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ABSTRACT

The Decker Family Development Center in Barberton (Ohio) is a holistic "one-stop shop" that provides services to families who are at multiple risk. During its 5 years of operation, this center has developed a model that goes beyond cooperation into co-construction to empower stakeholders. This paper describes the center and its successes and discusses the collection of data on early intervention and family programming. The Center represents the cooperative effort of the city schools, the University of Akron, the local children's hospital, the Summit County Department of Human Services, and the Akron Summit Community Action Agency. Its "DISNI" model requires agencies to: (1) devoid themselves of organizational territory issues; (2) increase communication; (3) share authority and power; (4) negotiate goals and objectives; and (5) have an intense sense of shared ownership in the model that is publicly displayed. Decker currently serves about 325 parents and their 435 preschool children. More than 75% are single-parent families. Services include day care, child development interventions, parent education programs, and various social services. There are many opportunities to collect data on the efficacy of early intervention and family support programs. While the data collected is not exhaustive, it provides the basis for demonstrating the efficacy of investing in children from birth. The Decker model shows communities that they can intervene with at-risk children in their early years. An example of annual report organization is attached as a model for program planners. (Contains three tables and three figures.) (SLD)

The Decker Family Development Center: Supportive Data of An Intervention Model for Multiple-Risk Families

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Introduction: The Decker Family Development Center is a highly successful holistic "one-stop shop" that provides services to families who are at multiple-risk. During its five years in operation, this center has developed a model that goes beyond collaboration, into a phase of co-construction, which empowers the multiple stake holders to become decision makers in defining the needs and solutions to the on-going and yet ever changing demands of the client families. This model produces a challenge for evaluation, in that it is extremely complex and interrelated at a number of levels. The purpose of this paper is to:

1) describe the multi-disciplinary, inter-agency, co-constructive efforts,

2) present supportive data of the program's success,

3) identify client characteristics,

4) identify the program goals and varied client services, and

4) indicate the excellent opportunities to collect data on early intervention and family programming.

Background: The Decker Family Development Center (DFDC) is a model for multiple-risk families that has received much attention during its five years of operation. Located in Barberton, Ohio, the Decker Center is a collaboration of the Barberton City Schools (BCS), the University of Akron (UA), and Children's Hospital Medical Center of Akron (CHMCA), with the cooperation of the Summit County Department of Human Services and Akron Summit Community Action Agency. Begun in 1990, this co-constructed vision of a holistic "one-stop shop" for families at risk, provides a wide range of services which are funded by a number of local, state and federal grants, operating on an annual budget of approximately $1,000,000.

The DISNI Management Model: Begun as a collaborative between the Barberton City Schools, the University of Akron and Children's' Hospital Medical Center of Akron, the center has adopted the DISNI model for making decisions which effect the growth, development and management of the center. This model requires the three principal participating organizations to:

•**D evoid themselves of organizational territoriality issues.** This requires parties to risk giving up some of their "turf" for the good of the organization.

•**I ncrease communication** through weekly face-to-face meeting where issues can be discussed and resolved by the program management team and where the shared vision can be nurtured and fine tuned.

•**S hare authority and power.** While contrary to the standard operating procedure for public, educational, and social service organizations, this concept of truly shared governance has strengthen the commitment of each organization to the center. All entities feel both the responsibility and the authority to make contributions for the continuing success of the DFDC.

•**N egotiate goals and objectives- then work toward their successful implementation.** This requires the maturity to recognize that individual goals must sometimes be abandoned or modified in order for the collaborative to move forward.

•**[have an] I ntense sense of shared ownership in the collaborative model that is publicly displayed.** Each member of the collaborative has identified the DFDC as an important entity- a source of pride and an integral part of what their organization represents.

As a result of the positive relationships, mutual respect and pride in accomplishment, the member of the program feel they have progressed from a successful collaborative to the next step- a "co-construction." At this stage, the organization is "co-constructed" by all multiple stakeholders involved, including staff and clients. Service delivery becomes co-constructed by management, staff and clients, as are evaluations. A signal of a mature collaboration, eventually leading to co-construction is the blurring of program distinctions and ambiguity on the part of clients and many staff concerning what agency is offering what service. With the blurring of participating agency program descriptions comes the point that the "collaborative" truly obtains an identity of its own.

