood at the outset, money is available, and the mechanisms for evaluation are built into the program model. The CSCD did not develop in a perfect world. With so many early factors uncertain--where space would be available, how best to recruit families, whether and how to provide on-site health services, when space would be licensed for day care--the program was not in a position to implement the basic pieces of a coherent data collection and evaluation system in its earliest phase. The Retrospective Analysis came about in response to the universal acknowledgment that an accounting of the CSCD's development was due. But it was only a first step. Today, staff are all involved in discussions about what kind of program evaluation is needed and how to accomplish it. A computerized data collection system to track participants while they're in the program has been established. Much time has been devoted to talking through the need and uses for data collection and program analysis, and a formal evaluation, sponsored by the Annie E. Casey Foundation, is currently underway.

Lesson Six: New Programs Need Some Breathing Space

Even before the CSCD got its own home, news spread of a brave new approach for helping children in poverty become ready for school. The *New York Times* dubbed it "A Head Start on Head Start" and published glowing, optimistic articles by Kathleen Teltsch. *Education Week* visited several times, as did the networks and local television stations. Giving tours to the visiting press and politicians became a time-consuming task in the first year. Because the program sponsors felt that it was important to share the story of the developing CSCD with the social service community and general public, the press was accommodated despite the attendant diversion from program. During this blizzard of attention, the CSCD was declared a success and copied almost before it had welcomed its first participating family.

Without media attention, promising programs like the CSCD might never come to light and funds for program development and innovation would surely be harder to find. But it also places new programs under public scrutiny at a time when they need to work out

their kinks. The frequent presence of reporters and television cameras made participants skeptical that the CSCD truly possessed a community-based service orientation.

Also frustrating was the constant demand for results before a complete program design had even emerged. The media kept coming back for progress reports and agencies around the country, alerted by the press, asked for written materials and greater access. When the CSCD responded that many program components had yet to be initiated, press reports suggested that the early enthusiasm might have been ill-advised, implying that the program was already in trouble.

It took time for the CSCD to establish each of its components. It took more time than we or the press anticipated for the CSCD to negotiate its licensing requirements with public welfare and licensing agencies, to discover which approaches were most effective and which less so, and to know and become known to a skeptical community. Our expectations, magnified in the press, added pressure and created distractions during the critical start-up phase. It was the wrong time for scrutiny, and the program didn't need additional pressures. Staff also did not need to spend precious hours arranging tours, making presentations, and answering time-consuming if well-meaning questions. They wanted and needed to be developing the program. The press attention, in the first years at least, too frequently interfered with that basic goal.

Lesson Seven: Intractable Issues Cannot Be Wished Away

Some issues the CSCD faced over the first five years did not respond to program adjustments and will continue to challenge the CSCD and other programs like it in the future. Two such issues are the role of drugs in impoverished communities and the need for staff members with different training and experience to find common ground. While each of these issues was discussed earlier in the report, a few brief observations are worth making.

Diversity. As the academic world and the program world converge on an understanding that families must be supported in a comprehensive manner, new disputes arise over whose approach and which services should take priority. Comprehensive strategies are becoming the norm in human services. Comprehensive strategies require effective cooperation among service providers and professionals of various backgrounds. The CSCD experience is helpful in showing how diversity both advances and hinders program development. Programs benefit from sensitivity to cultural norms and from the variety of perspectives brought to bear on complex problems. However, the blending of academic training and personal experience is a challenge.

At the CSCD, sensitivity to cultural and community norms is favored over rigid definitions of program approach and goals. Attention is paid to how ideas are conveyed, by whom, and in what context. To decrease interdepartmental disputes about program emphasis, the CSCD created a team approach to link developmental and health professionals with paraprofessionals. By requiring the different disciplines to create their own ways of cooperating, we shifted the argument from "Which approach is best?" to "How do we draw on the strengths of all to do what's best for the family?" in much the same way as families draw on the strengths of individual family members and community resources for the good of the whole.

