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ABSTRACT

This report describes four demonstration projects, funded from July 1989 to December 1990 in Oregon, on early identification and prevention of mental and emotional disorders in children. The intention of the projects was to find ways to identify children at risk of suffering emotional disorders and to intervene early enough to prevent these disorders. The first program described, the Interpersonal Cognitive Problem Solving Project, trained 407 second and third grade children, 84 of whom were identified at-risk, in social problem solving skills. Results found that the children who were at-risk demonstrated improvement in problem solving skills. In the second program, the Temperament Project, results found a reduction in the problem behavior of the children of the approximately 100 parents that received temperament services. The third project, the Jackson County Early Intervention Mental Health Project, offered special friends for children who are at-risk, socialization groups, and parent training. Preliminary findings indicated positive and significant changes in socialization. The last project, the Family Service Project, offered parent education and support groups with concurrent and follow-up home visits. Anecdotal evidence from participating parents and agency staff suggested that the project was having a positive effect. (References accompany each section.) (CR)

Portland State University

Oregon Mental Health and Developmental Disability Services Division

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Interim Report

STARTING RIGHT

Early Intervention Demonstration Projects
July 1989 to December 1990

Prepared by

Nancy Koroloff, Ph.D.
February 1991

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STARTING RIGHT:

An Interim Report on Early Identification and Prevention Services for Children at Risk of Mental or Emotional Disorders Demonstration Projects.

July 1989 to December 1990

Prepared for
Oregon Mental Health and
Developmental Disability Services Division

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EXECUTIVE SUMMARY

Four demonstration projects on early identification and prevention of mental and emotional disorders in children were funded in the last legislative session. Two of these projects were continued from the previous biennium and two began in this biennium. There are now four models of early intervention and prevention services that have been demonstrated in the state of Oregon. The intent of these projects is to find ways to identify children who are at risk of suffering emotional disorders and intervene early enough to prevent these disorders. Two of the projects intervene directly with parents, teaching them parenting or social skills that will result in more positive home environments for children. Two of the projects intervene primarily with the children, usually in an elementary or preschool setting. One of these projects teaches children problem solving skills that can be used when interpersonal problems arise. The other project focuses on the bonding process and provides children with positive adult modeling followed by a group experience which increases their socialization skills.

The two projects that have been in place for close to three years have made significant strides toward establishing the effectiveness of these programs for Oregon's children.

The two programs that began in January 1990 are still in the process of implementation. Preliminary data on effectiveness is available, but it is unwise to judge the effectiveness of these programs until they have functioned at full intensity for a period of time. Making decisions about these programs prematurely may lead to eliminating models of prevention that are effective. The state should continue to support these two programs so that a full evaluation can be completed. Other models of early identification and prevention should also be explored so that counties will have a full range of options to choose from.

The following paragraphs provide a brief summary of each of the four projects. Additional details can be found in the full report.

The *Interpersonal Cognitive Problem Solving Project* (ICPS) is situated at Morrison Center in Portland, Oregon. This project is demonstrating that training elementary age children in social problem solving skills can reduce the risk of socioemotional maladjustment. The ICPS was implemented in conjunction with a complementary project, Parents as Partners, funded by the Meyer Memorial Trust.

ICPS began in January 1988 and over the past three years has examined the impact of its curriculum on children in kindergarten through third grade. The conclusion of project staff is that first and second grades are the earliest grades that show benefit from the training. The project uses the Social Problem Solving curriculum to teach children a series of steps to use in solving interpersonal problems. Children are involved in 18 lessons delivered twice a week for 20 minutes per lesson. After children have acquired the skills of problem solving, efforts are made to help them generalize these skills through ongoing classroom strategies. Children who are at greater risk are identified and given extra skill support through concurrent small group instruction.

During the 1989-90 school year, instruction was given to 407 second and third grade children, 84 (21%) of whom were identified as at-risk. In the first semester of the 1990-91 school year, instruction was provided for a group of 235 first grade children, 86 (35%) of whom were identified as at-risk. In the second half of the school year a group of

approximately 216 second grade children will be instructed. All children attend two elementary schools in the Centennial School District.

Evaluation of the project suggest that, as a result of the training, children learn interpersonal problem solving skills and improve their school behavior. Consistent with the finding in the initial 18 months of the project, at-risk children demonstrated improvement in problem solving skills. The increase in prosocial responses and the decrease in antisocial responses are significant although significance was not achieved on other subscales. There is also a significant change in teacher rating of problem behaviors of at-risk children. Six of the seven scales showed statistically significant positive improvement over time for children who received training in the first semester of 1989-90. Improvement for at-risk children in the second semester was less consistent.

A program manual is being developed to be used by agencies or school districts wishing to replicate this project. It is hoped that the Centennial School District will be able to fund continuation of the ICPS project within its schools.

The *Temperament Project* is housed within the Center for Parenting Excellence in La Grande, Oregon. The project is based in temperament theory which states that temperament is an inborn characteristic and that behavior related to temperament often cannot be managed through traditional parenting practices that make use of rewards and punishments. The primary emphasis of the Temperament Project is to provide temperament related parenting consultation to parents of children 18 months to 18 years old. Services are delivered by Temperament Specialists who are parents trained in the temperament model of parenting. Temperament Specialists meet individually with parents on a weekly basis for 6 to 8 sessions.

In order to assess appropriateness for the temperament intervention, Project staff have screened close to 300 parents through preschool screenings in the past two years. In addition, parents may call directly for services or they may be referred by service providers. Approximately 100 parents have received temperament services over the contract period.

Evaluation of the project suggests that children's problem behaviors diminish over the time that their parents are involved in temperament counseling. Significant behavior changes were found in the overall Modified Eyberg Child Behavior Inventory (ECBI-M) Intensity score, particularly due to changes in oppositional and defiant behaviors. There was also a significant change in the total ECBI-M Problem score as well as significant decreases in several of the subscales. This suggests that parents perceive a significant decrease in their child's problem behavior but do not leave the program with a perfectly behaved child.

The Temperament Project has worked collaboratively with other community agencies, particularly Children's Services Division. The project has extended its services to parents of children with special needs such as children who have been abused, children living in foster homes and children who are adopted. The project was providing temperament counseling to foster parents until the contract with CSD was terminated for lack of funds. The project is developing material and training for CSD adoptive workers.

The Temperament Project has developed a program manual and is in the process of producing a training manual. This Project hopes to continue on a fee-for-service by asking parents to pay $40 per hour for the program. This will eliminate services to low

income or financially needy families with the exception of those who might be supported through a scholarship program.

The *Jackson County Early Intervention Mental Health Project* is located within an existing network of service providers with Jackson County Health and Human Services providing the coordination and planning. This project has been funded for about 12 months. The Jackson County Project was developed around the core bonding process as described in the Social Development model. The project offers three separate services: 1) Special Friends (the primary intervention with at-risk children), 2) socialization groups (small group interaction for at-risk children) and 3) parent training. All services are provided at elementary schools or preschool sites. Children are selected for the project through screening using the AML, a teacher rating scale.

Children involved in Special Friends participate in 12 individual play-counseling sessions with a trained and supervised child aide at the school site. Sessions last 30 to 40 minutes and occur weekly over a three-month period. The socialization groups consist of ten 30-40 minute group session with six to eight children who have been identified as isolated or rejected and are lacking social skills. The group leader presents a progressive series of group games and activities while allowing modeling, practice, and reinforcement of social skills. The format for parent training is a series of seven participatory session in which parents explore and discuss child development, behavior management and positive parent-child interactions.

In less than a year the project has been active in nine schools and two preschool sites. During spring and fall semesters, 1990, 226 children were involved in Special Friends. An additional group of students will be enrolled in Special Friends in spring semester of 1991. Socialization groups are being carried out during 1990-91 with approximately 55 children served. Parent orientation sessions were offered at each Special Friends site during fall 1990 and seven session of parent training were subsequently offered at four sites.

Evaluation of the outcomes of this project's intervention is not complete due to the short time period it has been functioning. Preliminary findings for children participating in the first semester of the project indicate positive and significant results in all seven testing scales of the Teacher-Child Rating Scale.

Interagency collaboration is at the heart of this project. Four school districts, Head Start and OnTrack, Inc. provide program sites. The socialization groups are facilitated by a therapist from the Southern Oregon Child Study and Treatment Center. Parent training is done by Crisis Intervention Services. Jackson County Health and Human Services provides coordination and administrative services.

The passage of Measure 5 is a major event affecting this project's future. Due to the economic depression of the region, there is little hope that agencies or local school districts will fund this work if the project is not continued through state funds.

The *Family Service Project* is a collaborative effort between Umatilla County Mental Health Program and Umatilla-Morrow County Head Start. First funded in January, 1990, this project has been functioning for 12 months. The Family Service Project employs a social interaction model developed into an early identification and prevention curriculum by Childhaven of Seattle. The project is designed to demonstrate that providing parenting and social skill training combined with social network development to parents of

high-risk children can increase parents' ability to resolve emotional or behavioral difficulties with their children.

The Family Service Project offers parent education and support groups with concurrent and follow-up home visits to reinforce the skill training received in the groups. Development of the social support network is a structured part of the parenting curriculum. Groups meet for two to three hours each week for 10 weeks. There are 10-12 participants in each group. All support group members have children in the Umatilla/Morrow County Head Start or WIC Program. Recently, the Family Service Project began working with three alternative schools in the county and is currently facilitating groups for pregnant and parenting teens as well. Between January 1990 and December 1990, 20 groups were completed, serving 139 families.

Evaluation of this project's outcomes are not complete due to the short length of time the project has been functioning. The instrument selected to measure program impact is the Adult-Adolescent Parenting Inventory (AAPI). Differences on pre- and post-intervention scores for the second and third quarter were not large. Questions are being raised about the appropriateness of the instrument and whether or not a 10-week intervention is intensive enough to cause change in scores on this instrument. Anecdotal evidence from participating parents and agency staff suggests that the project is having a positive effect.

Implementation of the Family Service Project requires that the Mental Health Program, the Head Start Program and the schools work closely together. There has been a a long term positive working relationship between the Project Coordinator for the Family Service Project and the Director of the Head Start Program. This, and the fact that the two programs are co-located, has made it easier to integrate the Family Service Project into the existing Head Start Program, allowing for the use of Head Start assessment measures as well as sharing other resources such as transportation and child care. Presently, agencies in Umatilla County are meeting to discuss the development of a collaborative countywide program to delivery parent support and education. Multiple funding sources including grants, foundations and agency financing will be explored.

INTERPERSONAL COGNITIVE PROBLEM SOLVING PROJECT
MORRISON CENTER
PORTLAND, OREGON

Background

Morrison Center is a private, nonprofit agency dedicated to the needs of children and their families. The agency is located in Multnomah County but serves children from all over the state through its many programs. The two primary service settings are located in Portland and Gresham. The current project is housed in the Gresham office.

Morrison Center has a long tradition of interest in the Interpersonal Cognitive Problem Solving (ICPS) model and of working closely with local schools to implement the curriculum. In collaboration with Portland Public Schools, the Morrison Center, in 1979, sponsored a major conference that brought Dr. Myrna Shure, a co-developer of the model, to Portland to present the ICPS model. As a result of this conference, hundreds of professionals were influenced by the model. Portland Public Schools in particular was impressed by the model and currently uses ICPS intervention techniques in many of its schools.

The Interpersonal Cognitive Problem Solving Project (ICPS) is an early intervention project funded by the Mental Health Division. Its purpose is to demonstrate that training elementary age children in social problem solving skills can reduce the risk of socioemotional maladjustment. The ICPS project has been implemented in conjunction with a complementary early intervention project, Parents as Partners (PAP). PAP, funded by Meyer Memorial Trust, promotes the reinforcement of problem solving skills in the home environment and works to build collaborative relationships between the school and parents.

The ICPS Project was first funded in fall 1988. Its current contract covers funding through June 1991. The 1989-90 project year concluded the research and demonstration phase of the project, with the current 1990-91 year focusing on integration of the curriculum within the host school district and production of a program manual. The project received about $56,000 in the 1990-91 fiscal year.

Interpersonal Cognitive Problem Solving Model

The ICPS model was developed by Spivack and Shure (1974) and is used to identify poor social adjustment in preschool and kindergarten children and to teach those children problem solving skills. One of the primary goals of intervention with the ICPS model is to improve children's behavioral adaptation by teaching them how to think as opposed to what to think. The model has been extensively documented and found to be effective in teaching interpersonal and problem solving skills to children in nursery school through elementary grades.

The Spivack and Shure curriculum is appropriate for kindergarten and first grade children. Project staff wanted to expand the ICPS training to second and third graders for the 1989-90 school year. The Rochester Social Problem Solving (SPS) Program was chosen as a curriculum for older elementary school children (Cowen, 1982). The SPS Program was developed for children in first and second grade by Emory Cowen and is consistent

with Spivack and Shure's ICPS model. Both Cowen and Shure were consulted by Morrison Center staff, and both agreed that the models are conceptually consistent.

Description of the ICPS Project

As a result of analysis by the project team of the first project period (January 1988 to June 1989), several steps were taken in an effort to strengthen training effects on classroom behaviors. In order to train second and third grade children, the project adopted the Social Problem Solving Curriculum (SPS). (See Appendix A for a more detailed description.) This curriculum teaches children a series of steps to use in solving interpersonal problems. The curriculum also provides the children and their teacher with a common language to use when communicating about problems. Children are involved in 18 lessons delivered twice a week for 20 minutes per lesson. After the children have acquired the skills of problem solving, efforts are made to help them generalize these skills through ongoing classroom strategies, and through the efforts of Parents as Partners to involve parents in reinforcing the use of these skills at home. At-risk children are identified and given extra skill support through concurrent small group instruction. As a result of offering small groups concurrent with classroom instruction, staff reported that the at-risk children tended to be more knowledgeable and participative during the all-class instruction and demonstrated a greater sense of competency among peers.

The second contract for ICPS began in July, 1989. At the end of summer break two .75 FTE child specialists were hired to replace the prior year's staff, who went on to full-time positions in the public schools. Dean Garrison, M.S., was hired half-time as coordinator for both the ICPS-SPS and Parents as Partners projects.

At the end of the 1989-90 school year, one of the child specialists left the project to accept a position in the public schools. It was decided not to replace this position and to increase the remaining child specialist position from .75 FTE to full time. The program design for the final year was modified so that one child specialist taught all classes with the assistance of the classroom teachers. This necessitated the development and offering of a training program for teachers in instruction of the curriculum. The training program included information on the problem solving concepts and prepared teachers to assist in teaching and generalization of the skills. Continuing Education credit are available to those teachers who participate. These changes were made to reflect the project design most feasible for replication.

The remaining staff position was dedicated to a half-time professional writer who is developing the program manual. This position was filled just prior to the beginning of the 1990-1991 school year. The program manual will include the curriculum and specific implementation strategies for both the ICPS and PAP projects so that communities interested in adopting this early identification program can have the benefit of the project's experiences. The program manual is also referred to as the replication manual.

During the first 18 months of the project (1988-89), instruction was given to kindergarten and first grade students. The 1989-90 school year provided the training to second and third graders. In 1990-91, instruction was administered to first and second graders. Since the goal of the project is intervention as early as possible, it is the conclusion of the staff that these are the earliest grades that show benefit from the training.

In 1990-91, first graders were taught in the first semester with second graders receiving instruction in the second semester. Weekly small group instruction to first grade at-risk

children is continuing throughout the school year. The purpose of this is to optimize the impact of intervention and the opportunity for generalization of the problem solving skills for these children. Small group instruction will not be offered to second grade at-risk children. The limited child specialist time availability precluded offering small group instruction simultaneously to both first and second grade children. The value of offering small group instruction for the entire year to at-risk first grade children seemed to outweigh the value of offering shorter term small groups to both grades. Because second grade at- risk children received both classroom and small group instruction as first graders, the second grade training is intended as a less intensive "booster" for the training received the previous year.