One example of the Decker Center moving into a co-construction phase is the leadership role being assumed by Decker's "parent council." This is a core group of parents who, in the past two years, have become increasingly active in suggesting and promoting changes to Decker's service delivery system. The empowerment of parents is being fostered by staff who often see these parents as "colleagues," and not "clients."

Recognizing Success: During its five years of operation, the Decker Family Development Center has received local, state national, and international

recognition for its outstanding success in providing services to predominately low-income families and their pre-school children. Prominent among these awards are the *Secretary's Award for Excellence in Community Health Promotion* (1995, Ohio Department of Health), *Ohio BEST Practice Award for Educational Partnerships* (1995) , designation as a *"Venture" Capital School* (1995-1999, Ohio Department of Education), the *Community Service Award* (1994, Northern Ohio LIVE Magazine), designation as an *Akron Knight Family Literacy Site* (1994-1996, J.S. Knight Foundation & National Center for Family Literacy), a *NOVA Award* (1994, American Hospital Association), a *Barbara Bush Family Literacy Grant* (1994, Barbara Bush Family Literacy Foundation) and the *Governor's Educational Leadership Award* (1992, State of Ohio). Additional recognition and awards have been received from the Ohio Legislature and Senate, and the U.S. House of Representatives. The Decker Center is also used as a model by the Ohio Governor's "Families and Children Together" Task Force and is regularly visited by individuals, groups and organizations seeking to replicate our success in their communities.

Client Characteristics: Decker currently serves about 325 parents and their 435 presechool children who range from six weeks to five years of age. More than 75% are single families. Participating adults are almost exclusively female (96%) and 98% are white with an annual income of under $10,000. More than 80% have entry level literacy below 9th grade. The Barberton community as a whole is considered a chronically depressed urban area with high levels of unemployment and multiple-risk families.

When compared to other communities in Ohio and across the country, Barberton is below the median for income, education and has a larger than average number of people receiving social assistance. Most families have children living in poverty in one of the six public housing projects, with a parent who is a high school dropout. Infant mortality in this community (the annual number of deaths aged 0-12 months per 1,000 live births) is almost half again as high as both the state and country levels, and the number of teenage pregnancies is alarming. Most families have no vehicles for transportation which would facilitate their seeking services and employment, and they need help with reading, math, science, English and social studies skills. To be eligible to participate in the Decker program, most parents must also be JOBS (Jobs Opportunity Basic Skills) eligible.

Description of Program Goals: The primary goals of the Decker Center focus on strengthening all aspects of the lives of the families they serve. These goals include the following:

- To enable parents to recognize they are the first and most important teacher in the lives of their children.
- To provide parents with support, parenting skills and education they need to help their child(ren) reach their academic potential.

- To work with children as infants to promote their self-esteem and to enhance the probability that they will remain in school and complete their education.

- To have all preschool children developmentally ready to enter kindergarten.

- To provide multi-disciplinary services to special needs children so that they may reach their maximum potential and to facilitate their parents' ability to become their own service coordinator.

- To provide encouragement and support services to families which will enable them to become self-sufficient members of society.

To achieve these goals, the three primary organizations, along with the County of Summit Department of Human Services, Akron Summit Community Action Agency, Inc., and at least 17 other agencies participate in the programs offered to Decker families. These 17 service agencies include: Akron Adult Vocational School, Akron Child Guidance Center, Akron Metropolitan Housing Authority, Barberton Citizen's Hospital Family Practice, Barberton Health Department, Barberton Public Library, County of Summit Board of Mental Retardation and Developmental Disabilities, HM Life Opportunity Services, JOBS Training Partnership Act, Katherine I. Raymond, D.D.S., Akron Knight Family Literacy Program, Portage Lakes Career Center, Private Industry Council, Project: LEARN, Summit County Children Services Board, United Disability Services, and Western Reserve Legal Services.

A multitude of services are offered at the Decker Center to benefit participating parents and their preschool children. Services to parents include child care (ages 6 weeks to five years), parent education programs (e.g. Parents As Teachers- PAT), nurturing programs, parent/child education classes, family literacy (Adult Basic and Literacy Education) classes, shadowing programs, pre employment training, New Vision displaced homemaker program, family health care, nutrition education, mental health care (including crisis counseling, therapy, stress management, and adult emotional growth and management), human resources management services, home visitor and outreach services, public assistance eligibility evaluations, family legal services, and computer commuter literacy services. Program participation, attendance and progress is carefully tracked as clients are encouraged to work toward self-sufficiency and improved family functioning.