Drugs. As our interviews with both staff and participants demonstrate, one cannot discuss life in the Robert Taylor Homes community without acknowledging the impact of the drug economy. It is abundantly clear that, without drugs, violence would be a very different issue, families would face fewer risks, and daily life would be differently defined. *Every* staff member interviewed alluded to drug use among participants. Every one of them said that not being able to treat or adequately refer for drug treatment was the CSCD's greatest drawback and need. Staff estimates of how many participants used drugs ranged from 30 percent to 70 percent, but all of them acknowledged that even children whose parents did not use drugs were still likely to witness drug use by a family member or close friend.

Drug use undeniably affects parents' motivation to use the CSCD's services, affects the quality of care they can give their children, and cripples their ability to control or respond appropriately to family demands and events. Despite constant efforts to find treatment, staff say that referrals usually aren't available. When they are available, treatment is often delayed too long to be any use; the CSCD staff report that a seven-to-eight-month wait for a bed in a program is not unusual.

The CSCD works with Grand Boulevard agencies that provide services related to drug use. The CSCD cannot make up for a general lack of treatment centers, nor can it end the enduring, ironic prejudice that limits drug treatment for pregnant women. And we are not sure that the benefits of raising the visibility of the drug use problem outweigh the risk that participants will no longer feel comfortable trusting the CSCD to welcome them unconditionally. The only things we can be sure of are that the problem will not go away, and that we cannot hope to address it alone.

5. Summary and Conclusion

At its inception, the Center for Successful Child Development set out to make a difference in the lives of the youngest and most impoverished children in Chicago. No child, so far as we could help it, would be predetermined to fail in school because he or she was shortchanged or neglected before arriving at the kindergarten classroom door.

Every year of the program brought surprises and frustrations that helped us learn, helped us ask new questions, and helped us adapt the program to the different needs of participants and the broader community. The task was more difficult than anticipated. We continue to be challenged by the changing environment, the support needs of staff, and the complex lives of participants. Our ability to adapt to each challenge has meant that programs and procedures have changed over time. In each instance these changes followed a period of testing and adjustment.

Some problems faced by the CSCD cannot be addressed by simple programming innovations. The increasingly violent environment and the high mobility of the Robert Taylor Homes population has influenced the CSCD's ability to provide consistent, long-term support to as many families as originally envisioned. Of the first hundred families recruited, more than half have moved at least once either within the Robert Taylor Homes or out of the community entirely. (Yet, as we said above, moving out of Robert Taylor can be a sign of program success rather than failure.)

The level of stress for the staff has also created some instability. Recruiting and retaining experienced staff has been difficult and time-consuming. And, given the importance to the program of familiarity and trust between participants and staff, staffing decisions and patterns have tremendous impact on program continuity and the willingness of participants to use the program services.

Unlike a controlled research program, a family support program does not exact promises of attendance from its participants. Each level of program participation is voluntary. As a consequence, enormous energy must be devoted to determining the correct atmosphere, program mix, and incentives to keep a diverse program population at a high level of utilization.

To counter these difficulties, the CSCD has continually tried new strategies and services. The range of programs has expanded steadily since the first year, and these program components are now well established within the Robert Taylor community. Our most recent efforts have focused on ensuring that the services of these components are well integrated, providing a cohesive program for parents and children.

Defining the Center's Success

A major accomplishment of the CSCD has been the development of the program itself. It is rare indeed to find an array of support services and referrals aimed at the particular needs of families with infants and toddlers. The CSCD offers a full complement of services essential to early childhood development and family support: home- and center-based programs; on-site maternal and child preventive health care, early childhood care and

education; full-day, full-year childcare; and linkages of these components to other community services and resources. Each of these components has integrated, to the best of its ability, the guiding principles of the field of infant mental health.

During the Project's earliest months, the obvious good sense of providing comprehensive services to families with children from birth to age three became apparent to the nation. Press coverage illuminating the importance of reaching the Head Start population before they reached Head Start drew the attention of Congress, which established twenty-five (and ultimately forty) comprehensive Beethoven-type model programs. Today the guidelines for a Head Start program for families with infants and toddlers are being created. Initially 3 percent and ultimately 5 percent of all Head Start funding will go to this new initiative. The CSCD's focus on children's earliest years and support to families has now caught the attention of the entire nation.