Prior to the 1990-91 school year, extensive data was collected on the acquisition of problem solving skills by the children involved in the program. With the primary research phase of the project completed at the end of the 1989-90 school year, project staff determined not to pre- and posttest children for problem solving skills during 1990-91. Attention and resources were focused on modifying the model to approximate replication, developing and implementing a teacher training program, writing the replication manual, and the continued provision of quality services. In order to identify the at-risk children, the teachers continued to do the AML-R assessments on all children.

Description of Participants

During the 1989-90 school year, instruction was administered to 407 second and third grade children, 84 of whom were identified as at risk (21%). Concurrent small groups were offered to at-risk groups during both semesters of the 1989-90 school year.

Beginning in the 1990-91 school year, a new group of first grade classes was instructed in the fall. A total of 235 children were included in the instruction, 86 of whom were identified as at-risk (35%). A new group of second graders are receiving instruction in the second half of the school year. The second grade classes currently include 216 children.

Demographic data is available for those children served during 1989-90. Consistent with earlier practices, teachers assessed all second and third graders using the AML-R. This is a behavioral observation instrument used to identify children at risk. It measures acting out, moodiness, and learning difficulties. The AML-R was completed by the classroom teacher on each student at the beginning of the school year. Children who scored lower than 85% of the established norm were considered at-risk.

Table 1 presents a comparison of demographic and risk variables for a randomly selected sample of at-risk and not-at-risk children. Assessment of these characteristics were done by the classroom teacher. Statistical significance is based on a chi-square test of significance.

As Table 1 suggests, the at-risk children are more likely to have transferred schools and are thus less likely to have been exposed to problem solving training in earlier grades. At-risk children are significantly more likely to be involved in remedial education classes and to have experience with counseling or therapy. The at-risk children are also more likely to be working with a resource specialists, although this difference is not statistically significant. The at-risk children are more likely to appear drowsy or tired in class and were less often perceived as easy to like. These children are more likely to be from

single-parent or blended families and more likely to lack adult supervision after school (as perceived by the teacher). At-risk children also appear to be from families with possible economic difficulties. In general, the demographic evidence suggests that the AML-R did identify those children who are at-risk and in need of intensive early intervention.

Table 1. Comparison of a Sample of At-Risk and Not-At-Risk Children

		DEMOGRAPHIC AND RISK VARIABLES WITHIN SAMPLE	NO RISK N=34	AT RISK N=34
		AGE		
		7 years	29%	35%
		8 years	59%	56%
		9 years	12%	9%
		SEX		
		male	50%	57%
		female	50%	43%
		SCHOOL		
		Lynchview	35%	31%
		HOP	65%	69%
		GRADE		
		second	56%	51%
		third	44%	49%
		EDUCATIONAL CHARACTERISTICS		
		repeated a grade	6%	6%
	•	transferred schools	21%	51%
	•	attended problem solving training before	79%	50%
		attended special speech/language classes	6%	23%
		attended special day classes	3%	6%
		attended resource specialist program	6%	17%
	•	attended remedial education classes	6%	29%
	•	had counseling/therapy	6%	34%
		CHILD CHARACTERISTICS		
		physically immature	0%	3%
		lacks fine motor coordination	6%	20%
		lacks gross motor coordination	3%	9%
		difficulty with speech	12%	23%
		difficulty with language	12%	20%
	•	appears drowsy or tired	3%	26%
		poor grooming	3%	14%
		visits school nurse often	0%	11%
		frequently absent	12%	9%
		on-going medical problems	6%	11%
	T	child seems easy to like	100%	85%
		disciplinary visit(s) to office	3%	15%
		LIFE EVENTS		
	•	parenting situation		
		both birth parents	76%	40%
		single parent household	19%	40%
		blended family	3%	14%
		other	3%	6%
		death of a family member	0%	3%
		serious illness of a family member	3%	12%
	•	child lacks adult supervision after school	3%	24%
	T	possible family economic difficulties	17%	41%
		has moved residence frequently	3%	12%
		subsidized lunch program		
		free	17%	32%
		reduced	6%	12%

* = $p < .05$; T = $p < .07$

Evidence of Program Impact and Teacher Satisfacation

The primary instrument used to assess change in problem behaviors of at-risk children is the TCRS (Teacher-Child Rating Scale). This is a behavioral observation instrument that is completed by the classroom teacher and is thought to be more sensitive than the AML-R. The TCRS is used to measure change in behavior over time and yields seven scale scores. The TCRS was completed on a sample of at-risk children at three points: prior to the beginning of the first instructional phase of the year (September 1989), between the first and second phases (February 1990), and at the end of the second phase (May 1990).

The primary instrument used for measuring the acquisition of problem solving skills in second and third grade children is the SPSAM (Social Problem Situation Analysis Measure). This tool assessed social problem solving skills and preferences. Children are presented a series of illustrated problem situations and are systematically interviewed with prescribed questions designed to measure such factors as degree of prosocial or antisocial response to a problem situation, how obstacles are overcome, and anticipated outcomes. Interviews are taped and later reviewed and scored. The SPSAM was administered to samples of at-risk and not-at-risk children at the same three points at which the TCRS was administered. The SPSAM is used instead of the PIPS, which is more appropriate for use with kindergarten and first grade children.

Administration and scoring complexity of the SPSAM required some changes in the design of the evaluation of intervention. All at-risk children and an equal number of randomly selected not-at-risk children were administered the SPSAM prior to the beginning of the first phase of instruction. It became clear that the SPSAM test was difficult, complex, and highly time-consuming to administer and score. At each testing point, the instrument required 20 minutes to administer and 30 minutes to score for each child. For each of the three planned testing points, it would have required a total testing time of 2 hours and 30 minutes per child. Constraints on time and personnel required the project staff to reduce the sample population to 100 children (cells of 25 at-risk children and 25 not-at-risk children selected at random from each of the two instructional phases). Due to student attrition and other problems with administration and scoring of the SPSAM, the final sample size varied from 16 to 18 children per cell.

The demographics of the random sample (prior to attrition) were compared to the general population of children in the program. The not-at-risk sample did not differ from its cohort group. The sample of at-risk children, however, may have been somewhat more behaviorally disturbed than their cohort group. They were significantly more likely to have experienced prior counseling and exhibited lower AML-R scores. This means that the at-risk sample may be of even higher risk than the at-risk group in general.

A second issue examined was whether the 1989-90 first semester instructional group was comparable to the second semester instructional group. The first semester, including half the second and third grade classes, began in October and ended in January. The second semester, including the other half of classes, began in February and concluded in May. Since the second semester is used as a control for the first, it is important to examine the two groups for differences that would interfere with this design.

Findings suggest that 1989-90 first semester at-risk children had more behavior problems than second semester at-risk children, as indicated on the AML-R and TCRS. Although the selections of classes for instruction in either the first or second semester was done at random, later information suggests that the classes with the highest numbers of the more

difficult at-risk children were selected for the first semester. These pre-existing behavior problem differences make the two groups less than ideal comparison groups since reduction of behavior problems is one outcome measure. As will be seen in the next section, this is especially apparent on the shy-anxious scale, on which second semester at-risk children had a mean pre-treatment score quite close to the norm while first semester at-risk children exhibited scores that were significantly lower than the norm.

Impact on Problem Solving Skills In the initial 18 months of the project, at-risk and not-at-risk children demonstrated improvement in problem solving skills (as measured by the PIPS) following intervention. The following highlights the improvement in problem solving skills (as measured by the SPSAM) for the 1989-90 project year. Details of this analysis are found in Tables 14, 15, 16, and 17 in Appendix A.

> Although the statistical significance isn't overwhelming, the data display a trend that suggests that *at-risk children* tend to do better across the three testing points. For the most part, the mean and percentage scores are moving in a positive direc tion. There was an increase in prosocial responses in both phases which is statistically significant in the first semester of 1989-90. There is also a decrease in antisocial responses in the second semester children. These results are consistent with, although not as strong as, the findings of the initial 18 months.
>
> There was no change in problem solving skills in the *not-at-risk children.* This contrasts with the initial 18 months which showed changes in both not-at-risk and at-risk groups.

There are several explanations for these findings. Part of the failure to achieve statistical significance is due to the small cell sizes in the final sample. The lack of change in this year's not-at-risk children may be attributable to the fact that many had previously participated in problem solving instruction. The proportion of at-risk children who had previously received problem solving instruction was lower because many had begun attending this school recently. In addition, the SPSAM is a new instrument that has not been used in this agency before. Given its complexity, it is difficult to determine whether it is measuring accurately the constructs under consideration.

Impact on Problem Behaviors In the first 18 months of the project, improvements in behavior were somewhat inconclusive, although the data showed trends in a positive direction. The following summarizes the changes in problem behaviors in the 1989-90 project year. Details of this analysis are found in Tables 18 and 19 in Appendix A. Changes in problem behavior are examined only for at-risk children.

> There was a significant change in teachers rating for *at-risk children* in the first semester of instruction for 1989-90. Six of the seven scales showed statistically significant positive improvement between the first measure and the third measure (main effect). These children received intervention between time one and two and exhibited major changes in scores over this time period (significant on five of seven scales). They seemed to maintain or increase their command of the problem solving skills over the next time period.
>
> Improvement for *at-risk children* in the second semester of 1989 90 was more mixed. Second semester at-risk children showed significant improvement on two of the seven scales. (Second semester children received intervention between time two and three). This group of children began at a point very close to normal on

the Shy- Anxious scale, so little change was expected. Lack of positive improvement on the Learning Difficulties, Frustration Tolerance and Task Orientation scales is more difficult to explain.

The acting-out scale does show some improvement, though not significant. Project staff have begun to question whether *acting out behavior* is correlated with problem solving skills. The scale measures attention-getting or disruptive classroom behaviors which are often likely not to be a response to a social problem situation. The training is intended to increase the child's repertoire of problem solving skills. Such an increase may not impact acting out behavior.

Again, the small sample sizes must be considered a contributing factor to the lack of statistical significance, especially since all of the mean scores show trends in a positive direction. Although improvement was noted on all scales for first semester at-risk children, some scales did not show significant improvement until later in the year. In addition, results for second semester children, who did not receive their training until spring, were not as strong as first semester children, who received instruction at the beginning of the school year. This suggests that children who receive training earlier in the year may benefit the most, having more time left in the school year to practice and integrate the training after the end of instruction. Greater improvement on TCRS scales for first semester children may also be due to teachers' opinions about the children being less fixed earlier in the year. Also, there is research to indicate behavior change sometimes does not occur until one or two years after intervention.

Teacher Satisfaction In May 1990 a survey was administered to all teachers whose classrooms had received instruction in the Social Problem Solving curriculum. The purpose of the survey was to assess their degree of satisfaction with the program and to allow feedback on suggestions for improvement. The overall return rate of SPS Teacher Surveys was 83%.

When asked to rate the quality of the SPS instruction that had occurred in the classrooms, 42% said superb, 50% rated it as good, and 7% indicated fair. Eighty-six percent of the teachers reported some or much improvement in social relationships and problem solving in the classroom since the students received SPS instruction. Thirty-three percent reported that at-risk children had benefited from the small group instruction. When asked if SPS is a valuable curriculum and whether it should continue to be taught in the school, 86% indicated yes, 13% were undecided, and none indicated no.

Some important ideas for modification offered by survey respondents include the following: increased use of role plays, including problems with adults and family members as well as problems with other students; instructing all children at the beginning of the year with concurrent sessions of small groups for at-risk students; continuing small groups after completion of instruction; monthly refresher lessons in classrooms after instruction is completed; training of teachers and other personnel before the beginning of classroom instruction; providing teachers with information on the stages of learning and generalization; and involving classroom teachers in the actual instruction of children. Many of these changes have been integrated into the model.

Collaboration with the School System

It has been a goal of the project to promote recognition by the school district of the value of problem solving skills training and to gain a commitment from the district to

internalize the model within the school system. A comprehensive plan and manual is being designed to facilitate statewide replication of the model.

A number of activities were implemented during the first semester of 1989-90 to effect the transfer of training of problem solving skills to environments outside the immediate classroom. In order to give teachers a needed primary role in educating students in the problem solving method and to ensure generalization of program effects, a number of resources have been offered to teachers. These include a monthly training/support group for teachers, a classroom reinforcement program for problem solving behaviors, a teacher's manual on social problem solving in the classroom, additional printed information about the problem solving model, and information on how to receive college credit for participation in generalization activities. Attendance varied at the teacher meetings, with an average monthly participation of 35% of teachers whose students were receiving instruction in the problem solving curriculum. For the 1990-91 project year, the course "Social Problem Solving in the Classroom" was developed and required all classroom teachers whose students received SPS instruction to participate. Participation has been 100%.

Another tool to help students generalize the skills they were learning was the distribution of student self-monitoring forms and adult monitoring forms to support the use of the problem solving method. The adult monitoring form offers feedback to the child and child specialists from teachers and parents on the child's use of the problem solving skills. The overall return rate on the student self-monitoring forms was 32% (42% of at-risk forms, 29% of not-at risk forms). There was a 10% overall return rate of the adult forms (9% of at-risk forms, 11% of not-at-risk forms). By the end of the second semester (June 1990), the use of the adult monitoring form was discontinued due to a lack of adult cooperation and a very low return rate.

Involving Family Members

The ICPS Project has been fortunate to have the continued support of its complementary project, Parents as Partners. The home environment plays a critical role in the generalization of the problem solving skills learned in the classroom. A Social Problem Solving Family Evening was held in each phase. The purpose of the activity was to familiarize parents, particularly those with at-risk children, with the problem solving model and enlist their support in generalization and maintenance of these skills. Parents observed their children role-play the skills and also received the Social Problem Solving "Super-Solver" Parent Manual. Parents were given an opportunity to discuss issues around problem solving at home. These evenings were designed to optimize parental involvement, with the goals of familiarizing parents with the model and encouraging support of their children.

At the beginning of the first semester of 1989-90, weekly parent-child activities were sent home to reinforce concepts taught in the training groups. Tear-off slips were signed by parents and returned by children for reinforcement. The overall return rate of parent-child activities was low (14%) in the first semester. The low rate of return led to a redesign of the handout in a way that motivated the child to get involved at home by including a fun game or puzzle and a change in the tracking and reinforcement program wherein completed activities were monitored and reinforced more on an individual rather than strictly a group basis. In the second semester, there was a significantly higher return rate. Out of three assigned activities, there was a 48% overall return rate (20% of at-risk, 56% of not-at-risk). Small laminated "refrigerator magnet" charts outlining the

problem solving steps were offered to all second and third grade parents as an aide for use of the model at home.

A total of 339 family members from 84 families attended one of the three Family Nights offered following the first semester. Of particular significance, 70% of families with children identified as at-risk participated. This is important in light of the customarily low par ticipation level of these families for similar school-based activities. Following the second semester, 93 out of 187 families from both schools attended the event. This included 17 out of 38 at-risk families, or nearly half.

Future Plans

Centennial School District is convinced of the value of this project and has included project activities in it budget for 1990-1991 fiscal year. However, the priority of the project is uncertain given reduction of school district revenues occurring as a result of Ballot Measure 5.

Progress continues to be made on the development of a program manual to be used by agencies or school districts wishing to replicate the program. The project budget provides very little for publication and dissemination. The staff have submitted a foundation request for additional funds in order to produce 100 manuals and a promotional brochure to enable dissemination throughout the state. Project staff feel that dissemination is best done with consultation services accompanying the project manual.

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UNION COUNTY TEMPERAMENT PROJECT
CENTER FOR PARENTING EXCELLENCE
LA GRANDE, OREGON

Background

The Temperament Project is located in La Grande, Oregon, the rural northeastern part of the state. La Grande is a town of about 12,000 and is the Union County seat. The surrounding area consists of agricultural lands and several national forests. Smaller towns are located in the county and depend on La Grande for services.