Services to children include the Learning Center Program (6 months to 3 years), infant enrichment programs (6 weeks to 16 months), toddler enrichment program (16 months to 36 months), preschool enrichment/wrap around child care program, gross and fine motor development programming, Special Needs Pre-school, Developmental Kindergarten, Head Start, speech and hearing assessment and intervention, pediatric health care (Mom's Health Care),

occupational and physical therapy, mental health care (including child emotional growth and management), food services, foster grand parenting, and a toy lending library.

Staff who provide these services include: a pediatric nurse practitioner, speech and language therapists, a pediatrician, outreach workers, parent educators, social workers, preschool teachers, Head Start teachers, child care workers, Adult Basic Education instructors, educational assistants, administrators and program coordinators, secretary/receptionists, a human resource manager, a program evaluator, mental health workers, a child psychologist, food service personnel, and a registered dietitian. To make sure clients can attend the center to participate in programming, vans are sent to each home to provide transportation for the70% of the families who are regularly in need of this service.

Opportunities for Data Collection: The opportunities to amass data on the efficacy of early intervention and family support programs are endless. At the DFDC demographic data is collected on all families and individual family members. This includes information about family structure, income, gender, race, educational attainment, primary language, health and immunizations for children, and literacy functioning of parents at program entry, employability status and progress outcomes, adult age at program entry, and special needs of children.

Longitudinal data is also collected to answer the question, "What happens to program participants?" For the 1995 program year, 83% of the families who completed the orientation session were retained for the year and 88% of those retained (121/141) had "positive" separation from the program or are committed to continuing with their programming. Of those who had positive separation, 38% left with a GED, 45% obtained a job, and 18% went on to college or trade school. Only 12% left for reasons beyond the control of the staff (e.g. the family moved, medical problems).

Program participation and attendance rates are also carefully tracked both for billing and to determine program needs. This includes information on individualized home-based and center based instruction; center-based preschool developmentally appropriate sessions; weekly small group literacy/GED, parenting, and support groups; center-based medical, mental, nutrition, pre-employment and social support services; weekly Parent and Child Together (PACT); Transportation; and child care for eligible families while parents attend ABLE and parenting classes.

Family functioning levels are assessed after the two week orientation and when exiting the program (if possible). A questionnaire is used to assess four domains:

* personal/family
* educational

* self-sufficiency
* staff evaluation after an intake/exit interview, and a
* final overall functioning level.

Ratings range from a score of 1- is minimal at-risk/transitional functioning, to a score of 5- is profound at-risk functioning. When used as an in-take assessment, clients can be recommended for services and programming based upon their identified needs. When used as an exit interview, this information provides information about the success of the programs for the individual clients. For the 1995 year, statistically significant gains were found for overall, educational, and self-sufficiency functioning. About 37% of the continuing Decker participants showed overall functioning level improvement. However, it is important to note that many of the families first assessed as a level 5, most at-risk, were unable to continue and the post-test are not included in the analysis.

Additional data is collected on the special needs (developmentally delayed) children using the Early Learning Accomplishment Profile (E-LAP), Learning Accomplishment Profile (LAP), PPVT, and/or the DIAL-R. Sixty-four (80%) were identified as special needs. Of those, 15 made sufficient progress to be recommended for enrollment in Barberton City Schools kindergarten programs. Of those 15, 11 (73%) were mainstreamed into regular classrooms and 4 (27%) were enrolled in the Developmental Kindergarten program. It should be noted that a regression analysis was used to control for normal expected normal gains in maturation. Growth beyond the normal maturation level is referred to as the Decker Effect, indicating that those gains are likely do to the effectiveness of the program. The Decker Effect answers the question, "To what extent does the child's Decker experience enhance his or her "normal" development?" Analysis of the 1995 data indicates that the Decker program enhances a child's overall development by 30% over and above "normal" growth.