By hiring and training community workers, the program has succeeded in moving a number of people from welfare to work; many individuals previously dependent on welfare are now well on their way to becoming economically self-sufficient. These workers provide important role models for program participants and other community residents. While their jobs have enabled some to move out of the Robert Taylor Homes, the workers' continued presence in the community and commitment to the program helps build and strengthen the community itself.

Parents and staff gave us a wealth of encouraging information during interviews for the Retrospective Analysis. They tell of improvements in children's health care. Mothers are obtaining more timely health care for their children, and there seems to be a gradual movement toward preventive care. Immunizations, well-child care, and prenatal visits have all improved since the Primary Health Care Center opened. Parents also say they better understand the individual and age-specific needs of their children. They use emergency hospital services less frequently. They have increased knowledge of children's development and have learned how to strengthen their relationships with their children to create opportunities for learning and growth.

Participants talk about the CSCD's importance as a safe, bright place where they can relax, learn, and enjoy their children. There are frequent references to the value of what the CSCD calls respite care for parents--time during which parents are engaged in activities in the Center and relieved for a period of the parenting pressures they face around the clock. This seems to provide parents with greater emotional availability for nurturing their children's development when they're at home. Parents and staff report that children have improved social and interaction skills, an essential component of school readiness. Through opportunities for play at the Center and through activities parents are encouraged to provide at home, children have shown improvement in their large and small motor development skills (walking, running, writing, drawing, for example), as well as improvements in their language development.

Parents also credit the CSCD for supports which provide them with the confidence to pursue education, prepare for employment, and access other services. In particular, parents seem better able to be advocates for their children at school. The CSCD staff have placed special emphasis on parents whose children are making the transition to school, helping to

introduce them to teachers and encouraging them to ask questions about their children and the school. Both staff and parents also note some improvements in relationships with others, in particular children's fathers and grandmothers.

Perhaps most important have been the subtle changes in parents and children over time. Staff say they can see the changes in the family dynamics by watching the faces of participants. Voices become softer, more yielding. Laughter is more often heard; hugs are exchanged. A child who enters a new space with confidence and a sense of discovery will be able to learn the lessons that school has in store.

Conclusion

We have come to understand that, undeniably, we are able to achieve results only through the committed, tireless hard work of smart, caring, and well-trained staff. Although there has been turnover at various levels, occasionally due to burn-out and sometimes to personal development, there are many crucial staff members who have remained throughout the duration of the project. They provide the foundation for learning for the rest of us. Only with this institutional memory can we draw on lessons of the past to build for the future.

The families we have seen came to the CSCD because they cared about their children. They came because, despite their experiences with transient programs in the past and with intrusive, judgmental social services, parents were willing to give something new a chance if it would help them make life better for their children. We are proud that the Center for Successful Child Development has allowed families to develop personally and to grow out of old patterns of interaction and into easier, more positive, more enjoyable relationships with each other and with their children.

The individuals and families of Robert Taylor Homes are, as one resident wrote in the *Chicago Tribune*, "survivors." They overcome extraordinary obstacles every day, and we believe the Center for Successful Child Development enhances their ability to go even further with their hopes and dreams. Our greatest hope is to continue to reach more children and more families. We are confident that CSCD children entering kindergarten are more at ease with their peers, better able to interact with new adults, and more likely to receive support at home for their achievements. That is our greatest satisfaction.

Appendix A: The Center Today

The Center for Successful Child Development continues to serve families in the six Robert Taylor high-rise buildings that comprised the original service area. The CSCD works to promote healthy child and family development by combining the four basic early intervention models described in the preceding report--home-based family support services, center-based family support services, maternal and child health services, and early childhood education--into a single, comprehensive program designed to prepare children for kindergarten entry and later school success. This appendix to our report highlights a few of the major changes in program operation that have occurred since the CSCD's fifth anniversary in 1991.

Home-based family support services. As we describe in the body of this report, the initial link between the Center and the families it serves is usually the Parent-Child Advocates (PCAs). PCAs are staff members trained as home visitors. These PCAs conduct a regularly scheduled, door-to-door canvass of the six buildings to locate and recruit into the program adolescents and women who are pregnant or have children younger than six years of age. For the past two years, PCAs visited between 130 and 160 families. These families had more than 400 children.