The Temperament Project is a part of the Center for Parenting Excellence (CPE). This center was developed with input and support from the staff at the Union County Center for Human Development, the local mental health authority. The CPE opened in May, 1988 with a grant from the Meyer Memorial Trust. This grant will end with the fiscal year. CPE provides parenting services to Union County residents. An additional resource to the Temperament Project is Parenting Excellence, Inc. (PEI). PEI is a non-profit corporation which has a national mission. It creates, develops, evaluates, and disseminates products, programs, and services which support and empower parents. The PEI board of directors has agreed to oversee the dissemination, evaluation and development of Temperament Project materials.

The Temperament Project was first funded in fall 1988. Its current contract covers funding through June of 1991. The project received about $60,000 in each fiscal year. Originally, administrative support was provided by the Center for Human Development. Because of budget reductions in Union County, the project had to assume most of these costs in the past year.

Temperament Model

The Temperament Project is based in the theory that children are different from one another from the time they are born. While the most obvious differences are in physical appearance, it is also true that each child is born with a unique style of behavior. These differences in styles of behavior are called temperament.

The original research in this field was done by Doctors Alexander Thomas and Stella Chess more than 30 years ago. Through a longitudinal study they identified several temperament patterns exhibited by children (Chess & Thomas, 1984). These include the "easy" child (35%), the "slow-to-warm-up" child (15%), and the "difficult" child (10%). The "difficult" child often causes stress for parents and is most likely to develop significant behavior problems by age 10.

Chess and Thomas argue that most parenting approaches operate on an assumption of behavioral similarity among children. Parenting is most commonly taught as a system of rewards and punishments. Many temperament related behaviors are not easily changed through this system. For example, the parents of a highly active child can punish the child's overactive behavior (and reward the less active behavior) regularly and still find that their child remains active. According to the temperament model, a more effective approach would be to help the child channel the high activity level into positive behaviors. Parents, however, usually do not have either the skills or adequate information to help them do this.

Description of the Project

The Temperament Project was originally designed to include two programs: one for parents of infants and one for parents of children aged 18 months to 6 years. The original program for parents of infants, the Temperament Education Project, was based on educational materials developed by Dr. James Cameron. A new version of these materials, Pediatric Blueprints, was published in the fall of 1989. Recruitment of parents into the Project was delayed because software for scoring the expanded temperament questionnaire contained in the new materials was not available. When the software was still not available in the fall of 1990, implementation plans were suspended. Separate, private funding for a program similar to the Temperament Education Project is being sought.

The primary emphasis of The Temperament Project has been to provide temperament-related parenting consultation to parents of children 18 months through 6 years. Over the course of the project, this age range has expanded to the point that project staff now serve parents of children up through age 18. This extension of ages was a natural outgrowth of the project's work with families. Parents who had participated in earlier years of the project began to return for a one- or two-session review; they inevitably brought with them children who had grown older. Project staff are rewriting some project materials to make them more appropriate for parents of teenagers. In addition, parents are now being encouraged to return to the project whenever new problem behaviors emerge.

The staff of the Temperament Project consists of a Program Coordinator and several (from three to seven) Temperament Specialists. Temperament Specialists are parents who are specially trained in the temperament model of parenting. They do not generally have an advanced degree or professional training. Temperament Specialists meet individually with parents on a weekly basis for approximately 6 to 8 sessions. The number of sessions vary depending on the needs of the parents. All Specialists work part time for ten months of the year. The program does not function during June and July because parents tend to be unavailable during those months. A typical Temperament Specialist works 11 hours a week including 8 hours of direct contact with parents, 2.5 hours in staff and supervision meetings and .5 hours in miscellaneous tasks.

Over the course of the project, staff turnover has occurred although it has not been unusually high. Because of the intensive training and initial need for supervision, incorporating more than one or two new staff persons into the project at any one time is difficult. For a short period of time one of the Temperament Specialists was from Elgin and was providing services to that small, isolated community. Unfortunately, this person moved from the area after a short period with the project. Such a staffing arrangement, however, is a creative way of doing much needed outreach into rural communities.

Parents are recruited into the Temperament Program through two primary mechanisms: preschool screenings and self referrals. Parents call directly for services based on the recommendation of former participants, suggestions from service providers and local publicity. The project receives 2 to 4 referrals from these sources each week. The project also participates in pre-school screenings that are held in spring and late summer in various parts of the county. In August of 1989, staff screened 92 parents at the pre-school screening sponsored by the Union County Educational Service District. Thirty-two parents were identified as appropriate for services and of this group 21 actually enrolled. A new, on-site computerized scoring procedure was inaugurated during this pre-school screening and proved efficient and popular. Other pre-school screenings included Wallo-

wa County pre-school screening in spring 1990 (125 parents), and the 1990 Union County pre-school screening (100 parents). The number of parents attending pre-school screenings has been declining, making them a less efficient recruiting source than expected. The project has also experimented with screening parents by sending packets through the mail resulting in a 4% return rate.

During the past year, a parent support group was started for participants who had completed their work with a Temperament Specialist. Although several parents said they were interested in such a group, attendance was low (two to eight attendees) and after six meetings the group was terminated. This approach may be more successful when there is a larger mass of graduates.

The Temperament Project has also begun to charge a fee to parents as a means of supporting its work. Beginning in fall of 1989, parents were charged a maximum fee of $30 per session with a sliding fee scale available based on family size and income. The actual cost of providing services is $40 per session. The project has consistently been able to collect 97% of the fees assessed.

Participants have not been charged for the initial Temperament Assessment interview or for materials. In 1990-91 fees will be charged for these services and the maximum fee will be raised to $40. The sliding fee scale will be replaced with a scholarship system. Donations from the community will be used to fund the scholarships. When this fund is depleted, parents who cannot afford the services will be placed on a waiting list until scholarship funds become available. Under this system, every hour of service will be reimbursed at full cost, allowing the program to be financially independent of all revenue sources except client fees.

Few problems were encountered in the transition to a fee-charging program. The only complaints came from clients who were referred by participants who did not have to pay. The fee system may also be partially responsible for the declining numbers of parents that are recruited through pre-school screenings.

Revenues lost through missed appointments has also been an issue. The project has consistently reported about a 30% missed appointment rate. Staff have tried several strategies to reduce this rate. Charging a penalty equal to half the regular appointment fee for missed appointments will be implemented in the coming year.

Description of Participants

Table 2 summarizes the number of clients enrolled in the Temperament Program by quarter and their current status with the program. Clients enrolled in each quarter are broken down into three categories: Completed, Did Not Complete, and Still Open. Clients in the "Still Open" category will eventually end up in either the "Completed" or the "Did Not Complete" category. Seventy-six percent of the clients who have enrolled in the project to date have completed the program.

Table 2. Numbers of Participants by Quarters

Quarter Ending	Enrolled	Completed	Did Not Complete	Still Open
Sept 1988	2	2	0	0
Dec 1988	9	9	0	0
Mar 1989	36	26	10	0
Jun 1989	11	9	2	0
Sept 1989	11	7	4	0
Dec 1989	11	7	2	2
Mar 1990	28	18	7	3
Jun 1990	23	12	5	6
Sep 1990	16	3	0	13
Dec 1990	14	0	0	14
TOTALS	161	93	30	38

The most common reason parents give for not completing their work with the Temperament Specialist is that they are too busy to keep up with the requirements of the program. Project staff are working to minimize this effect by (1) negotiating solutions earlier in the process with parents and (2) fine tuning services more carefully so that the homework can be kept at a minimum.

The next most common reason for lack of completion is a referral by the Temperament Project to other professional services. Some of these parents, especially those with many other demands on their time, need to drop out of the Temperament Project so they can devote energy to these other services.

Table 3 provides a description of the demographic characteristics of the families that participated in the Temperament Project. The income of these families is primarily in the lower to middle income ranges with single parent households representing 20% of the families.

Evaluation of Outcome

The Temperament Project has collected two kinds of evaluation data. First, data on participants' opinions about the services has been collected via a follow-up questionnaire. Second, reassessment of the child, using the Modified Eyberg Child Behavior Inventory (ECBI-M), provides a measurement of the change in the child's behavior.

Participant Satisfaction. Follow-up questionnaires were mailed to all parents who had completed the Temperament Project by December 6, 1990 (the program first started providing services in 1988). One questionnaire was sent for each child. Thus, parents who received temperament services for more than one child were sent a questionnaire for each child. In total, 84 parents were sent 93 questionnaires. A month later a reminder letter was sent to parents who had not returned their questionnaire. Included with the reminder letter was another copy of the questionnaire to be used if the parent had lost the previous copy. Each questionnaire had a unique form number which allowed for tracking. About a week later a third letter was sent to all 84 parents. This letter (1) thanked parents who had returned their questionnaires, (2) encouraged parents who had

Table 3. Demographic Description of Program Participants
(n=161)

INCOME (141 Respondents*):		
0 - 9,999	31	(22%)
10,000 - 19,999	29	(21%)
20,000 - 29,999	40	(28%)
30,000 - 39,999	26	(18%)
OVER 40,000	15	(11%)
MOTHER'S EDUCATION (144 Respondents):		
Did not graduate high school	8	(6%)
Graduated high school	24	(17%)
Completed some college	53	(37%)
Graduated technical school	13	(9%)
Graduated college	31	(22%)
Earned a graduate or professional degree	14	(10%)
FATHER'S EDUCATION (117 Respondents):		
Did not graduate high school	7	(6%)
Graduated high school	27	(23%)
Completed some college	39	(33%)
Graduated technical school	11	(9%)
Graduated college	17	(15%)
Earned a graduate or professional degree	16	(14%)
FAMILY TYPE:		
Single parent (126 Respondents)	25	(20%)
Blended family (123 Respondents)	29	(24%)

*Demographic data is missing for some participants

not returned their questionnaires to do so in the next few days, (3) informed parents about how the Temperament Project had been improved in response to previous parent input, and (4) encouraged parents to re-enter the Temperament Project as needed.

Fifty-seven questionnaires (61%) were returned by the date this report was written. Six parents had moved without leaving forwarding addresses, so actually 66% of the questionnaires received by parents were completed and returned. Table 4 provides a summary of the data from the parent satisfaction portion of the follow-up questionnaires.

Table 4. Participant Satisfaction With Services

Questionnaire Item	1988-89	1989-90	1988-90
1. How much were you helped by the Temperament Program?			
1 None	0 (0%)	0 (0%)	0 (0%)
2 A Little	0 (0%)	1 (4%)	1 (2%)
3 Some	7 (23%)	4 (15%)	11 (19%)
4 Much	15 (50%)	15 (56%)	30 (53%)
5 Very much	8 (27%)	7 (26%)	15 (26%)
Mean	4.03	4.04	4.04
2. How much did your child's behavior improve as a result of what you learned in the Temperament Program?			
1 None	0 (0%)	0 (0%)	0 (0%)
2 A Little	3 (10%)	2 (7%)	5 (9%)
3 Some	15 (50%)	9 (33%)	24 (42%)
4 Much	8 (27%)	13 (48%)	21 (37%)
5 Very much	4 (13%)	3 (11%)	7 (12%)
Mean	3.43	3.63	3.53
3. How helpful were your weekly meetings with your Temperament Specialist?			
1 Not helpful	0 (0%)	0 (0%)	0 (0%)
2 Somewhat helpful	4 (13%)	1 (4%)	5 (9%)
3 Helpful	10 (33%)	14 (52%)	24 (42%)
4 Very helpful	16 (53%)	12 (44%)	28 (49%)
Mean	3.40	3.41	3.40
4. How helpful was the written information you received?			
1 Not helpful	0 (0%)	0 (0%)	0 (0%)
2 Somewhat helpful	5 (17%)	2 (7%)	7 (12%)
3 Helpful	10 (33%)	12 (44%)	22 (39%)
4 Very helpful	15 (50%)	13 (48%)	28 (49%)
Mean	3.33	3.41	3.37
5. How often are you now using what you learned in the Temperament Program?			
1 Never	0 (0%)	0 (0%)	0 (0%)
2 Sometimes	12 (40%)	9 (33%)	21 (37%)
3 Often	12 (40%)	15 (56%)	27 (47%)
4 Very Often	6 (20%)	3 (11%)	9 (16%)
Mean	2.80	2.78	2.79

The questions presented in Table 4 were designed to investigate various aspects of participant satisfaction. Overall, participant seemed satisfied with the program services. Seventy-nine percent said they were helped either "much" or "very much" by the program. Ninety-one percent reported that meetings with the Temperament Specialists were either "helpful" or "very helpful". A similar percentage (89%) found the written material helpful. Respondents were most likely to say that they were currently using the temperament methods "sometimes" or "often" (84%). Respondents tended to see "some" or "much" change (79%) in their child's behavior as a result of their involvement in the Temperament Project. Seven participants (12%) reported that their child's behavior had changed "very much".

Table 5. Mean Comparisons for Fiscal Years 1988 and 1989

Question Number	1988-89	1989-90	t
1	4.03	4.03	- .02
2	3.43	3.63	- .89
3	3.40	3.41	- .04
4	3.33	3.41	- .40
5	2.80	2.78	.12

p> .05 for all t-tests.

Comparison of the responses of participants over the two years of the program yielded no significant differences (Table 5). It was hypothesized that parents who entered the program during fiscal year 1989 received a more comprehensive service than parents who entered during fiscal year 1988 and thus might have rated the program higher. It was also possible that parents who had the training most recently might be most positive about the changes that occurred.

No significant differences were found between mean ratings on any of the five questions. Parents who entered the program during fiscal year 1988 were about equally as satisfied as parents who entered during fiscal year 1989. This suggests that even the earlier, less sophisticated versions of the Temperament Program were meeting the needs of parents at a fairly high level and that this effect has been sustained over time.

Two additional questions asked participants to identify the most important things they learned in the program and to suggest ways of improving the program. The findings from these written answers and comments are summarized below.

Most Important Things Learned in the Temperament Program

-Specific parenting techniques	17
-Accepting my child	14
-Each child is different	14
-I am generally a more effective parent	14
-Understanding my child better	10

A review of the complete list of responses to the open-ended question suggests that parents are (1) becoming more confident in their parenting abilities, (2) developing a number

of parenting techniques that work for their children, (3) becoming more understanding and accepting of their children, (4) becoming more optimistic about their children's futures, and (5) generalizing the information they received to influence the way they think about and respond to other children.

Only one respondent listed punishment techniques as one of the most important things he or she learned in the program. Additionally, reward techniques were mentioned by 6 parents. Punishment and reward techniques are discussed with just about every parent who completes the program. Also, almost every parent receives a substantial amount of written information about reward and punishment techniques. Still, few parents indicate that this information was most helpful.

This finding corresponds directly to some of the changes recently made in the program. Program staff find that most parents are already familiar with and skilled at punishment and reward parenting strategies. When parents enter the program, the problem behaviors they are concerned about tend to be issues that don't respond well to these types of strategies. Thus, the materials are being rewritten with more flexible options regarding the inclusion of information about reward and punishment strategies.

When asked to suggest ideas for ways of improving the Temperament Project, respondents gave a range of ideas. The most frequent suggestions were ideas for "program renovations" (15) and "more follow-up" (13). Suggestions for program renovations included increasing the interaction between parent and Temperament Specialists, offering evening sessions, reducing waiting time and reducing length and intensity of the program. No one suggestion for revision dominates.

To some extent participants are requesting more from the program. In addition to follow-up contacts, 6 respondents asked for support groups and 6 respondents asked for more information. Some parents also want the program to be easier for them to complete. This is especially true for parents who have gone through the program recently. Six parents reported that the workload, process or pace of the program needed to be reduced. As mentioned earlier in this report, the workload and pace of the program is the main reason why some parents do not complete the program. This factor may also contribute to the rate of missed appointments.

Program staff are introducing modifications that will reduce the workload and slow down the pace of the program. Less time will be spent on reward and punishment strategies in the future and staff will be more selective about the readings and exercises that are assigned.

