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ABSTRACT

The report describes the model and evaluation results of a project serving birth to 3-year-old developmentally delayed/handicapped children through a parent training approach. The transdisciplinary program featured center and home visits to train parents in all activities of assessment, planning, and intervention activities. Parents were to become managers of their child's program plan. The organizational structure included four program instructors representing physical, occupational, and speech therapy as well as social work. Team development focused on staff training and parent training. Strategies found to be most successful included immediate interpretation of child assessment results after testing, establishment of a toy and lending library, and flexibility. The project featured ongoing evaluation of its effectiveness through assessment of child and parent progress. Program successes included reaching children early, communicating with the medical community, and demonstrating significant child gains across a broad spectrum of developmental areas. (CL)

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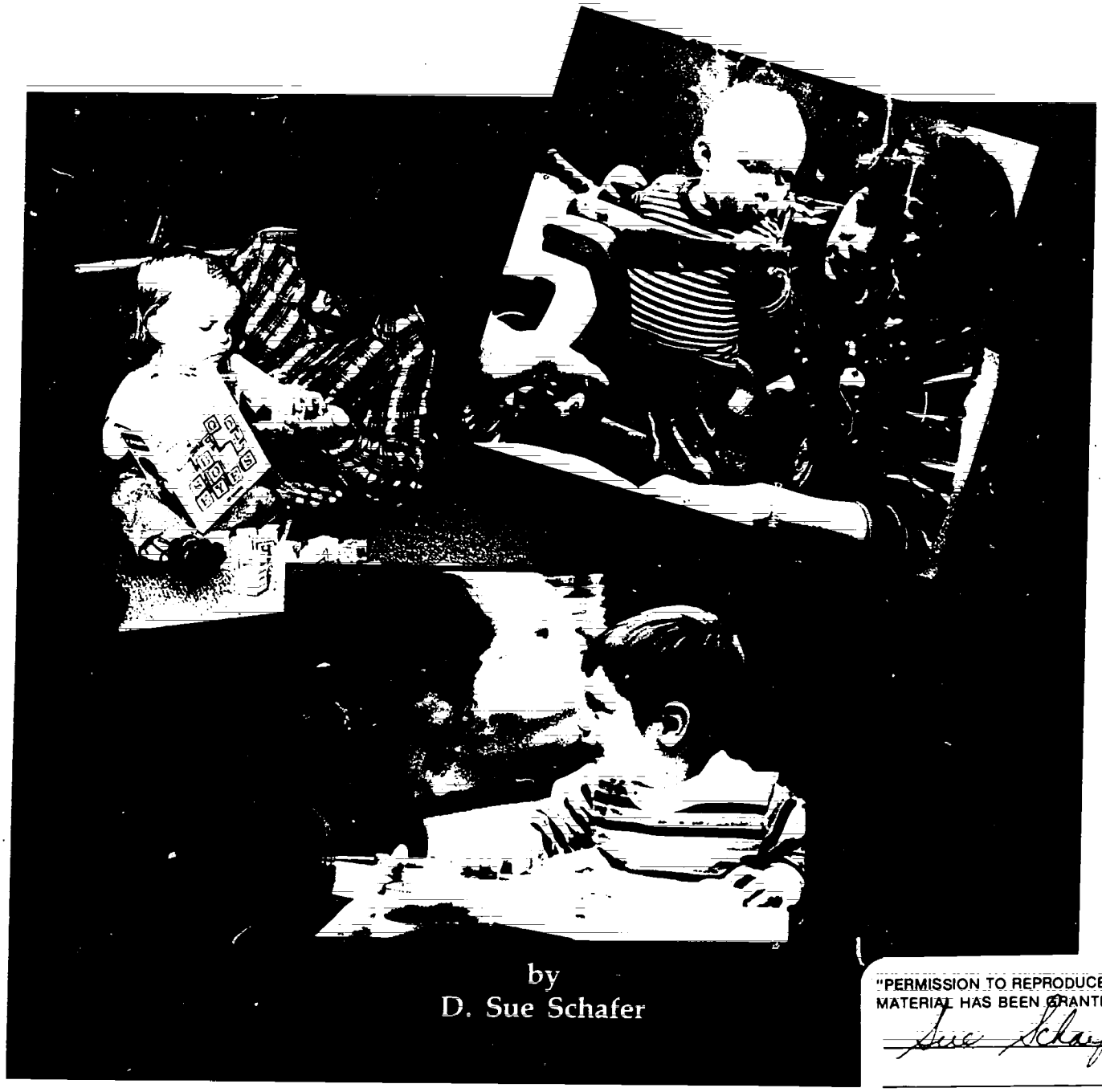
Child Success Through Parent Training