Robert Taylor families face overwhelming problems and life stresses and PCAs are an important source of continuing emotional support. The PCAs' primary role is to establish relationships with families so that they will feel comfortable coming to use services on-site. Much of the CSCD's success hinges on these relationships. PCAs are generally hired on the basis of their abilities to relate positively to participants, their willingness to learn, and their reliability. They receive intensive training and participate in ongoing professional development activities.

However, we have learned that this on-the-job training cannot always substitute for formal education and does not necessarily produce the critical observation skills which are necessary to engage parents with extreme problems, such as depression and substance abuse. In response, the CSCD has amplified its outreach capability by hiring a child development specialist and a medical assistant dedicated to actual outreach and to addressing some of the extreme problems encountered in the context of providing services. Other CSCD professionals who specialize in health, child development, parent-infant interaction, social work, and psychology augment our assessment and service capabilities by supporting and modeling appropriate interaction in the home and by offering consultation to outreach staff on site. CSCD professional staff members accompany PCAs on home visits whenever necessary. The Parent-Infant Consultant, who has worked with the program for many years, also spends time working with the PCAs and goes out on home visits as a part of a new training program. She observes and models interactions in the home and subsequently provides feedback to the PCAs.

The addition of more professional staff time to the home visiting teams provides ongoing professional development opportunities for the PCAs and helps to bring better observational and assessment skills into the homes of the hardest-to-reach families. It has also increased our capacity to engage parents and intervene with them on issues of child

development and parent-child interaction. While PCAs still travel in pairs to canvass, this new "flexible team" approach to home visiting provides more support to them as they assess the home environment, the children's health and development, and parent-child interaction. We hope that these new teams will enhance the strengths and minimize the weaknesses inherent in home visiting models that utilize community outreach workers or professionals only.

Center-based family support services. The CSCD Family Enrichment Center is now the site of scheduled programs such as teen parent support groups, Knowing Your Child sessions, job readiness activities, and a wide variety of structured and informal activities. These programs support parents, provide respite time, build parenting skills, and increase parents' knowledge of child development.

Maternal and child health services. The CSCD's Primary Care Health Center provides basic, prevention-oriented health services to children and their families. At the clinic, prenatal, postpartum, and family planning care are available to mothers participating in the program. Delivery services are provided at community hospitals. High-risk pregnancies are referred to appropriate specialists in obstetrics and gynecology. Well-child care includes comprehensive physical examinations, developmental screening, and parent education. Last year, the CSCD began using the part-time services of a speech pathologist. Individuals needing specialized assessment or treatment are referred to appropriate providers.

The Primary Care Center's services are supported by ongoing educational programs throughout the CSCD. The health care staff teaches classes and leads support or discussion groups on such topics as preparing for childbirth, child growth and development, nutrition during pregnancy, breast feeding, substance abuse issues, sexually transmitted disease prevention and treatment, HIV/AIDS awareness and prevention, and family planning. The Clinic Coordinator, a registered nurse with many years of experience in community health programs, provides a continuing series of nine-week prenatal classes. Participants who attend all of the sessions receive layettes and other items for their babies. These items are donated by a local church group.

The Primary Care Health Center was established in 1988 through a five-year grant from the Robert Wood Johnson Foundation. The grant supported most of the clinic's direct medical services. In May of 1993, the Ounce applied for a renewed five-year grant to support a declining share of the direct medical costs and more health promotion programming to reduce developmental delays and substance abuse. The proposal was approved and the new grant period began on November 1, 1993.

Early childhood education. The CSCD provides developmental childcare services for children aged from three months to five years. The CSCD has a licensed capacity of fifty-six and serves, primarily, children of parents who are completing school, in training, or working full time. At least 10 percent of the slots are reserved for children with special needs or children of parents who are in need of respite care. The CSCD also serves thirty-three children in its home-based Head Start program.