Child Behavior Outcomes. The Modified Eyberg Child Behavior Inventory (ECBI-M) is a paper and pencil assessment of the child's behavior which is completed by the parent (See Appendix B for a copy of the instrument). The ECBI-M, containing 88 items, was used throughout most of fiscal year 1989. During that year, parents of 73 children were enrolled in the program. Seventy ECBI-M's were completed pre-intervention (3 parents completed the previous version of the ECBI). Parents enrolled during fiscal year 1990 are not included in this analysis because post-intervention ECBI's have not yet been collected. Also, parents enrolled during fiscal year 1988 are not included in this analysis because they were included in a prior study (Koroloff, 1990).

The comparison of pre-intervention child behavior data with post-intervention child behavior is complete for 30 children. This data is influenced by several methodological

factors. These factors include:

1. Instrument Changes: The development of the ECBI into the current ECBI-M Version 2.1 has evolved from four different versions of child behavior questionnaires over slightly more than two years of operation. On occasion, one version was given pre-intervention and another version post-intervention. In these instances, test results could not be compared.

2. Timing of Post-Intervention Assessments: In the follow-up study for fiscal year 1988, parents were mailed post-intervention ECBI's one to nine months after completing the program. Because return rates were low, another system was tried during fiscal year 1989. Parents were asked to complete the post-intervention ECBI-M prior to their final appointment. Under this system it appears that parents do not report as much behavior change on the ECBI-M as before, even though, verbally, parents reported the same levels of satisfaction with services and the same levels of behavior improvement.

Most likely, this effect results from a combination of at least two factors. First, through follow-up phone contacts most parents report continued behavioral improvement in their children during at least the one- to three-month period after they complete the program. Thus, administering the ECBI-M prior to program completion may not allow enough time for these improvements to take place.

Second, there is some evidence to suggest that the ECBI seems to be especially vulnerable to effects from the parent's state of guardedness at the time at which it is completed. It is likely that parents are more guarded when they enter the Temperament Program than when they complete it. Thus, at the time of enrollment, parents are more likely to under-report the intensity of problem behaviors in their children.

These factors suggest that there is, in fact, more positive behavior change at program completion and in the months after than is evident in the pre- / post-ECBI comparisons. It is possible that more behavior change would be found if post-ECBI's were completed a month or more after program completion.

3. Within Group Differences: During fiscal year 1988, services were provided to a group of families that were quite homogeneous when compared with the group of families served during fiscal year 1989. During fiscal year 1989, services were provided to parents having children with a broader range of temperament and non-temperament factors influencing their behaviors. Ideally, pre- / post- analyses would be run on subgroupings of families. However, when dealing with small numbers of families, this is not possible.

4. Post-Intervention Data Lost to Summer Hiatus: In spring of 1990 a decision was made to combine the completion of the follow-up ECBI's with the follow-up phone contact that is routinely made four to six weeks after each parent completes the program. During the summer hiatus many of these follow-up phone contacts were not done. As a result, follow-up ECBI-M data was not collected on 16 participants.

Each item on the Modified Eyberg Child Behavior Inventory is rated by parents in terms of the intensity of the behavior and the extent to which it poses a problem for the parent. This yields two different scores: the Intensity Score and the Problem Score.

Through empirical tests, cutting scores have been established: 127 for the Intensity Score and 11 for the Problem Score. Scores at or above these cutting scores are considered outside the norm. Table 6 summarizes the mean Intensity Scores for those children served during fiscal year 1989 who completed both pre- and post-intervention tests.

Table 6. Mean ECBI-M Intensity Scores: Pre- and Post-Intervention

Scale	n	Pre	Post	t
ECBI	30	134.3	119.9	3.06**
Externalizing Problem Behavior	29	53.2	46.4	3.50**
Internalizing Problem Behavior	29	27.7	27.9	-.14
Withdrawal	29	26.0	26.6	-.48
Emotional Sensitivity	29	22.0	22.0	-.08
Sensory Threshold	29	17.4	18.0	-.66
Activity Level	29	31.1	30.2	.82
Attention Span	30	16.1	14.9	1.30
Persistence	29	22.7	19.8	2.64*
Adaptability	29	21.3	21.0	.37
Defiant/Oppositional Behavior	30	16.0	14.1	2.05*
Disrespect for People/Things	29	24.0	22.7	1.31
Critical Items	29	23.7	22.4	1.24

*$p < .05$. **$p < .01$.

Significant behavior changes were found in the overall ECBI Intensity Score, particularly due to changes in the externalizing dimension and in oppositional and defiant behavior. Similar changes were found in the earlier study. Temperament theory holds that this type of behavior is most often a symptom of poor fit between the parent's approach and the child's temperament. As such, it makes sense that temperament intervention would have a positive effect on this type of behavior. Parents are usually most distressed by oppositional-defiant behaviors in their children. Once these behaviors are under control, parents are usually able to gradually helping their child with other behaviors.

In comparison with the previous study, the present study found less behavior improvement on the externalizing dimension. This probably resulted from at least two factors: (1) the fact that most post-intervention ECBI-M's were completed at least one month earlier in the present study and (2) the fact that more parents in the present study entered the program to work on non-externalizing problem behaviors in their children (thus, the pre-intervention means for externalizing behaviors in the present study were substantially lower than in the previous study). The specific problem behaviors most affected by the intervention are listed in Table 7 below.

Table 7. Mean Intensity Scores for ECBI-M Items Showing Significant Behavior Change Pre- and Post-Intervention

Item	n	Pre	Post	t
1. Dawdles when getting dressed.	30	4.76	3.57	4.58**
5. Refuses to do chores when asked.	30	4.38	3.53	3.66**
8. Doesn't obey house rules on own.	30	4.30	3.40	3.59**
9. Refuses to obey until threatened with punishment.	30	4.40	3.73	2.34*
10. Acts defiant when told to do something.	30	4.43	3.70	2.12*
13. Has temper tantrums.	30	4.13	3.00	4.34*
19. Destroys toys and other objects.	30	3.07	2.23	3.28*
20. Is careless with toys and other objects.	30	3.57	2.97	2.26 *
26. Physically fights with friends his own age.	30	2.80	2.33	2.14 *
38. Over-reacts to loud sounds or bright lights.	29	2.41	3.45	-3.31**
55. Is bothered by how clothing feels.	29	3.00	3.55	-2.08*
62. Acts w/o considering consequences.	29	4.57	3.97	2.31*
78. Is not easily calmed when upset.	29	3.89	3.28	2.53*
80. Wakes up in a bad mood.	29	3.41	2.86	3.02**
83. Likes to start trouble.	29	2.96	2.48	2.45*

*$p < .05$. **$p < .01$.

Most of these problem behaviors are of the externalizing type with two exceptions: items 38 and 55. Interestingly, both of these items are sensory threshold items and the change in mean score was in the positive direction. This probably resulted from some parents becoming more aware of sensory threshold issues during the intervention. Parents often misinterpret sensory threshold issues as defiance until they realize what is actually happening.

The ECBI-M also yields a Problem Score for each of its 13 scales. The Problem Score is a tally of "YES" responses to the question "Is this a problem for you?" Thus, it is a measure of the parent's perceived ability to deal with the types of behaviors which make up each scale. Mean Problem Scores are presented in Table 8.

Overall, it appears that there were more positive changes in the Problem Scores than in the Intensity Scores. This is consistent with what was predicted. Parents usually leave the Temperament Program feeling more capable of responding effectively to the problem behaviors of their children. They rarely, if ever, leave with a perfectly well-behaved child. As parents continue to help their children with temperament issues, however, we predict a continued decrease in problem behaviors.

Table 8. Mean ECBI-M Problem Scores: Pre- and Post-Intervention

Scale	n	Pre	Post	t
ECBI	30	13.7	8.0	2.97**
Externalizing Problem Behavior	29	5.2	3.0	2.64*
Internalizing Problem Behavior	29	1.7	1.0	1.98
Withdrawal	29	1.2	.3	2.57*
Emotional Sensitivity	29	1.5	1.2	.93
Sensory Threshold	29	1.1	.8	1.16
Activity Level	29	3.0	2.0	1.73
Attention Span	30	1.2	.4	2.57*
Persistence	29	2.7	1.7	2.60*
Adaptability	29	1.7	1.1	1.71
Defiant/Oppositional Behavior	30	2.0	1.1	2.49*
Disrespect for People/Things	29	1.6	.9	1.77
Critical Items	29	2.1	1.3	1.73

*$p < .05$. **$p < .01$.

Collaboration With Other Systems

In spring of 1990, the project entered into two agreements with the local Children's Services Division (CSD). The first agreement was to provide Temperament Project services to foster parents needing help managing the behaviors of their foster children. CSD paid for the services at a rate of $15.00 per visit. The second agreement was to work with CSD to repackage the project for use by adoption workers. After working with several adoptive families within the Temperament Project, plans were made to develop materials and training for CSD workers. By fall of 1990, funding cuts made it necessary for CSD to terminate the foster parent contract and reduce the adoption contract.

The project also extended its services to parents with children who have special needs. The project services have been provided to parents of children in the following categories: children who have been sexually abused, children who have been physically or emotionally abused, foster children, adopted children, children with chronic medical conditions, children with Attention-Deficit Disorder, children with learning disabilities and children who are mentally retarded. Temperament can influence the problem behaviors of all these children, with special need an additional factor.

Project staff have taken a special interest in working with children who have been sexually abused. Usually these children are receiving other forms of treatment and family therapy in addition to temperament guidance. It appears that the effects of abuse often interact with temperament. It is clear that the abuse can have a more dramatic effect on the child's total behavior than does temperament. This can be true even when the child has a very difficult temperament.

The project has also done some work with a local family therapist to develop a family therapy model that takes individual differences into account. Staff have referred cases to this therapist and is collaborating with him regarding treatment plans.

A new avenue of collaboration with the Center for Human Development (CHD) may open up through Medicaid. Medicaid's EPSDT program may provide a way to fund parent education services for low income families. Public Health Services at the Center for Human Development is presently doing EPSDT assessments. Behavioral Assessment and Case Management services for EPSDT children will also be provided by CHD departments. There may be a role for the Temperament Project to play in providing prevention services through EPSDT.

Plans for the Future

Presently, much of the theoretical understanding of the process for providing the Temperament Program intervention is in the hands of Bill Smith, Project Director. Over the next few months, the Temperament Specialists will each be gaining this theoretical understanding through a process similar to that which has taken place over the past two years. Without the direct involvement of the director, the Temperament Specialists will be writing their own training manual.

At the same time the Temperament Specialists will be learning to write child behavior management strategies. A database for management strategies has been set up. In the future, as management strategies are created for clients, they will be written into this database. Within the next few years, this database could include more than 300 management strategies. By using a database, it will be possible to enter a child's temperament and let the database software search for relevant management strategies. The selected strategies could then be printed, eliminating the need for stockpiling multiple copies of each strategy.

As a result of some of the reorganization and cost efficiency measures, many of the current activities of the Temperament Project will need to be eliminated or reduced if state funding is no longer available. These activities include:

a. **Providing Services to Low Income / Financially Disadvantage Families:** It is likely that the scholarship fund will not be able to keep up with the need for financial assistance. Many parents who want and need the service will not be able to participate. As a result, the services will be delivered to a disproportionate number of financially advantaged families. This will be a major shift from past and current practices.

b. **Pre-school Screenings:** Participation in ESD Preschool Screenings and other screenings (e.g., Headstart) will not be possible due to the costs involved. As a result, the Temperament Project will become less able to reach out to the general population and more dependent on referrals and word of mouth.

c. **Outcome Research and Program Development:** While some data will still be collected, it will not be possible to (1) collect as much data, (2) analyze the collected data, (3) produce research reports, and (4) use research findings to make improvements in the program.

d. **Child Care:** Even for traditional parenting classes, child care rarely pays for

itself. The Temperament Project provides its services individually to parents making it is very expensive to provide child care. Because drop-in child care is expensive and often hard to find in Union County, the elimination of child care will make it harder for some parents to participate in the Temperament Project.

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JACKSON COUNTY EARLY INTERVENTION MENTAL HEALTH PROJECT
JACKSON COUNTY HEALTH AND HUMAN SERVICES
MEDFORD, OREGON

Background

The Jackson County Early Intervention Mental Health Project, based on a social development model, provides three services to children in preschool and elementary school sites. The project is located administratively within Jackson County Health and Human Services. It utilizes an existing network of service providers, with Jackson County Health and Human Services (JCHHS) providing the planning, coordinating and technical assistance to ensure quality project programs. The Jackson County Early Intervention Project began in January, 1990 and had operated for one year at the time data were collected for this report. The contract for the first 18 months of operation is for approximately $107,000.

JCHHS is a multifocused department which administers county health, mental health, veterans and human service programs. The agency has also been an active leader in planning and providing contract services for children through the Student Retention Initiative, the Children's Agenda, and the Juvenile Services Commission. Its mental health component has recently been reorganized with the goal of providing more effective crisis intervention and children's services. The children's component of the agency is organized into its own sub-department. The children's sector employs two full-time therapists and has hired a project coordinator for this project, who also serves as a half-time child therapist.

Description of the Community

Jackson County is located in southern Oregon. Both Medford and Ashland are located in Jackson County as well as several smaller rural communities. The 1990 population of the county was 92% white, 4% Hispanic, and 4% "other." There are an estimated 3,500 single parents receiving AFDC; 3,200 of these parents have children under the age of eight. Eighteen percent of preschool children in Jackson County live in poverty. There are approximately 9,200 children ages four to eight in the county. Using state and national epidemiological estimates, 1,840 of these children are at-risk for serious dysfunctioning and 920 would be expected to have some degree of emotional/mental impairment.

Problems of drug addiction have become increasingly serious in the county. Federal and state statistics show that Southern Oregon has a drug problem incidence second only to the inner city of Portland. Southern Oregon is also suffering from an economic crisis due to severe problems in the wood industry. This economic crisis has implications for county services that are dependent upon revenues from timber.

The Social Development Model

The Social Development Model was formulated by Christopher Hall after a two-year review of successful prevention and early intervention programs throughout the country (Hall, 1986). Much of his model was based on the research findings and theories of David Hawkins of the University of Washington in his work on delinquency prevention (Hawkins & Weiss, 1985). The work of David Hawkins is one of the theories used in

develping the Drug-Free Years middle school parent training program being offered throughout Oregon.

The Social Development Model gives at-risk children an opportunity to bond successfully with the four major social forces in his/her life: family, school, peers, and community. This bonding process is ensured by offering children an opportunity for positive involvement in order to build interactive skills and be reinforced for those skills within his/her natural environment.

The criteria used in the selection of the Social Development Model included comprehensiveness, cost-effectiveness, program impact on community needs, generalization beyond funding period, program flexibility, and potential of taking clinic resources and services out into the community. Project planners examined early intervention models in terms of their ability to develop the bonding and skills described in the Social Development Model. Based on these skills, the project selected three specific programs: a primary intervention project with children, a parent education project, and a socialization project.

Primary Mental Health Project. The primary intervention with children was based on the Primary Mental Health Project (PMHP) which originated in Rochester, New York, in 1964. As of 1983, 335 schools had successfully used the project (Weissburg, Cowen, Lotycaewski & Gester, 1983), and since then it has been adopted by the California State Department of Mental Health for statewide replication.

Program effectiveness has been well documented in the literature. Weissburg et.al. (1983) studied seven separate school districts that had implemented the project and found that all seven projects were successful in meeting the goal of greater child adjustment. Projects have demonstrated gains that endured over time (Cowen, Dorr, Trost, & Izzo, 1972; Lorion, Caldwell, & Cowen, 1976); control group studies have demonstrated project success (Cowen, Zax, Izzo, & Trost, 1966); and studies using independent judges have produced positive results (Cowen, et al., 1975). The one critical article located in the review of the literature did not show lack of program success but rather recommended an increase in the number of control studies (Stein & Polyson, 1984).