Preliminary analysis of data following Decker's at-risk preschool children into elementary school indicate that 80% are progressing at rates similar to those children who were not "at-risk." Of the 26 children and their parents who participated in the Learning Center for 12 months preceding January 1, 1995, 10 tested out of the Learning Center and have been placed in Decker early childhood classrooms. The implications for public education are enormous. Providing for special education in school settings is extremely costly and very often is long term. Now that the Decker Center has a cadre of children who have moved through the programs from infancy to kindergarten we are able to demonstrate the emotional, educational and cost benefits derived from this full service model.

An additional set of data assesses participant satisfaction with programming. Using a 5-point Likert opinion scale, scores range from 5= strongly agree with the statement, to 1= strongly disagree with the statement. This format is used to assess satisfaction with each of the programs offered and with the services provided. Participant responses indicate that parents are "satisfied" or "very satisfied" with the programs they participate in. Their

satisfaction is manifested by their retention, attendance and positive comments they make regarding the programs available to them and their children.

A final set of data reports qualitative responses to a staff focus group evaluating their perceptions of the program. Selected staff were asked to respond to four focus questions:

1) What do you see to be the strong/weak points of the program?
2) How do you think parents/children feel about the program?
3) Do you have any family stories that are especially poignant?
4) Have you found help or hindrance from your colleagues, supervisors, community people you have contact with?

Common themes revealed the staffs sensitivity to parental concerns, family needs, and the importance of parents modeling appropriate behaviors. They see the programs make the parents as well as the staff accountable, and working together enhances the educational opportunities for the children. Interviewing the staff not only provides an additional perspective into the programs provided by the Decker Family Development Center, it also empowers staff to actively become involved in "co-construction" on the program. Their expert and caring delivery of service is key to the success for the parents and children who are the Decker families.

One of the problems with data of this complexity is that it must be effectively communicated to individuals who have largely discrepant skills and experiences in interpreting such information. The Decker data, which is both formative and summative in nature, and which is both quantitative and qualitative in nature, needs to be presented in a format that is as simple and easy to interpret as possible. Examples of this data are presented in the appendices. Another option for reporting, which we have not yet undertaken, is to index and cross reference data by programs-by assessment. This would allow one to look at possible relationships such as the correlation between specific client needs and program success, while holding other variables constant.

While the data collected is not exhaustive, it provides the basis for demonstrating the efficacy of investing in children from birth. It gives hope to at-risk families and provides a data based argument for continuing and increasing the funding to programs that have demonstrated their effectiveness. It also provides communities with the information that they have a choice- they can either intervene with "at-risk" kids during their very early years, or they can plan to provide expensive special education programming throughout their school years.

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(This monograph and all prior monographs are available fro the Decker Family Development Center, 633 Brady Rd., Barberton, OH 44203; phone: 330-848-4264) (This is a new area code after March 9, 1996).