FINAL REPORT 1982-83



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D. Sue Schafer

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Child Success Through Parent Training

FINAL REPORT 1980-8

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Introduction

The Child Success Through Parent Training project was funded from July 1980 through September 1983 by a U.S. Department of Education grant (Handicapped Children's Early Education Program, Special Education Programs). Child Success was located on the Denton campus of Texas Woman's University, the project's fiscal agent.

In 1980 the public schools of Texas were working to establish special education programs for all eligible three-to-five-year-old handicapped children, but no comprehensive programming for Texas' birth-to-three population was in place. The Child Success Project was created to demonstrate an effective method for filling this void in services to the birth-to-three handicapped/developmentally delayed population.

During the project's three-year federal funding cycle, the Early Childhood Intervention (ECI) Program of Texas was established (Senate Bill 630, passed June 1981). The ECI Program was developed to provide a coordinated state-wide approach to services for developmentally delayed birth-to-three year olds. The Child Success Project received supplemental funding from the ECI Program from October 1982 through December 1983.

The Child Success Through Parent Training model for serving the birth-to-three handicapped/developmentally delayed population is provided in this report. The report includes a description of the model and evaluation results. Comments on this report are welcome. Readers who wish to receive additional information about the project's procedures are invited to contact the author.

Goals and Objectives

The goals of the Child Success Through Parent Training project were to stimulate increased services to young handicapped children and to develop an innovative model to serve handicapped children in three counties (Denton, Wise, Cooke) of north Texas.

The major end results of the Child Success Project were expected to be:

1. Development of a transdisciplinary service delivery model for developmentally delayed/handicapped children between the ages of birth and 36 months using allied health professionals as primary parent trainers.
2. Expansion of parents' roles in the development and implementation of their handicapped child's individualized management plan, i.e., integration of parents into the transdisciplinary team.

These results were achieved. During the course of the project, 193 children were referred to the project. They were processed by a team of professionals representing the disciplines of physical therapy, occupational therapy, speech-language pathology, and social work. The project's procedures clearly reflect the role of the parent in all areas of the program and the project's committment to transdisciplinary team development which included the parents.

Model development required that additional objectives also be attended to by the Child Success Project, objectives which facilitated the acceptance and continuation of the model in the community at large. Therefore, the following goals were also addressed by the Child Success Project:

3. Achievement of community awareness of the project's goals and objectives.
4. Implementation of cooperative efforts with community agencies to generate referrals to the project, to coordinate services for project children involved with other agencies, and to facilitate transition of the project children to other agencies (e.g., public schools).
5. Evaluation and selection of the most appropriate methods for developing individualized education programs for both the children and their parents.
6. Development of strategies for assisting public schools and other agencies in adopting project methods.
7. Development of publications describing project methods for use by others.
8. Establishment of continuation sites.

Goals 3 and 4 (community awareness and cooperation) became an integral part of the project's dissemination plans which are reported herein. Coordination with community agencies (local, regional, state) became an important ingredient in the project's success and complimented the national trend which focuses much attention on networking.

Goal 5 (selection of methods) was accomplished early in the project's timeline and the following report discusses the tools selected for project use.

Goals 6 and 8 (continuation) were determined to be outside the scope of the project during its three-year funding period. These goals would have been more realistic had the project not had to develop its service delivery model "from scratch." However, documentation of the project's procedures in this final report should lay the foundation for adoption of the model's components by interested others.

Goal 7 (publication) will be partially attained with the distribution of this final report. Additional research reports will be completed during the coming year.

Philosophy

The Child Success Through Parent Training model operated with the philosophy that parents have the skills to nurture the development of their child, no matter how normal or delayed the child may be; that the relationship between parent and child should be reinforced and made as positive and natural as possible, especially during the formative first three years of life; and that parents should remain the primary decision makers for their child's program.