Socialization Groups. Albert Bandura has done a number of studies of psychotherapy based upon modeling principles in a group setting (Bandura & Berkowitz, 1975). While most of these studies were done with autistic children, Bandura also did several studies with at-risk children who were lacking in social skills. His model demonstrated that group therapy was effective with children when it involved modeling of the desired behavior by the therapist or peers combined with rewarding the child when he/she demonstrated progress toward the desired behavior. Hansen, Miland and Zani (1969) showed that they could change children's social status with peers through group counseling with unpopular children which combined modeling of the desired behavior, practice by children, and reinforcement.

Description of the Jackson County Early Intervention Project

The Jackson County Early Intervention Project was developed around the core bonding process described in the Social Development model. The project utilizes three separate services: 1) the Special Friends Project (patterned after the Primary Mental Health Project), 2) parent training, and 3) socialization groups. All three services are provided at elementary and at-risk preschool sites. The project utilizes the existing network of service providers, with JCHHS coordinating the various aspects of the project.

High-risk children are initially enrolled in the Special Friends Project. In this project, children work with a nurturing adult on a one-to-one basis for three months in a specially designed play setting within their school. During the course of the semester, parents of children in the project are invited to parent training sessions held at the school in order to improve parent-child relationships and increase parenting skills. The following school semester, children in the project who have been identified as isolated or rejected by peers will be enrolled in socialization groups which assist children in developing social skills with other children. Thus, the project enables high-risk children to develop effective bonds with school, parents and peers through positive skill-building and nurturing relationships.

Special Friends. This component of the project involves 12 individual play-counseling sessions with a trained/supervised child aide at the school site. Sessions last 30 to 40 minutes and occur weekly over a three-month period. The child aide works with the child through the medium of play, allowing the child to identify with, copy behavior from, and incorporate the image of a caring adult. The aide uses play materials and encourages skill development based on the strength and need areas outlined in the assessment scales.

Throughout this time the child aide also maintains contact with teachers, parents, and the child development specialist as a team member in supporting the growth of the child. The child aide receives specialized training in the following areas: communication skills, child abuse reporting, nondirective play, child development screening, recordkeeping and techniques for developing relationships with hostile/acting out and shy/withdrawn children. They meet every other week during the school year to staff children, discuss programatic issues and receive additional training. Each child aide receives individual supervision twice a month from a trained mental health professional as well as receiving on-site supervision from a child development specialist.

Parent Training. This component of the project was planned to include a minimum of four parent training sessions focused onchild development, effective communication, discipline, and nurturing parent-child relationships. Parents are invited to one individual session at the end of their child's play counseling sessions to review progress and reinforce home/project continuity.

The format for the parent training is a series of seven participatory sessions in which parents explore and discuss child development, behavior management and positive parent child interactions. Children are enrolled in comparable children's sessions with parallel curricula.

Socialization Groups. This component consists of ten 30- to 40-minute group sessions with six to eight children from the project who have been identified as isolated or rejected children and are lacking social skills. The group leader presents a progressive series of group games and activities while allowing modeling, practice and reinforcement of social skills.

The group leader provides experiences for the groups including: exploration of self in a group, empathy training, friendship skills and cooperative games. The child development specialist at the school attends the group sessions in a training capacity. They receive a notebook of curriculum material in addition to the training so they can continue offering socialization groups when the project is no longer offered in the school.

Recruitment and Screening. The project was designed to work with high-risk kindergarten through second graders at elementary schools, Head Start centers, and a day care setting at a drug treatment program. Sites were chosen based on high poverty populations and high referral rates to services for high-risk children (CSD, Juvenile Department, Mental Health Department).

The primary screening tool for selecting children for the project is the AML Behavior Scale which targets children with school adjustment problems. These problems focus in three general areas: hostile/acting out, moody/shy, and learning problems associated with behavioral/emotional components. The screening items used in the AML are consistent with Hall's key risk factors associated with delinquency, emotional disorders, substance abuse, school failure, and teenage pregnancy: age of onset, low degree of positive bonding to prosocial systems, poor academic performance, and early school adjustment difficulties.

Selection criteria for inclusion of individual children within the project include: a score of 20% or lower on the AML Behavior Scale with congruent teacher assessment; or children with parents in the Jackson County Mental Health MED, DD, or Methadone programs and who are also attending targeted elementary school or Head Start centers; or children with parents in a drug/alcohol treatment program who are attending the treatment center's day care program.

A second level of testing is completed on all children selected for the Special Friends Project using the Teacher-Child Rating Scale (TCRS) which was developed by Southwest Regional Laboratory for the California State Department of Mental Health to use with the PMHP. The TCRS is a classroom behavior assessment tool that evaluates acting out, shy, learning skills, frustration tolerance, social skills, and peer sociability. It was developed to provide projects with baseline data to compare children's progress pre- and post-project. There seems to be consensus in the literature (Stein et.al., 1984) that one of the strengths of the PMHP project lies in the assessment tools developed through the project, including the TCRS. These measurements are particularly effective in that they look at both problem behaviors and personal strengths and weaknesses in designing the therapeutic program.

The 80 children (11%) served in year 1 were selected from 707 children who had been pretested by use of the AML. Permission slips were then obtained from the parents of children considered "high-risk" and TCRS pre-tests were administered for baseline data.

In the fall of year 2, 830 children were pretested and 146 children (18%) were selected for services. For year 2 slightly different selection criteria were utilized. Those children whose AML scores placed them within the 0 to 10 percentile were identified as high-risk; those whose scores fell within the 10 to 20 percentile range were considered at-risk. While the California project targeted the at-risk (10-20 percentile) group because they felt there would be a better chance of program success and positive child change with this group, the Jackson County project decided that, where feasible, they would serve high-risk children in the first group at each site and at-risk children at those sites where there was a second group. This was done so that evaluation data relevant to the two groups could be compared.

Current Stage of Impementation

In the spring of 1990, five child aides for the Special Friends Project and a project

coordinator were hired to implement the project. Other persons who assisted in staffing the project included the JCHHS mental health supervisor, elementary school counselors, and teachers. During year 1, the project was active at the following four sites: White City, Glen D. Haley, and Trail Elementary Schools (all housed within the Eagle Point School District), and the Eagle Point Head Start Center.

During year 2 the project has been active at the original four sites plus an additional five: Washington Elementary School, Medford School District; Patrick Elementary, Central Point School District; Walker Elementary, Ashland School District; South Medford Head Start Center; and OnTrack Child Care Program. Year 2 implementation involved the hiring of an additional six child aides (total of 11), who are all performing services on a part-time basis, with a combined total of approximately 160 hours per week.

Special Friends. During the spring semester of 1990 (year 1), the first Special Friends sessions were completed. Eighty children attended up to 13 sessions each. During the fall semester of 1990 (year 2) 146 children were enrolled in the Special Friends project at eight sites. These children will complete the Special Friends phase of the project by the end of January 1991. Children will be selected for the winter semester Special Friends programs in January 1991. These children will begin Special Friend sessions on February 1st.

Information is not provided for the ninth site, OnTrack Child Care Program. The children in this program began with Special Friends in the summer and would have been scheduled to complete this component sometime in the Fall. It has been difficult to do this project at the OnTrack center because of the lack of parent and child continuity. Parents move, are jailed, and children move from one foster placement to another. The OnTrack program is still very new and in the process of developing.

Parent Training. Parent trainings for year 1 were limited to two sessions at the four elementary school sites. The initial session included dinner and discussion sessions for participants from all four sites. One hundred ninety people participated in the event. A follow-up training session for parents was held at each of the individual sites. A total of 37 parents participated in these sessions. Subjects covered in the parent sessions included program information, parent-child communication, summer activities, and discipline.

In year 2, parent orientation sessions were offered at each of the Special Friend sites in mid-fall and included information about the program and a chance for parents to ask questions. Parents were also asked at the orientation what goals they might have for their child in the project. Crisis Intervention Service provided seven session of parent training in each of the four elementary school sites following the parent orientation sessions. Head Start and OnTrack include parent training as a part of their core programs.

Socialization Groups. Socialization groups did not begin until year 2 (Fall, 1990). The socialization groups at the three Eagle Point sites were facilitated by a child therapist from SOCSTC, with co-facilitation provided by the child development specialist from each school. Socialization groups for winter semester began in mid-February with groups at five elementary school sites, involving a total of 35 children.

Description of the Participants

Special Friends. Two hundred and twenty six children have been served through the Special Friends Project. The project has worked primarily with first and second graders.

Staff decided not to enroll children in kindergarten in the fall quarter because of scheduling issues. Four-year-olds were enrolled in the two Head Start sites.

For purposes of comparison, approximately 40% of the children currently participating in Special Friends component are considered "at-risk" (10-20 percentile on the AML), and approximately 60% are considered to be high-risk (0-10 percentile on the AML). This includes the children enrolled from the Head Start sites.

Socialization Groups. Twenty children were enrolled in the socialization groups in the fall of 1990. All had previously participated in Special Friends during year 1 and were selected based on deficits in socialization and problems relating to peers. The groups attempted to have a balance of acting-out and withdrawn children.

Interim Data on Outcome

Input from participant levels during year 1 was uniformly positive. Four of the five child aides returned for the second year; the fifth aide left because she moved out of the country. Teachers and child development specialists rated the project as positive and effective. Children seemed to enjoy the sessions.

Outcome evaluation on the Special Friends component of the project was accomplished through pre and post-intervention completion of the TCRS. This scale was completed on each child by a classroom teacher. The child aides did the original tabulation. Scores were entered into the computer by the program secretary, and the program manager tabulated and analyzed the results.

Initial findings related to the children participating in the first semester of the project indicate that the program showed positive and significant results on all seven scales of the TCRS. Results from the first group of participating children show mean percentile increases of seven to ten points on the seven subtest and mean normal curve equivalent increases of four to seven points. These results are found in Table 9.

Table 9. TCRS Scores of Participants in Special Friends Project, Spring, 1990 (n=80)

Scale	Pre-test Mean	Post-test Mean	Mean Difference	t Score*
Acting-Out	33.43	41.66	8.23	3.18
Shy-Anxious	34.88	41.94	7.06	3.66
Learning Skills	30.95	36.96	6.01	4.06
Frustration Limit	31.27	39.63	8.36	5.86
Social Skills	42.97	47.16	4.19	2.51
Task-oriented	32.31	39.87	6.56	6.28
Peer Social	29.20	36.68	7.48	4.70

*All scores significant at 95% level

School personnel and project staff also reported that they observed positive change in children who participated in the project. All children enrolled in the first group were high-risk children who scored at the 10th percentile or lower on the AML. Teacher observations were that acting-out children had a chance to release energy positively in

the sessions and returned to class better able to tolerate class routine. Shy and withdrawn children appeared to make lasting behavioral changes in terms of greater participation in class and improved peer relationship skills. Two children who had not previously talked in a classroom setting began to participate regularly after several sessions with their Special Friend.

"The Mail Tribune," a Medford newspaper, printed an article in its December 16, 1990, edition which described the program and included a portrayal of one child who has been a participant in the project. The article describes the child as having progressed from being nonverbal with low socialization skills to being able to express herself and make friends. Her mother indicated, according to the article, that the child is getting the help she needs to combat her quiet, shy behavior. The child's mother is relieved that this help is being offered.

Description of Start-up Activities

Due to delays in getting the contract from the state and difficulty in hiring the project coordinator, the project didn't start until mid spring of 1990. Because the Special Friends Project is a school-based project which requires at least 10 and preferably 12 weeks of services, two important activities had to be omitted in order to get started on time with the children: teacher orientations and parent orientations. Attempts were made throughout the quarter to get general program information out to parents and teachers, but the feeling was that this was not as comprehensive or organized as it would have been if the orientation sessions had been held.

The initial start-up activities that took place after the contract award included:

Identification of year 1 sites;
The purchase of initial program materials;
The hiring of child aides and project coordinator;
Training of child aides;
Screening of children (AML);
Selection of children for intervention;
Obtaining parental permission;
Selection and preparation of Special Friend playrooms;
Staffing sessions.

Eighty children were enrolled in the initial stage of the project. The grant cost for this stage was $23,200. The cost per child was $290.00.

The curriculum for the socialization groups was designed during year 1 for use in fall 1990. The curriculum was modified and adapted on an ongoing basis, and an updated version is now ready to be used in the groups that will begin in February. An outline of the socialization groups curriculum is included in Appendix C.

By the beginning of the fall 1990 school term, teacher orientations were added to ensure teacher understanding of the project. Coordination in the second year was much more complex and time-demanding because four school districts were involved. Supervision of the nine sites had to be shared between the project coordinator and clinical staff. Uniform time lines and processes for all project sites proved not to be practical given differences in site needs and personnel. School principals and child development specialists have been very supportive, but they are spread out over different locations with very

little consultation time available.

Family Member Participation

Parents are required to sign permission slips before children can participate in either Special Friends or the socialization groups. Two sessions of parent training were held in the first year and consisted of a project dinner and discussion session which were well attended. A total of 37 parents attended the follow-up training session. All sites conducted an orientation meeting in mid-fall of year 2 to talk about the program and answer questions which parents might have.

The largest obstacle in gaining family participation is the problem of getting parents to come to the school for meetings. Child care and food are provided as an incentive to draw parents in. It would be ideal to be able to meet individually with parents in their homes, but the project does not have the resources to provide this service.

Working with Other Systems

Interagency collaboration includes the following agencies: Southern Oregon Child Study and Treatment Center (SOCSTC); Southern Oregon Head Start (SOHS); Eagle Point, Medford, Central Point and Ashland School Districts; OnTrack, Inc.; Crisis Intervention Services; and the Health and Human Services Department.

JCHHS and Crisis Intervention Services expanded their service capabilities to accomodate this project. An additional child therapist was hired by the Mental Health service to provide coordination, treatment and follow-up. A Great Start Grant provided resources to Crisis Intervention Services for additional parent training. The Josephine County Special Friends project received a Fred Meyer Grant to provide training and technical assistance to Special Friends projects, and they have collaborated on program training and provided access to materials.

The committment of teachers and staff to this project has been reflected throughout this first year. The project coordinator duties were initially shared by the JCHHS clinic staff until a project coordinator was hired. Child aides doubled as painters and maintenance personnel in the preparation of the child playrooms. School sites were very cooperative. Heroic efforts were made to creatively identify playroom space, with school staff giving up space they were already using.

The Eagle Point School District, which housed three of the initial sites, had a difficult year. Their school funding levy was defeated and four of the five district administrators left to take other jobs. Site morale continues to be relatively positive, but school staff are more stretched and uncertain about the future of their district. The project was most directly affected by the loss of elementary counseling aide positions.

Future Plans

The passage of Measure 5 is the major event affecting the project's future. The project has only been in existence for one year and is still in the start-up phase. If the project is not continued, school sites will have the benefit of children served and staff experience with the programs of the project. However, there won't be time for transition planning due to the uncertain atmosphere in schools and human services as a result of budget uncertainty.

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FAMILY SERVICE PROJECT
UMATILLA COUNTY MENTAL HEALTH PROGRAM
PENDLETON, OREGON

Background

The Family Service Project, located in Pendleton, Oregon, offers early intervention services for children at risk of mental or emotional disturbances. The Family Service Project is part of the Umatilla County Mental Health Program, the main provider of mental health services for this large rural county. Pendleton and Hermiston are the two major cities in the county which also includes several small rural communities. Agriculture and forestry are the primary industries in this part of the state.

The Family Service Project is a collaborative effort between Umatilla County Mental Health Program (UCMHP) and Umatilla-Morrow County Head Start (Head Start). Head Start is an early education program for three- and four-year-olds designed to involve parents in the social, emotional and educational development of their children. Head Start is additionally the grantee for WIC and the Oregon Pre-Kindergarten programs. In Umatilla County, there is a unique connection between Head Start and UCMHP. In both Pendleton and Hermiston the two agencies are located adjacent to one another and have well established working relationships.