The CSCD offers full-day, year-round infant/toddler and "wraparound" Head Start services in accordance with Head Start standards and municipal and state licensing requirements. The CSCD's childcare programs are staffed by experienced child development specialists who are dedicated to the primary program goal of stimulating the growth and development of children in all domains: social, emotional, cognitive, and physical.

The CSCD continues to assess the mental health needs of the children we serve, children who experience the daily stresses and violence of living in the Robert Taylor Homes. One way in which the CSCD addresses these needs is through a contractual relationship with a psychologist. The psychologist serves on multidisciplinary staff teams that assess family needs for counseling and treatment. He provides guidance to staff in identifying and dealing with drug-abusing parents and drug-exposed infants and children. The psychologist also works with children in the CSCD's Head Start and childcare classrooms to assess their mental health needs. In addition to observing the Head Start classes, he advises staff, conducts individual assessments, and provides brief transitional or crisis counseling.

In addition, the Ounce has entered into a partnership with the Early Childhood Group Therapy Program (ECGTP) at the Child Development Center in New York City. The Child Development Center is a division of the Jewish Board of Family and Children's Services, Inc. The JBFCS is a training center of the Columbia University School of Social Work. The ECGTP Director, a nationally recognized expert in children's mental health, will help the CSCD develop a stronger mental health focus within its Head Start program and will train staff to facilitate small, counseling groups for children aged three through six years who are inhibited, acting out with peers, hyperactive, or verbally underdeveloped. The aim is to provide children with alternative and more positive ways of expressing themselves in a small group so that they can then take better advantage of ongoing activities in the Head Start classroom and socialize in ways that help them learn and develop. Eventually, this will minimize the number of children with social and emotional problems who are placed in special education classrooms when they enter elementary school.

Early childhood group therapy begins with professional observations in a group setting--such as a Head Start classroom--to identify children who would benefit from participation in facilitated group activities. With parental consent and involvement, these children participate in small therapy groups for about ninety minutes twice each week. We estimate that approximately 50 percent of the children we serve in Head Start would qualify for this special group socialization experience. Early childhood group therapy has been very successful in New York childcare settings.

The CSCD Assistant Director is participating in the early childhood group therapy training institute by telephone and in person. In early 1995, the Assistant Director will begin the CSCD's first counseling group. We are now working with the ECGTP Director to develop a plan to allow additional Ounce Head Start staff to be trained and supervised in this group counseling modality, to become trainers themselves, and eventually to launch a Chicago-based training institute for the program. The early childhood group therapy model shows promise for replication in the Head Start setting and we are seeking private funding to pay for most of the training and development costs.

In addition to training a small number of staff to facilitate the counseling groups, we are also preparing to introduce a mental health focus and approach into the everyday activities of our Head Start classes. Head Start has not traditionally worked with children from this perspective. We are now developing a plan for general teacher training and support to address the complex situations teachers face when working with children who are experiencing tremendous stress at home and in their community.

This is a way of bringing critically needed mental health services to children in communities where there are currently not enough services available. The value of treating children with social and emotional problems in the least restrictive and most normative setting possible has been well established. The early childhood group therapy program is an effective way of bringing strategies to Head Start for channeling children's maladaptive behavior more appropriately and for fostering parents' understanding of and mediation of the environmental effects of community and domestic violence on their children.

Program evaluation. During 1993, the CSCD was selected by the Annie E. Casey Foundation to receive funding under a Foundation-sponsored initiative to evaluate four comprehensive family support programs across the country. With Casey Foundation staff, we developed a limited evaluation plan and a request for proposals from potential outside evaluators. In September of 1994, we selected the evaluation team at the National Committee to Prevent Child Abuse to conduct the evaluation. This year they plan to interview 60 current and 60 new participants (to enroll by March of 1995) across all of the CSCD's programs. The evaluation will use a mix of traditional evaluation instruments and measures as well as newly refined instruments and specially adapted measures.

As a result of an assessment by Casey Foundation consultants, the CSCD has recently installed a new network-based tracking system called FACTORS. The operating principle of the network is that direct service staff can enter data themselves about what they do each day which will substantially decentralize the data collection process at the Center. We expect that the new program will be up and running early in 1995.

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