Child Success parents participated in all program activities (e.g., assessment, planning, intervention) as determined by their interest, availability, capability, and motivation. The program used a combination of center and home visits as opportunities for parent training, opportunities to assist parents discover how to provide appropriate intervention strategies during their normal daily routine.

The Child Success Project capitalized on the expertise of a team of developmental specialists who were the parent child instructors. The team had the combined knowledge and skills needed by most handicapped and/or developmentally delayed children under three years of age and their parents. The team represented the disciplines of physical therapy, occupational therapy, speech-language pathology, and social work.

All program activities reinforced the establishment and maintenance of a transdisciplinary philosophy of team function. This team approach culminated in having one team member, the case manager, become the vital link between the child's family and the rest of the team. The project established training procedures for assisting each team member become an effective team member as well as an effective case manager.

These philosophical guidelines are reflected in the following sections of this report which describe the major components of the Child Success Through Parent Training Project model.

Organizational Structure

The Child Success Project's organizational structure is shown in Figure 1. Names of persons filling each position between 1980 and 1983 are listed in another section of this report.

The *Director*, the author of the original proposal and a fulltime faculty member in the School of Physical Therapy of the Texas Woman's University, was the administrator of the project throughout its funding period. Her primary function was to develop and evaluate progress toward program goals and objectives. Some specific responsibilities included (1) promotion of community awareness of and support for the project, (2) organization and coordination of resources to accomplish project objectives; (3) coordination of student training activities, (4) coordination of team development activities, (5) preparation of fiscal and programmatic reports required by the fiscal agent and funding sources, and (6) preparation of materials for publication.

A *Program Instructor's* primary function was to carry out service delivery functions as outlined in the project's goals and objectives. The maximum number of program instructors that the project could support at any one time was four. Although there were nine different program instructors during the course of the project, the disciplines represented at any one time were a single representative from each of the following professions: physical therapy, occupational therapy, speech-language pathology, and social work.

Each Program Instructor (1) conducted preadmission, intake, management, and exit/follow-up procedures; (2) was case manager for approximately 12 clients at any one time who were in the management phase; (3) participated in team development activities; (4) prepared and summarized written reports; (5) contributed to the review and revision of overall project goals and objectives; (6) communicated project goals, objectives, and procedures to others; (7) provided coordinated services with appropriate community agencies; and (8) provided specific disciplinary expertise as determined by educational background.

All Program Instructors were licensed and/or certified for providing services in their respective professions in the State of Texas.

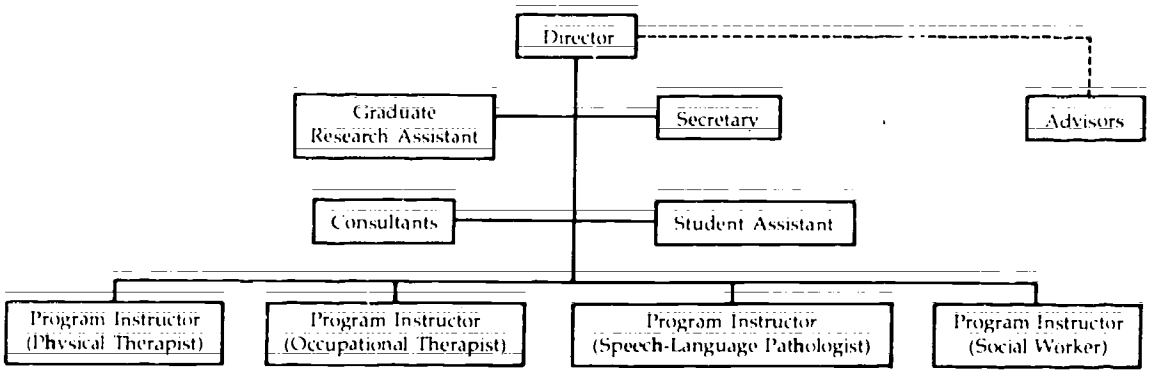
A *Secretary* was hired on a parttime basis to serve as receptionist and to provide advanced secretarial services. She was assisted by *student assistants* who served as clerical aids.