The Family Service Project was first funded in January, 1990, and thus had been in existence for one year at the time data were collected for this report. The contract for the first 18 months of operations is for approximately $124,000. The Family Service Project was developed to provide parent and social skill training combined with social network development to parents of high risk children. The focus of the program is on increasing the parent's ability to resolve social, emotional or behavioral difficulties with their children. The program also helps parents develop skills that will allow them to seek community help at the earliest appropriate time.

The Social Interaction Model

The Family Service Project employs a social interaction model developed into an early intervention program by Childhaven of Seattle. The social interaction model targets skill deficits in parenting, stress reduction, problem solving, and social isolation. In 1986, Childhaven of Seattle, Washington, a therapeutic day nursery, developed a parent education program for teaching coping skills to parents at risk of abusing and/or neglecting their children. The curriculum covers child development, values clarification, social skills, anger and stress management.

Parents, by their role in the social and cognitive development of children have been the focus of a number of preventive interventions in recent years. The premise behind the interventions is that training parents in proper childrearing methods and/or educating them about child development and social interaction skills will help prevent certain psychological problems from developing in their children. Many studies indicate that parent education has a positive impact on parent-child relationships, and can prevent childhood behavior problems (Dubanoski & Tanabe, 1980; Kantor, Gildea, & Glidewell, 1969; Glidewell, Gildea & Kaufman, 1973; Walsh, 1977; Yahraco, 1977).

A number of studies report the use of parents as change agents to modify specific behaviors such as tantrums, oppositional and aggressive behavior, and bedwetting (Johnson & Katz, 1973; Patterson & Reid, 1973; Wahler, 1969). Wahler (1969) found that behavior changes do not generalize across situations unless environmental support is provided to maintain them. Although environmental stress and isolation from community resources may significantly contribute to abuse, little evidence exists to show that either are necessary or sufficient for abuse to occur. The way the family responds to stressful circumstances, however, has led to the social interaction approach model.

This model rests on the frequent observations that parents often lack certain fundamental social and parenting skills, prematurely expect and demand more than children can give and show disregard for the child's limited ability and helplessness (Helfer & Pollock, 1968; Parke & Collmer, 1975). A parent who has had little exposure to appropriate models of childrearing simply may not possess a set of effective techniques to reduce the child's undesirable behavior and develop new prosocial skills. Many parents who are experiencing difficulty with their child ultimately resort to strong punitive measures to manage behavior. Attempts at modifying behavior by parents experiencing problems with their child have repeatedly shown that parenting skills need to be systematically taught. This suggests the need for parent education in the areas of child management, instructions in anger and impulse control, and education in child development processes (Dubanoski, et. al. 1978; Wolfe, Sandler & Kaufman, 1981).

"A relationship exists between the lack of support parents have from their social networks and poor child care" (Lovell, 1988). Parent programs can help families learn new behaviors; however, the lack of a prosocial network can lead to failure to maintain the increased parenting skills (Wahler, 1980a,b). Social support has been found to be important to learning and continued practice of difficult-behavior change (Levy, 1983; Lovell, et. al., in press; Richey, et. al., in press). Socially supportive networks convey norms for improved parenting, provide encouragement to maintain lifestyle and parenting changes, and provide opportunities for problem-solving (Lovell, 1988).

Description of The Family Service Project

The Family Service Project is designed to demonstrate that providing parent and social skill training combined with social network development for parents of high-risk children can increase the parent's ability to resolve social, emotional or behavioral difficulties with their children and/or seek community help at an earlier time. In Umatilla County there are approximately 1600 children ages 0 to 5 years of age enrolled in the Head Start and WIC programs. These children and their families served as the pool from which parents were selected for the Project.

The Family Service Program offers parenting groups with concurrent and follow-up home visits to reinforce the skill training received in the groups. Development of the social support network is a structured part of the parenting group. The Project builds upon the existing Head Start program elements, such as home visits, parent involvement in the classroom, and boards and councils, to further refine the parent's support network.

The Family Service Project is staffed by a Program Coordinator, two Family Service Advocates and a clerical specialist. Both the Program Coordinator and the clerical specialist work for Umatilla County Mental Health, and part of their time is assigned to the Family Service Project. The Family Service Advocates usually come to the program with some college education and prior experience in early childhood education or public

school teaching. One of the two Advocates is assigned to work in the eastern portion of Umatilla County (Pendleton, Mission, Milton-Freewater). The other Advocate is assigned to work in the western portion of Umatilla County and portions of Morrow County (Echo/Stanfield, Irrigon/Umatilla, Hermiston).

The Family Service Advocates conduct the parent support groups which run for 10 weeks and involve 10-12 participants in each group. The first set of groups ran from April to June of 1990; a second set of groups began in July 1990 and continued through the end of the summer; a third set of groups ran from October 1990 through December. Another set of groups began in early 1991 and will continue through spring. At least one experimental group will be allowed to continue for 26 weeks to see if the expanded time frame results in a more effective intervention.

Groups meet two to three hours each week and are facilitated by a Family Service Advocates, sometimes with the assistance of a co-facilitator. Following the Childhaven curriculum, the group time is divided into the following parts: the first half hour is devoted to positive reporting on how the week has gone for the parents; the second half hour is spent discussing child management issues and developing appropriate ways to resolve difficulties; the last one to two hours are spent in developing the curricular concept of the week and role playing or practicing the skills being learned. Homework assignments are given each week and are reviewed at the beginning of each session. Head Start provides transportation, child care, and refreshments. Some of these supports are augmented by a Great Start grant. Both day and evening groups are offered.

The number of groups active at any time has varied over the life of the project. Fewer groups were offered during the first quarter of the grant due to other start-up activities. Groups were held during the summer months for WIC parents, but these were poorly attended and several had to be combined or discontinued. During fall, 1990, between six and ten groups were active. Throughout the project, emphasis has been placed on making sure that parent groups are accessible to the more isolated parts of the county. Sites have varied but groups have been held in Hermiston, Irrigon, Echo, Milton-Freewater, and Pendleton.

The curriculum for the support groups is designed to teach social and parenting skills. The focus is on helping the group learn skills both to improve existing parenting skills and establish new pro-social behaviors in themselves. The training curriculum consists of the following units:

values clarification,
assessment of wants and needs,
stress management,
coping with stressful holidays,
anger management,
building self-esteem,
listening skills,
assertiveness,
problem solving,
child development,
healthy eating.

An important component of the project is the generalization of each skill to the parent's environment. Regularly scheduled home visits are conducted by both Head Start and

project staff, usually about twice a month. These visits focus on identifying areas of skill deficits, discussing realistic change expectations and rehearsing skills. Project and Head Start staff help parents design and carry out family activities based upon these individualized goals. These family activities reinforce the skills learned and give the family the opportunity to practice the skills in their own environment.

The project focus for the summer of 1990 was the development of parent support groups with the WIC program. In late May and June, Family Service Advocates recruited during WIC voucher days. Flyers were distributed in many area agencies frequented by WIC parents, and parents were personally contacted by phone or mail. Groups were begun and family assessments were completed by the first week of July. By mid-July it was necessary to combine some of the groups due to a drop-off in attendance. To ascertain the reasons for decrease in attendance, parents were interviewed. The following conclusions were reached:

1. Criteria for involvement in the WIC program is based upon a higher household income, and many families seek seasonal employment during the summer months.

2. The WIC program does not include parent involvement as part of their guidelines or requirements; therefore, WIC parents are less motivated and less committed to attendance.

3. Families in WIC have more opportunities to be involved in activities with their families and were not so reliant upon the parent support group to provide an outing for them.

In November, 1990, the Umatilla County Alternative School Program invited the Family Service Project to provide parenting information to their students. Consequently, three support groups are being provided in two alternative schools in Umatilla County (Pendleton and Hermiston). One of these groups had existed for some time as an alcohol and drug education groups facilitated by staff from Umatilla County Mental Health. This group is now presented as a parenting skills class co-facilitated by a Family Service Advocate and a staff member from UCMHP. There are two groups in place in Hermiston to provide parenting education and support in the Alternative High School. These groups are run by a teacher who uses the Family Service Project curriculum.

One of the Family Service Advocates has developed a group at the Mission Head Start site located on the Umatilla Indian Reservation. It was determined that the Childhaven Curriculum would not be ethnically appropriate for use with Native American Parents. At the suggestion of one of the tribal elders, the Positive Indian parent Curriculum from the North West Indian Child Welfare Association is being used instead. This group is called the "Parent Circle and is being co-facilitated by a Native American mother.

A Spanish speaking group is also meeting. There are five participants in this group, which is run through an interpreter. The groups is in its second session and is still working on developing cohesiveness. Additional details about the groups can be found in Appendix D.

Description of Participants

All parent support group members have children in the Umatilla/Morrow County Head Start or WIC Program with the exception of some teenagers who are pregnant. Head

Start and WIC covers a broad spectrum of disadvantaged groups. Therefore, all Head Start and WIC consumers are at high risk. However, the project has tried to target the "higher risk" families by working closely with Head Start teachers and staff to identify and contact those families with special mental health needs. To some extent, this outreach has to be subtle since the parent support group members all join on a voluntary basis. Consequently, project staff feel that there are "higher risk" parents in the community who still need to be encouraged to join a group.

General information is available about the demographics of the Head Start children and families. Of 185 children enrolled in Head Start in 1990, 99.5% were considered low income. About 17% of the children had disabilities. Thirty-seven percent are members of a minority group, predominantly African- American, Hispanic or American Indian. Approximately 42% of the children come from two-parent households, 54% live in single parent households and 3% live with other relatives or in foster care. Forty percent of the families include an adult who is employed full time; 32% of the families report that no adult is employed. Forty-six percent of the families report income from AFDC. Income for the majority of these families falls in the $3,000 to $9,000 range.

Referrals to the Project are also received from the Educational Services District, Children's Services Division, and Mental Health. These referrals are screened and served if they meet the criteria for eligibility used by Head Start/WIC.

Between January 1990 and December 1990, 20 groups, each meeting for 10 weeks, were completed. One hundred and thirty nine Head Start or WIC families were served through these groups. Several of these families continue to be ongoing members of support groups. Table 10 presents data on project activities.

Table 10. Family Service Project Activities

Activity	4/90-6/90	7/90-9/90	10/90-12/90
Letters sent	201	441	672
Phone Contacts	335	524	247
Home Visits	59	104	226
Number of different Groups	4	6	10
Groups Sessions held	25	33	67
Number attending groups*	143	88	329

*duplicated count, individuals attend several group sessions and are counted at each session.

Demographic information on the parents served is available for the second quarter (April

through June, 1990) and the fourth quarter (October through December, 1990) of the program. These data are displayed in Table 11. Due to turnover in Family Service Advocates during the summer months, demographics are not available for this period.

Table 11. Demographic Information on Participants

Variable	4/90-6/90 (26 families)	10/90-12/90 (96 families)
Sex of parent		
Female	20	84
Male	10	30
Marital status		
married	18	11
single	12	91
Age of child		
0-3	19	31
4-5	11	11
Race of parent		
Caucasian	*	88
Hispanic	*	11
Native American	*	4
African American	*	4

*Data on race were not collected in second quarter; however, 4 of the 26 families reported that Spanish was the primary language spoken at home.

During the period between October and December three of the group served teenage parents associated with the Alternative Schools. These groups consisted of non-parenting teens, pregnant teens, interested teens and a few teens who are currently parenting children. For this reason, not every family reflected in Table 11 reported data on a child.

Interim Data on Outcome

The evaluation of the Family Service Project impact is based on the following three assertions:

1) Parents involved in the skill training will demonstrate knowledge of concepts and skills learned in the parenting group.

2) Parents involved in the skill training will demonstrate an increase in their social support systems.

3) Parent skill training in conjunction with Head Start's programmatic interventions will impact positively the social, cognitive, behavioral, and emotional development of the children targeted by the project.

Evidence of the effectiveness of the project has been documented through pre- and post-intervention testing on the Adult-Adolescent Parenting Inventory (AAPI) and through home visit observations, homework assignment evaluations and by Head Start staff's evaluation of the child's progress in the classroom. Also the Project Coordinator is tracking all children referred to UCMHP as to date referred, who made the referral, prognosis and actual outcome of treatment of the child and/or family.

Quantitative evidence of impact. The instrument selected to measure program impact on parental skills training is the Adult-Adolescent Parenting Inventory (Bavolek, 1984). The AAPI is designed to assess the parenting and childrearing attitudes of adolescent and adult populations. It was developed from the known parenting and childrearing practices of nonabusive and abusive parents. Data generated from the administration of the AAPI indicate degrees of agreement or disagreement with maladaptive parent behaviors. As such, responses on the AAPI provide an index of risk (high, medium, low) for practicing abusive and neglecting parenting and childrearing behaviors.

Participants completed the AAPI pre-test during the second parent support group meeting. The instrument was scored and results were reviewed with the participants at the next group meeting. The results were used by participants for self assessment and goal setting. The participants completed a different form of the AAPI at the last group meeting.

Results of AAPI pre- and post-testing can be found in Table 12 and Table 13. Both the average raw score and the standard score are presented. The standard score converts the raw score to a ten-point scale. About 80% of the general population scores at or above 4.5 on this ten-point scale. The AAPI reports on four parenting constructs.

The first construct, *Inappropriate Parental Expectations of the Child* results in a low scale score for those with inappropriate expectations (e.g. expectations exceed developmental capabilities of the child) and a high scale score for those with appropriate expectations. The second construct, *Parental Lack of Empathic Awareness of Child's Needs*, results in a low scale score for those who lack empathy (e.g. children's needs not understood, lack nurturing) and a high scale score for those with appropriate empathy (e.g. recognizes children's feelings, communicates with child).

The third construct, *Parental Value of Physical Punishment*, results in a low scale score for those with a strong belief in the value of corporal punishment (e.g. hitting, spanking, slapping is appropriate) and a high scale score for those who value alternatives to corporal punishment (e.g. understands alternatives to physical force, democratic in rule-making). The fourth construct, *Parent-Child Role Reversal*, results in low scale scores for those who reverse parent and child roles (e.g. tends to use child to meet self-needs, perceives child as object) and high scale scores for those with appropriate family roles (e.g. finds support from peers, ownership of behavior).

The scores presented in Table 12 are from Head Start parents involved in parent support groups from 4/90 to 6/90. For two constructs, the mean scores went down slightly and for one construct, empathy, the mean scores stayed the same. In the case of the family roles construct, the mean scores increased slightly. Significance testing has not been completed on these scores.

Table 12. AAPI Pre-test and Post-test scores for second quarter

Parenting Construct	pre-test raw	standard	post-test raw	standard
Expectations	22	4	19	3
Empathy	32	4	32	4
Punishment	35	5	33	5
Family Roles	27	4	29	5

The scores presented in Table 13 are from WIC participants who were parent group members during the summer of 1990. The data suggests that these parents score higher on both the pre- and post-test AAPI than do Head Start parents. This difference was also substantiated by another assessment tool, the Family Functionality Profile. WIC families are different in several respects from Head Start families. The most important factor here is that WIC families fall into a higher income bracket than do Head Start families. Despite these differences, WIC parents scored lower on the punishment construct and showed an impressive increase in this score over the course of intervention. Significance testing has not been completed on these scores.

Table 13. AAPI Pre-test and Post-test scores for third quarter

Parenting Construct	pre-test raw	standard	post-test raw	standard
Expectations	24	5	22	5
Empathy	34	6	34	6
Punishment	30	6	37	6
Family Roles	30	6	31	6

The AAPI appears to provide useful assessment information to both project staff and participating families. It needs to be reassessed, however, as a pre and post measurement of outcome. One concern is whether or not there is enough time during a ten-week curriculum to make changes in attitudes and practices measured in the AAPI. Because of

this concern, one group is being allowed to run for 26 weeks to see if the AAPI scores show greater change.