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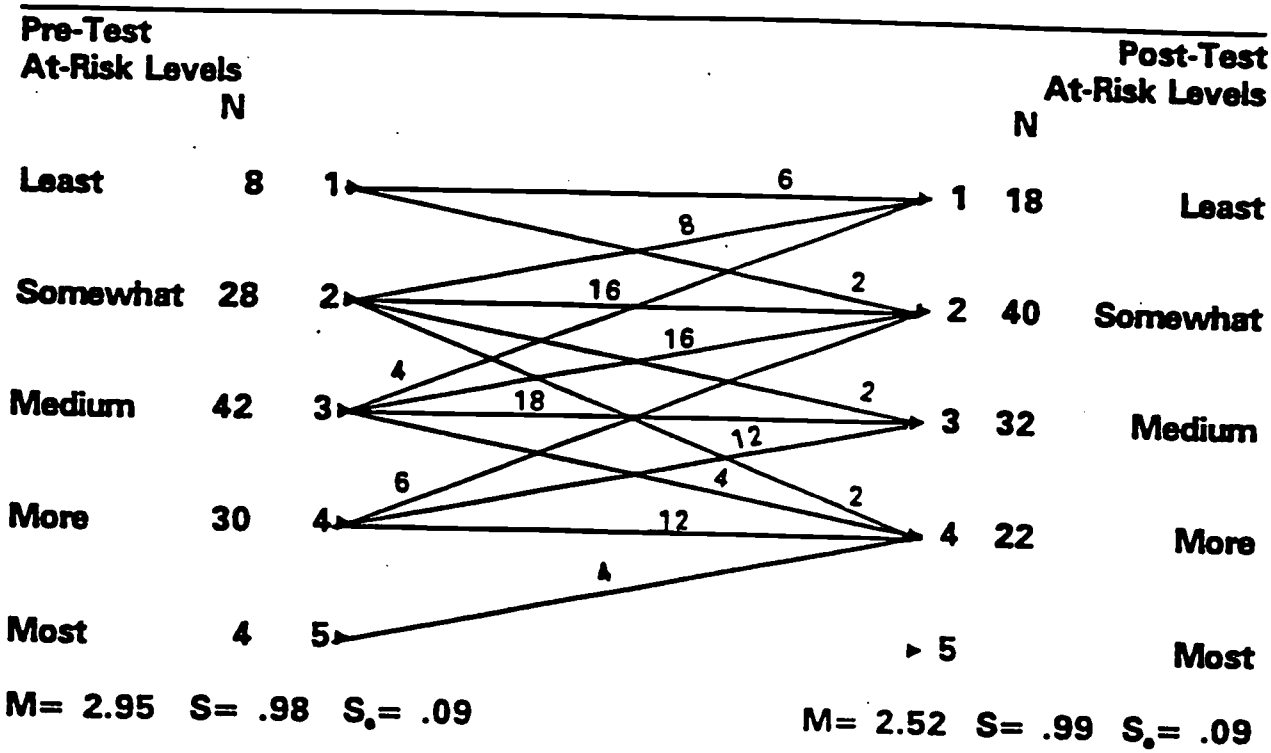
EXAMPLE OF ANNUAL REPORT ORGANIZATION

Table of Contents

Table 1: Characteristics of Participating Adults

Client Characteristics	Percentage
Family Structure	
Single with children	76%
Couple with children	9%
Extended family	13%.
Other	2%
Income	
$10,000 to 15,000	2%
$ 5,000 to 10,000	21%
Under $5,000	77%
Gender	
Female	96%
Male	4%
Race	
Black	18%
White	81%
Hispanic	1%
Educational Attainment	
8 Years	6%
9 Years	17%
10 Years	19%
11 Years	19%
12 Years (but did not graduate)	8%
GED	4%
High School Diploma	27%
Primary Language	
English	100%
Health Physical & Immunizations for Children	
Yes, completed	100%
Literacy Functioning Level at Program Entry	
9.0 - 12.9 grade level	19%
6.0 - 8.9 grade level	44%
5.9 and below	37%
Employability Status and Progress Outcomes (what happened to those completing the 1994-1995 academic year)	
[Positive Separations]	
Exited with GED	11%
Obtained Job	13%
Went to College/Trade School	5%
[Other Separations]	
Moved	6%
Exited for Medical Reasons	2%
Left Program/Quit/Ineligible	4%
[Continuations]	
Continuing in Preemployment	18%
Continuing in Regular Programming	42%
Adult Ages at Program Entry	
16-24	57%
25-44	35%
45-60	7%
Special Needs Children	
Among Those Ages 0-36 Months: Yes	87%
Among Those Ages 37-60 Months: Yes	63%

Self-Sufficiency Functioning Levels



Matched Pairs T-Test p= .001 (Very Significant)