A second concern lies in the potential bias toward socially appropriate answers. This is of particular concern since the instrument deals with issues related to child abuse. Since the pre-test is given early in the parent group, parents may not trust project staff enough to answer honestly. Instead they may select answers in order to appear as "good parents" or to avoid questions about their parenting practices. This would be particularly true if parents have had earlier contact with CSD or child abuse reporting. This tendency toward socially appropriate answers would explain why some of the pre-test scores are higher than the post-test scores. A third concern is that the AAPI measures only one objective of the Family Service Project, increase in parent knowledge, and does not measure other aspects such as increases in social supports.

Additional analysis will be done on the AAPI data and other data that is being collected by the project. Project staff are also examining other ways of collecting data on impact.

Qualitative evidence of impact. The project has met with enthusiastic parent response. Most individuals approached were more than willing to join a parent support group. In many cases, parents have requested that their groups continue after the ten-week curriculum is finished or have asked to join successive groups. One group planned and held a potluck dinner and exchanged addresses and phone numbers with fellow group members. Other evidence of the development of social networks include a group that has organized both a baby shower and a wedding shower; a group that shares rides, exchanges furniture and child care, and provides emotional support during marital problems. In a group held at an Alternative School, the young women socialize openly and help each other with their homework. More extensive descriptions can be found in Appendix D.

Description of Start-up Activities

The Family Service Project began start-up activities in mid-December, 1989, with the development of job descriptions for Family Service Advocates and clerical support staff. Money for the Project was received in January, 1990. To begin introducing the project, a Parent Bulletin with a cover letter from Head Start was sent to parents in early January. Letters introducing the project were also sent to the Head Start Health Advisory Board and all human services agencies within Umatilla and Morrow Counties. The Project Coordinator attended the Head Start Policy board in December, the Head Start Board Meeting in early January, the Health Advisory Committee and Early Intervention Committee, both in February. In addition to the letters of introduction, a newspaper article appeared in the last week of March.

Staff positions for the project, consisting of two Family Service Advocates and one clerical position, were filled by March 1, 1990. All staff attended Mental Health and Head Start orientation and training. Along with visits to parents and various agencies, both Advocates regularly attended Head Start Family Service Coordinators staff meetings.

During the month of April, one Family Service Advocate resigned her position with the Project for a career shift. A new Family Service Advocate was hired by June 1, 1990. Also during the month of April the clerical staff person resigned, and this position was filled from within the Umatilla County Mental Health Program clerical staff. Both Family Service Advocates then left the program for very diverse reasons in September.

The turnover in project staffing led to a reassessment of both the Project Coordinator and the Family Service Advocates' job descriptions. Implementation of the Family Service Project has required the development of an effective collaborative relationship between Mental Health staff and the Head Start/WIC Program. To some extent, Family Service Advocates belong to neither of these organizations. In addition, there is enough similarity between the role of the Family Service Advocates (Mental Health) and the role of the Parent Involvement Coordinators (Head Start) to require ongoing discussion and negotiation. After careful consideration of several options, agreement was reached between Mental Health and Head Start/WIC to implement the following changes:

> Mental Health would make available more direct time to the present Project Coordinator for liaison with Head Start. The Project Coordinator would provide training,attend weekly staff meetings with Head Start Social Services/Parent Involvement Coordinators as well as Family Service Advocates and provide consultation on dealing with crisis intervention with the Head Start/WIC families. The Project Coordinator now spends 40% of her time on the Family Service Project (as opposed to 25% of her time during earlier quarters). The Family Service Advocate positions were decreased to a 30-hour, four-day week.

Two new Family Service Advocates were hired in October, 1990. Both have had experience with training and with children and have moved quickly into being effective team members.

Working With Other Systems

As the provider of rural community mental health services, there is a long history of linkage in Umatilla County between Umatilla County Mental Health Program (UCMHP) and other human service providers. UCMHP, Adult and Family Service, Children's Services Division and Juvenile Services have routinely worked together. The Family Service Project has entered into a collaborative arrangement with the Umatilla County Alternative School Program to provide parent support groups at two alternative schools. The Family Service Project has also made use of the existing Health Advisory Committee for advice on planning, implementation, and evaluation. UCMHP provides facilities for project staff. When therapy is needed, it is delivered by UCMHP clinicians. A high percentage of children referred by the Family Service Project are Title XIX-eligible, which defers some of the cost of therapy.

There has been a long-term positive working relationship between the Project Coordinator and the Director of the Head Start Program. This has made it easier to integrate the Family Service Project into the existing Head Start Program, allowing for the use of the Head Start assessment measures and data as well as other resources. Head Start's contributions to child care and refreshments has reduced the overall costs of the Family Service Project. This Project has also made the best use of the natural linkage between parents and Head Start and WIC programs. It is apparent that using these ongoing, natural, innocuous and credible settings allows for the greatest involvement of families.

Future Plans

From the time this Project started, the intent was to expand the network to include all other agencies providing parenting training. Presently, Head Start and Mental Health have invited to a meeting held on February 25, 1991. At this meeting, a discussion was

held around the development of a collaborative county wide program to deliver parent support and education. Multiple funding sources, including grants, foundations, and agency financing, will be explored.

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APPENDIX A

INTERPERSONAL COGNITIVE PROBLEMS SOLVING PROJECT

MORRISON CENTER

PORTLAND, OREGON

CURRICULUM OVERVIEW
SPS (SECOND GRADE CURRICULUM)

DESIGN:

- Structured format for each lesson:
  - I. Objectives
  - II. Materials
  - III. Presentation and Procedure
  - IV. Special Notes
  - V. Enrichment Ideas

METHODS:

- Sequential learning of problem solving skills
- Taught through roleplaying, discussions, worksheets and games
- Paced to the level and needs of each particular class

KEY CONCEPTS:

- Generating Multiple Solutions
- Considering Consequences

UNITS OF INSTRUCTION (SKILLS):

1. **Recognizing Feelings**
   Learning how to recognize the feelings of oneself and others.

2. **Problem Identification**
   Learning to identify what impact the problem situation is having on oneself. Identifying constructive goals for resolving the problem.

3. **Generating Alternative Solutions**
   Learning to generate many different solutions for a social problem.

4. **Consideration of Consequences**
   Learning the concept of cause-and-effect. Understanding that emotions are important consequences. Learning to anticipate what might happen next if a particular solution is carried out.

5. **Integration of Problem Solving**
   Identifying problems, pairing solutions to consequences. Evaluating solutions before trying them. Trying out the best solution.

Table 14. Repeated Measure Analysis of TCRS Scores For At-Risk Children

	Phase 1 (N=18)			Phase 2 (N=16)		
Scales	1	2	3	1	2	3
Acting Out	21.0	25.5	29.6	23.4	17.5	25.9
Shy-Anxious	23.3	28.8	37.6	44.8	36.0	45.0
Learning	14.7	24.6	32.7	19.4	17.5	25.8
Frustration	19.9	31.9	33.5	24.4	22.8	29.9
Assertive-Social	22.1	41.5	40.5	26.9	28.6	34.9
Task Orientation	16.5	27.9	31.6	22.2	23.3	27.3
Peer-Social	16.1	24.9	26.0	19.1	21.4	28.4

Table 15. Statistical Significance Associated with Repeated Measure Analysis of TCRS Scores For At-Risk Children

	Phase 1			Phase 2		
Scales	1 v 2	12 v 3	Main	1 v 2	12 v 3	Main
Acting Out	NS	NS	.07	NS	NS	NS
Shy-Anxious	NS	.04	.05	NS	NS	NS
Learning	.02	.01	.001	NS	NS	NS
Frustration	.05	NS	.03	NS	NS	NS
Assertive-Social	.02	NS	.02	NS	.04	.05
Task Orientation	.03	.03	.01	NS	NS	NS
Peer-Social	.07	NS	NS	NS	.06	NS

Table 16. Repeated Measure Analysis of TCRS Scores
For Not-At-Risk Children

	Phase 1 (N = 18)			Phase 2 (N = 17)		
Scores	1	2	3	1	2	3
Total Number Responses	10.7	10.1	10.2	9.8	10.0	10.0
Number Active Responses	6.2	6.9	6.4	6.0	5.9	5.6
Number Different Responses	4.3	4.3	4.1	3.8	3.8	3.8
Last Primary Resolution Strtgy Mean	7.9	8.4	8.2	8.1	8.6	8.3
Last Obstacle Resolution Strat Mean	6.8	7.5	7.2	7.8	7.7	7.9
Percent of Prosocial Responses	41%	48%	42%	50%	58%	48%
Percent of Antisocial Responses	8%	5%	4%	3%	1%	2%

Table 17. Statistical Significance Associated with Repeated
Measure Analysis of TCRS Scores for Not-At-Risk Children

	Phase 1			Phase 2		
Scores	1 v 2	12 v 3	Main	1 v 2	12 v 3	Main
Total Number Responses	NS	NS	NS	NS	NS	NS
Number Active Responses	NS	NS	NS	NS	NS	NS
Number Different Responses	NS	NS	NS	NS	NS	NS
Last Primary Resolution Strtgy Mean	NS	NS	NS	NS	NS	NS
Last Obstacle Resolution Strat Mean	NS	NS	NS	NS	NS	NS
Percent of Prosocial Responses	NS	NS	NS	NS	NS	NS
Percent of Antisocial Responses	NS	NS	NS	NS	NS	NS

Table 18. Repeated Measure Analysis of SPSAM Scores For At-Risk Children

	Phase 1 (N=18)			Phase 2 (N=16)		
Scores	1	2	3	1	2	3
Total Number Responses	11.2	9.9	10.3	11.1	10.8	10.2
Number Active Responses	6.3	5.3	7.0	6.5	6.0	5.8
Number Different Responses	3.8	3.8	3.9	4.4	4.1	4.4
Last Primary Resolution Strtgy Mean	7.1	7.3	7.8	7.1	7.6	7.9
Last Obstacle Resolution Strat Mean	6.6	6.7	7.1	7.0	7.1	7.4
Percent of Prosocial Responses	37%	39%	47%	40%	42%	42%
Percent of Antisocial Responses	10%	8%	12%	11%	6%	3%

Table 19. Statistical Significance Associated with Repeated Measure Analysis of SPSAM Scores for At-Risk Children

	Phase 1			Phase 2		
Scores	1 v 2	12 v 3	Main	1 v 2	12 v 3	Main
Total Number Responses	NS	NS	NS	NS	NS	NS
Number Active Responses	NS	.03	NS	NS	NS	NS
Number Different Responses	NS	NS	NS	NS	NS	NS
Last Primary Resolution Strtgy Mean	NS	NS	NS	NS	.06	NS
Last Obstacle Resolution Strat Mean	NS	NS	NS	NS	NS	NS
Percent of Prosocial Responses	NS	.04	.06	NS	NS	NS
Percent of Antisocial Responses	NS	NS	NS	NS	.06	NS

APPENDIX B

THE TEMPERAMENT PROJECT

CENTER FOR PARENTING EXCELLENCE

LA GRANDE, OREGON

EYBERG CHILD BEHAVIOR INVENTORY (Modified)

Directions: Below are a series of phrases that describe children's behavior. Please (1) circle the number describing how often the behavior currently occurs with your child, and (2) circle either "yes" or "no" to indicate whether the behavior is currently a problem.

Think about the following child as you mark your responses.

Child's Name: _____ Age: _____ Birth Date: _____ Sex: _____

	How often does this occur with your child?							Is this a problem for you?	
	NEVER	SELDOM		SOMETIMES		OFTEN	ALWAYS		
1. Dawdles in getting dressed	1	2	3	4	5	6	7	Yes	No
2. Dawdles or lingers at mealtime	1	2	3	4	5	6	7	Yes	No
3. Has poor table manners	1	2	3	4	5	6	7	Yes	No
4. Refuses to eat food presented	1	2	3	4	5	6	7	Yes	No
5. Refuses to do chores when asked	1	2	3	4	5	6	7	Yes	No
6. Slow in getting ready for bed	1	2	3	4	5	6	7	Yes	No
7. Refuses to go to bed on time	1	2	3	4	5	6	7	Yes	No
8. Does not obey house rules on his own	1	2	3	4	5	6	7	Yes	No
9. Refuses to obey until threatened with punishment	1	2	3	4	5	6	7	Yes	No
10. Acts defiant when told to do something	1	2	3	4	5	6	7	Yes	No
11. Argues with parents about rules	1	2	3	4	5	6	7	Yes	No
12. Gets angry when doesn't get his own way	1	2	3	4	5	6	7	Yes	No
13. Has temper tantrums	1	2	3	4	5	6	7	Yes	No
14. Sasses adults	1	2	3	4	5	6	7	Yes	No
15. Whines	1	2	3	4	5	6	7	Yes	No
16. Cries easily	1	2	3	4	5	6	7	Yes	No
17. Yells or screams	1	2	3	4	5	6	7	Yes	No
18. Hits parents	1	2	3	4	5	6	7	Yes	No
19. Destroys toys and other objects	1	2	3	4	5	6	7	Yes	No
20. Is careless with toys and other objects	1	2	3	4	5	6	7	Yes	No
21. Steals	1	2	3	4	5	6	7	Yes	No

(Please Continue on Next Page)

	How often does this occur with your child?							Is this a problem for you?	
	NEVER	SELDOM		SOMETIMES		OFTEN	ALWAYS		
22. Lies	1	2	3	4	5	6	7	Yes	No
23. Teases or provokes other children	1	2	3	4	5	6	7	Yes	No
24. Verbally fights with friends his own age	1	2	3	4	5	6	7	Yes	No
25. Verbally fights with sisters and brothers	1	2	3	4	5	6	7	Yes	No
26. Physically fights with friends his own age	1	2	3	4	5	6	7	Yes	No
27. Physically fights with sisters and brothers	1	2	3	4	5	6	7	Yes	No
28. Constantly seeks attention	1	2	3	4	5	6	7	Yes	No
29. Interrupts	1	2	3	4	5	6	7	Yes	No
30. Is easily distracted	1	2	3	4	5	6	7	Yes	No
31. Has short attention span	1	2	3	4	5	6	7	Yes	No
32. Fails to finish tasks or projects	1	2	3	4	5	6	7	Yes	No
33. Has difficulty entertaining himself alone	1	2	3	4	5	6	7	Yes	No
34. Has difficulty concentrating on one thing	1	2	3	4	5	6	7	Yes	No
35. Is overactive or restless	1	2	3	4	5	6	7	Yes	No
36. Wets the bed	1	2	3	4	5	6	7	Yes	No
37. Gets upset easily	1	2	3	4	5	6	7	Yes	No
38. Overreacts to loud sounds/bright lights	1	2	3	4	5	6	7	Yes	No
39. Does not like new things or new situations	1	2	3	4	5	6	7	Yes	No
40. Is shy around new people	1	2	3	4	5	6	7	Yes	No
41. Clings to parents	1	2	3	4	5	6	7	Yes	No
42. Gets upset when things change	1	2	3	4	5	6	7	Yes	No
43. Is stubborn	1	2	3	4	5	6	7	Yes	No
44. Will only do things his way	1	2	3	4	5	6	7	Yes	No
45. Is anxious or fearful	1	2	3	4	5	6	7	Yes	No
46. Is very sensitive	1	2	3	4	5	6	7	Yes	No
47. Is loud	1	2	3	4	5	6	7	Yes	No
48. Prefers active play	1	2	3	4	5	6	7	Yes	No

(Please Continue on Next Page)