FIGURE 7
Staff Evaluation of Functioning

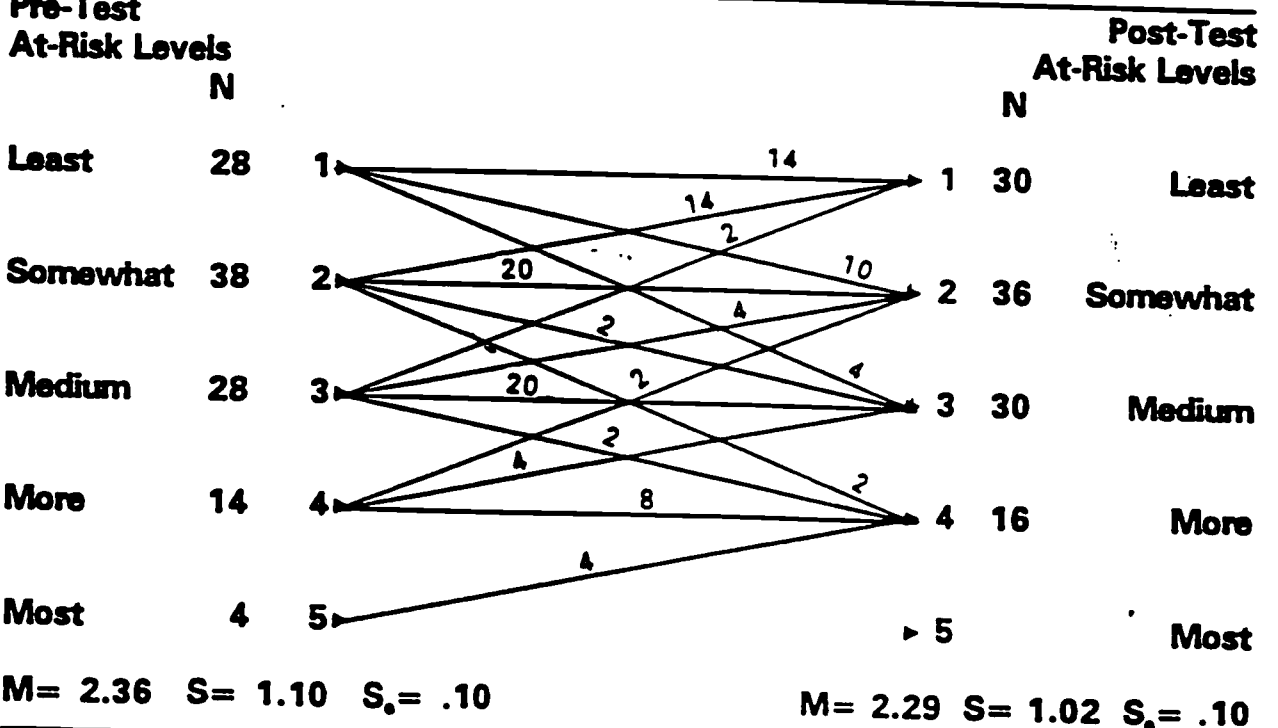
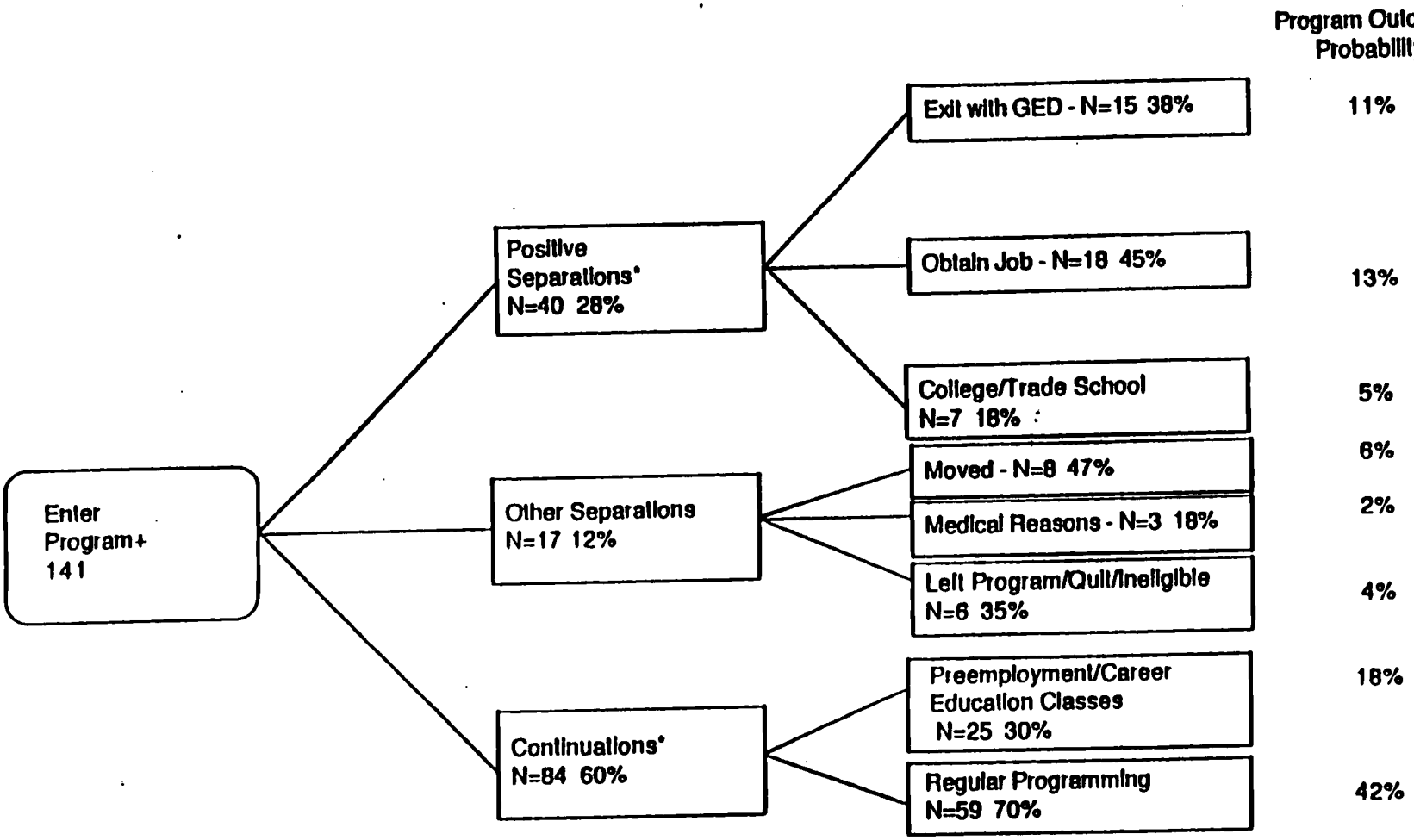