	How often does this occur with your child?							Is this a problem for you?	
	NEVER	SELDOM		SOMETIMES		OFTEN	ALWAYS		
49. Prefers quiet play	1	2	3	4	5	6	7	Yes	No
50. Lacks fear (is unafraid)	1	2	3	4	5	6	7	Yes	No
51. Is mean or cruel	1	2	3	4	5	6	7	Yes	No
52. Doesn't learn from punishment	1	2	3	4	5	6	7	Yes	No
53. Complains that he is bored	1	2	3	4	5	6	7	Yes	No
54. Nags for things he wants	1	2	3	4	5	6	7	Yes	No
55. Is bothered by how clothing feels	1	2	3	4	5	6	7	Yes	No
56. Overreacts to minor bumps and bruises	1	2	3	4	5	6	7	Yes	No
57. Has tantrums lasting more than 30 minutes	1	2	3	4	5	6	7	Yes	No
58. Is cranky or irritable	1	2	3	4	5	6	7	Yes	No
59. Has emotions which are hard to read or figure out	1	2	3	4	5	6	7	Yes	No
60. Has irregular or unpredictable sleep patterns	1	2	3	4	5	6	7	Yes	No
61. Has irregular or unpredictable hunger patterns	1	2	3	4	5	6	7	Yes	No
62. Acts without considering consequences	1	2	3	4	5	6	7	Yes	No
63. Doesn't notice things happening around him	1	2	3	4	5	6	7	Yes	No
64. Is easily frustrated	1	2	3	4	5	6	7	Yes	No
65. Only eats certain foods (is a picky eater)	1	2	3	4	5	6	7	Yes	No
66. Hates staying with a babysitter	1	2	3	4	5	6	7	Yes	No
67. Has no fear of strangers	1	2	3	4	5	6	7	Yes	No
68. Is very serious	1	2	3	4	5	6	7	Yes	No
69. Doesn't take things seriously enough	1	2	3	4	5	6	7	Yes	No
70. Talks too much (or talks too fast)	1	2	3	4	5	6	7	Yes	No
71. Is perfectionistic	1	2	3	4	5	6	7	Yes	No
72. Needs time to adjust when asked to change from one activity to another	1	2	3	4	5	6	7	Yes	No
73. Gets upset when family plans change	1	2	3	4	5	6	7	Yes	No

(Please Continue on Next Page)

	How often does this occur with your child?							Is this a problem for you?	
	NEVER	SELDOM		SOMETIMES		OFTEN	ALWAYS		
74. Refuses to give up when trying something which is too difficult for him	1	2	3	4	5	6	7	Yes	No
75. Fidgets when asked to stay still	1	2	3	4	5	6	7	Yes	No
76. Holds back in unfamiliar situations	1	2	3	4	5	6	7	Yes	No
77. Is very quiet, keeps to himself	1	2	3	4	5	6	7	Yes	No
78. Is not easily calmed when upset	1	2	3	4	5	6	7	Yes	No
79. Is very sensitive to what other people think	1	2	3	4	5	6	7	Yes	No
80. Wakes up in a bad mood	1	2	3	4	5	6	7	Yes	No
81. Is picky about what he wears	1	2	3	4	5	6	7	Yes	No
82. Deliberately does things to upset people	1	2	3	4	5	6	7	Yes	No
83. Likes to start trouble	1	2	3	4	5	6	7	Yes	No
84. Refuses to go places (e.g., shopping, school, relative's house, etc.)	1	2	3	4	5	6	7	Yes	No
85. Withdraws initially from new experiences	1	2	3	4	5	6	7	Yes	No
86. Is impulsive	1	2	3	4	5	6	7	Yes	No
87. Is reckless	1	2	3	4	5	6	7	Yes	No
88. Is very self-critical	1	2	3	4	5	6	7	Yes	No
89. Is very active	1	2	3	4	5	6	7	Yes	No

You're finished. Please check to make sure you completed all 89 questions.

Does your child have any troublesome behaviors which were not included in items 1 through 89 above? If he does, please list those behaviors below:

SCORING SUMMARY: ECBI-Modified

Child's Name: _____ Birth Date: _____ Age: _____ Sex: _____

		LO CUT	HI CUT			LO CUT	HI CUT
General Scales:							
ECBI Intensity Score: (total items 1-36)	____	75	126	ECBI Problem Score: (total items 1-36)	____	0	10
Externalizing Prob. Behav:	____	22	49	Externalizing Problem Score:	____	0	4
Internalizing Prob. Behav:	____	19	36	Internalizing Problem Score:	____	0	2
Primarily Internalizing Scales:							
Withdrawal Intensity Score:	____	13	33	Withdrawal Problem Score:	____	0	2
Sensitivity Intens. Score:	____	14	28	Sensitivity Prob. Score:	____	0	2
Threshold Intensity Score:	____	10	22	Threshold Problem Score:	____	0	2
Primarily Externalizing Scales:							
Activity Level Int. Score:	____	13	32	Activity Level Prob. Score:	____	0	2
Attention Span Int. Score:	____	7	17	Attention Span Prob. Score:	____	0	2
Persistence Int. Score:	____	9	22	Persistence Prob. Score:	____	0	2
Adaptability Intens. Score:	____	10	21	Adaptability Prob. Score:	____	0	2
Problem Behavior Scales							
Defiant/Oppositional Int.:	____	6	16	Defiant/Oppositional Prob.:	____	0	4
Disrespect Int. Score:	____	7	18	Disrespect Prob. Score:	____	0	2
Critical Item Int. Score:	____	11	22	Critical Item Prob. Score:	____	0	2

Externalizing Problem Behaviors:	INT	PROB
9 Refuses to obey until treatened w/ punish	____	____
10 Acts defiant when told to do something	____	____
13 Has temper tantrums	____	____
14 Sasses adults	____	____
19 Destroys toys and other objects	____	____
20 Is careless with toys and other objects	____	____
47 Is loud	____	____
51 Is mean or cruel	____	____
52 Doesn't seem to learn from punishment	____	____
62 Acts wothout considering consequences	____	____
82 OEliberately does things to upset people	____	____
83 Likes to start trouble	____	____
impulsive	____	____
Reckless	____	____
TOTAL:	____	____

Internalizing Problem Behaviors:	INT	PROB
40 Is shy around new people	____	____
41 Clings to parents	____	____
46 Is very sensitive	____	____
68 Is very serious	____	____
71 Is perfectionistic	____	____
74 Refuses to give up on difficult tasks	____	____
77 Is very quiet, keeps to hiaself	____	____
79 Is very sensitive to what others think	____	____
TOTAL:	____	____

SUBSCALE CALCULATIONS

Withdrawal:

		INT	PROB
39	Does not like new things/new situations		
40	Is shy around new people		
41	Clings to parents		
42	Gets upset when things change		
45	Is anxious or fearful		
76	Holds back in unfamiliar situations		
77	Is very quiet, keeps to himself		
85	Withdraws initially from new experiences		
	TOTAL:		

Sensitivity:

		INT	PROB
46	Is very sensitive		
68	Is very serious		
71	Is perfectionistic		
74	Refuses to give up trying something which is too difficult for him		
79	Is very sensitive to what other people think		
88	Is very self-critical		
	TOTAL:		

Threshold:

			INT	PROB
4	Refuses to eat food presented	T		
55	Is bothered by how clothing feels	F		
56	Overreacts to minor bumps/bruises	P		
65	Only eats certain foods (picky eater)	T		
81	Picky about what he wears	F		
	TOTAL:			
ALSO:	38 Overreacts to loud sound/or lights*			

Activity Level:

			INT	PROB
48	Prefers active play*			
(minus) 49	Prefers quiet play*			
	Active (item 48) - Quiet (item 49)	G		
35	Is overactive or restless	O		
47	Is loud	G,I		
52	Doesn't seem to learn from punishment	O		
62	Acts w/o considering consequences	I		
75	Fidgets when asked to stay still	G		
86	Is impulsive	I		
87	Is reckless	I		
	TOTAL:			

Attention Span:

		INT	PROB
30	Is easily distracted		
31	Has short attention span		
32	Fails to finish tasks or projects		
34	Has difficulty concentrating on one thing		
	TOTAL:		

Persistence:

		INT	PROB
12	Gets angry when doesn't get own way		
13	Has temper tantrums		
17	Yells or screams		
37	Gets upset easily		
64	Is easily frustrated		
	TOTAL:		

Adaptability:

			INT	PROB
43	Is Stubborn	S		
44	Will only do things his way	S		
72	Needs time to adjust when asked to change from one activity to another	T		
73	Gets upset when family plans change	T		
78	Is not easily calmed when upset	T		
	TOTAL:			

Abbreviations:

Threshold: T=Taste; P=Pain; F=Feeling/Touch

Activity Level: G=General; O=Overactive; I=Impulsive

Adaptability: S=Stubborn; T=Transitioning

* = Not included in total.

SUBSCALE CALCULATIONS (Cont.):

Defiant/Oppositional:	INT	PROB
9 Refuses to obey until threatened w/ pun.	____	____
10 Acts defiant when told to do something	____	____
11 Argues with parents about rules	____	____
14 Sasses adults	____	____
TOTAL:	____	____

Critical Items:		INT	PROB
18 Hits parents	O	____	____
21 Steals	A	____	____
22 Lies	A	____	____
24 Verbally fights w/ friends own age	AG	____	____
26 Physically fights w/ friends own age	AG	____	____
57 Has tantrums lasting more than 30 min.	O	____	____
59 Has emotions which are hard to read	M	____	____
80 Wakes up in a bad mood	M	____	____
84 Refuses to go places		____	____
TOTAL:		____	____

Disrespect for People/Things:		INT	PROB
19 Destroys toys and other objects	T	____	____
20 Is careless w/ toys and other objects	T	____	____
23 Teases or provokes other children	C	____	____
51 Is mean or cruel	C	____	____
82 Deliberately upsets people	I	____	____
83 Likes to start trouble	I	____	____
TOTAL:		____	____

Abbreviations:

Disrespect: T=Things; C=Cruel; I=Instigating

Critical Item: O=Out of Control; A=Antisocial; AG=Aggressive; M=Mood

---

Other Items: Place check mark to the left of items having intensities)4 and/or marked "YES" for "Is this a problem?":

ITEM:	INT	PROB	CORRELATES HIGHEST WITH:
___ 1 Dawdles in getting dressed	____	____	
___ 2 Dawdles/lingers at meal time	____	____	THRS/taste
___ 3 Has poor table manners	____	____	
___ 6 Slow in getting ready for bed	____	____	ATTN
___ 7 Refuses to go to bed on time	____	____	
___ 8 Does not obey house rules on own	____	____	PERS DEFI DISR/thing CRIT/anti CRIT/aggrs
___15 Whines	____	____	DEFI
___16 Cries easily	____	____	THRS/pain PERS
___25 Verbally fights sisters/brothers	____	____	
___27 Physically fights sisters/brothers	____	____	
___28 Constantly seeks attention	____	____	ADAP/trans
___29 Interrupts	____	____	ATTN PERS ADAP/stubb CRIT/anti CRIT/aggrs
___33 Has difficulty entertaining self	____	____	ACT/genrl ACT/over ACT/impls ADAP/stubb
___36 Wets the bed	____	____	
___50 Lacks fear (is unafraid)	____	____	
___53 Complains that he is bored	____	____	SENS
___54 Nags for things he wants	____	____	ACT/over ACT/impls PERS ADAP/trans DEFI CRIT/cntrl CRIT/mood
___58 Is cranky or irritable	____	____	PERS DEFI CRIT/mood
___60 Has irregular sleep patterns	____	____	
___61 Has irregular hunger patterns	____	____	THRS/taste Thrs/pain ADAP/stubb CRIT/mood CRIT/cntrl
___63 Doesn't notice things happening	____	____	
___66 Hates staying with a babysitter	____	____	
___67 Has no fear of strangers	____	____	
___ Does not take things seriously	____	____	ACT/over ACT/impls ATT
___ Talks too much (talks too fast)	____	____	ATT

APPENDIX C

JACKSON COUNTY EARLY INTERVENTION MENTAL HEALTH PROJECT

JACKSON COUNTY HEALTH AND HUMAN SERVICES

MEDFORD, OREGON

SOCIALIZATION GROUP

This is a general overview of the areas that need to be covered in the socialization skills training component of the Primary Intervention Project. Also included are various reference materials. Feel free to use any materials that that you are familiar with. We want a plan to be developed for each group session but also would encourage you to be flexible so that if natural social interaction develops that fit into the training areas, you would go with that. Many areas will overlap. Our expectation is by the end of the group sessions all of the general areas would be covered.

We recommend that the therapist talk with the children about why they are there have them set goals for themselves in terms of socialization. Social reinforcement needs to be provided by the therapist for growth seen in each child.

SOCIAL SKILLS TRAINING GUIDE

1. Exploration of Self in a Group
   -Who am I?
   -What do I value?
   -What are my goals and dreams?

2. Empathy Training
   -Ability to label and identify emotions.
   -Ability to experience and be aware of one's own emotions.
   -Ability to understand that others may see a situation differently.
   -Ability to assume and experience another's viewpoint.

3. Friendship Skills
   -Starting a conversation.
   -Establishing eye contact.
   -Listening.
   -Giving and receiving compliments.
   -Assertiveness Training.

4. Cooperative Experiences and Games
   -Provide experiences where social skills can be used in fun, enjoyable, activities.
   -Have games available that give children a chance to talk about their family in a supportive group environment.

RESOURCES

*Belonging. Jayne Devencenzi and Susan Pendergast.

*Helping Kids Handle Anger. Pat Huggins.

*Learning to Care. Norma Deitch Feshback and others.

Liking Myself. Pat Palmer.

T.A. for Tots. Alvyn M. Freed.

*Teaching Friendship Skills. Pat Huggins and Petra Hansen.

*The Cooperative Sports and Games Book. Terry Orlick.

The Mouse, The Monster and Me. Pat Palmer.

100 Ways to Develop Self-Concept in the Classroom. Jack Canfield and Harold Wells.

*These books are available through our office.

APPENDIX D

FAMILY SERVICE PROJECT

UMATILLA COUNTY MENTAL HEALTH PROGRAM

PENDLETON, OREGON

EXAMPLES OF PARENTING SUPPORT GROUP ACTIVITIES

Group A: This group, which meets at an alternative education school location, addresses the needs of pregnant teens, teen parents and students interested in parenting. Initially there was a great deal of giggling and leaving the room during the meeting but most of the students have become active participants in the group. The focus of this group has been to answer questions and clear up misinformation shared by the students.

Group B: One important aspect of this group is the level of trust which has developed between group members. During one session on stress management a mother shared that she had a son with multiple disabilities which led to another parent sharing about her autistic child. Those two mothers began to share their problems and be of support to each other by the exchange of information, magazine articles, and telephone calls. This exchange has served to improve the cohesion of the whole group as well as elevating the trust level among all the participants. For instance, one member was able to talk in the group about her depression and the fact that at one time in the past she had considered suicide. As the weeks passed by, this woman's appearance began to improve as she fixed her hair in new styles and began to dress up a bit.

Group C: This high school group is composed of nine girls, either pregnant or already parenting. Although these young women are from different social cliques in the school and have differing incomes and backgrounds, they have formed a tight bond with each other. They socialize openly with each other, help each other with homework projects, share rides to school and eat lunch together. These girls are able to openly discuss their lives in group and have established social support for each other.

Group D: The initial members of this group were a Mexican American woman who speaks very little English, a recovering drug addict with additional mental disorders and a woman whose past includes being the victim of battering. These three women from such diverse backgrounds and experiences worked together to help the Hispanic woman understand the curriculum and encourage the former drug addict to participate. The group has grown to include a husband and wife, a single mother and two single mothers who live at a facility for the treatment of drug and alcohol dependency. The group has adjusted well to each additional new member and having a father in the group adds a different perspective. Group members are supportive to each other outside of group time with visits, help with problem solving and transportation.

Group E: This group is comprised of twelve to thirteen individuals, four of whom have participated in previous groups. The most impressive aspect of this group is the group's ability to help individual members engage in a problem solving process. For instance, one couple, being investigated by Children Services Division for child abuse, arrived at their first meeting filled with hostility towards CSD and Head Start. The other members of the group diffused the couple's hostility by suggesting a channel through which to air their grievances; namely the Policy Council of Head Start. The parents took the group's suggestion and had a positive experience with council members. Now, when they attend meetings, they are able to talk about other things and participate in the curriculum lesson.

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Title: Starting Right: An interim report on early identification and prevention services for children at risk of mental or emotional disorders demonstration projects.	
Author(s): Koroloff, N.M.	
Corporate Source: Regional Research Institute for Human Services, Portland State University	Publication Date: 1991

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