Figure 2. Family Unit Progress- Probabilities of Success for 1994-1995



+141 of 169 "continued" programming for the year, representing an 83% retention rate for the year.

*124 of 141 had a positive program separation or are committed to continuing with their programming, representing an 88% retention rate for the year.

Program	"I feel I have made progress in this program" -Mean-	"This program is meeting my needs" -Mean-	"This program is well run and organized" -Mean-
1. Adult Education Classes	4.48	4.29	4.30
2. Childcare	4.50	4.62	4.66
3. Family Counseling	3.19	3.07	3.31
4. Head Start Parent Participation	3.60	3.67	4.33
5. Health Care Services	4.75	4.80	4.82
6. Home Visits	4.33	4.31	4.37
7. Individual Service Strategy	4.00	3.81	3.93
8. Learning Center	3.83	3.92	3.92
9. Nurturing	4.62	4.54	4.68
10. Nutrition	4.08	4.09	4.05
11. OPEN (Registration & Orientation)	3.71	3.82	4.00
12. Parent & Child Together (PACT)	4.38	4.35	4.44

Table 3. Childrens' Regression Coefficients and the DECKER EFFECT Score[4,5]

Dimension	Pretest Score	Posttest Score	Monthly Gain: TOTAL	Monthly Gain: NORMAL	Monthly Gain With: DECKER	% Of Total Gain From: NORMAL	% Of Total Gain From: DECKER	*DECKER EFFECT*
Gross Motor	23.6	33.4	1.2	1.00	.20	83	17	1.2
Pre-Writing	39.0	46.5	.9	.55	.35	61	39	1.6
Cognitive	22.3	32.6	1.3	.86	.44	66	34	1.5
Fine Motor	23.2	31.1	1.0	.96	.04	96	4	.1
Language	22.1	30.8	1.1	.89	.21	81	19	1.2
Personal/Social	23.0	34.0	1.4	.88	.52	63	27	1.4
Self-Help	26.6	36.5	1.2	.92	.28	77	23	1.3
Combined LAP	23.1	32.8	1.2	.91	.29	76	24	1.3
PPVT	44.8	55.0	1.3	.93	.37	72	28	1.4

[4] For all regression estimates, Adjusted R^2 figures were extremely high. The lowest was for pre-writing skills and the PPVT, where the Adj.R^2 figures were .55 and .56, respectively. The personal/social skills Adj. R^2 was .85, all others were .90 or higher. This means that each assessed dimension is highly explained by the child's age, adding credibility to the creation of these "pseudo" comparison groups and validating the creation of the ***DECKER EFFECT***.

[5] Because the pre-writing dimension is used only for those children 4 and older, only 35 children are assessed here.

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