A *Graduate Research Assistant* also was hired on a parttime basis. This position was supported by the federal grant during 1980-81 and subsequently by intramural research grants received by the project director during 1982-84.

Various *Consultants* were contracted by the project to assist with specific project components, e.g., parent training, dissemination, and evaluation.

The *Advisors* consisted of representatives from diverse community groups who were contacted on a regular basis. The function of the Advisors was two-fold: to assist in establishing a thorough referral network and to assist in identifying and securing continuation site(s) and/or funding. The Advisors functioned as community advisory support groups for the project rather than as a policy-making body. Advice was sought from persons representing the views of some of the following areas of interest: Texas Woman's University, the city of Denton, education, medicine, law, local service agencies, and parents.

Figure 1
Organizational Structure
(1980-83)



Team Development

The delivery of services by a transdisciplinary team of allied health professionals was a major element of the Child Success Project. The ultimate outcome of this approach was organized teamwork and proficient client care which incorporated the knowledge of many specialists and at the same time maintained continuity of communication between a single case manager and the parent/family. This outcome formed the basis of all Child Success' staff development activities.

The core team was composed of four professionals (physical therapist, occupational therapist, speech-language pathologist, and social worker) who had prior training and experience in the assessment and direct treatment of handicapped children and/or their families within their respective disciplines. Through a process of mutual teaching/learning (information exchange and skill transfer), each team member gradually gained additional knowledge and expertise in selected portions of the disciplines of the other team members.

As each team member became more knowledgable and skilled in total child management, s/he became better able to assume the role of case manager, i.e., a team member who represented the team during communication with the family, who conducted parent training during the home visit, who maintained the records of family intervention, and who worked with the child *through* the parent(s) rather than by direct therapy with the child.

Staff Training Tool for Child Assessment. Schafer and Moersch's (1981) *Developmental Programming for Infants and Young Children* (DPIYC) was the focus for staff development in the area of child assessment. The DPIYC provided a systematic means for assessing a child's status in six areas of development: perceptual fine motor, language, cognition, self-care, social, and gross motor. The DPIYC was designed to be used by professionals trained in direct child treatment such as those represented on the Child Success team. Each team member already had the expertise to administer one or more DPIYC scales.

Each team member was required to learn to administer the entire DPIYC. By doing so, each team member broadened his/her knowledge of child development in all the other areas and continually related this new knowledge to his/her areas of expertise. The process of learning to administer the DPIYC required team interaction through discussion, review and simulated practice of DPIYC items, administering the DPIYC to normal children, concurrent scoring while other team members administered the DPIYC to project children, and eventually scoring and administering the DPIYC independently while other staff members provided consultation.

Although the Child Success Project used a team assessment (arena) approach, there were times when a team assessment was not feasible. In these cases, one team member had to administer the DPIYC independently. In order to maintain consistent scoring procedures, all staff were required to achieve an acceptable interrater reliability score of 0.80 or better. To achieve this end, the Child Success Project produced three videotapes of normal children, each showing the administration of the DPIYC to a different aged child. The three tapes together allowed 274 items of the DPIYC to be scored by the observer. The training process took between one and three months depending on the team member's experience with child assessment.

Staff Training Tool for Developing Child Management Plans. The DPIYC was designed to bridge the gap between assessment and program planning and was used to train staff to develop child management plans. The Child Success team developed each child's management plan with the case manager directing the process. Staff training involved learning to write behavioral objectives in all developmental areas of the DPIYC. Activities to meet the objectives were derived from Volume 3 of the DPIYC, from other early intervention resources, and from the team's experience.

Staff Training for Implementation of the Child's Management Plan Through Parent Instruction. The Child Success Project team engaged in a variety of staff development activities to gain skills in the area of parent instruction. Specifically, 664 man-hours over a three-year period were targeted for staff development in the parent training area (see Evaluation section).

The project gathered as much written information on this topic as possible, hired consultants with expertise in this area, and even considered creating materials of its own. In the end the project decided to use existing materials, to expand the team to include a social worker who had special expertise in family dynamics, and to include parent goals as a part of the child's management plan.

Staff Meetings as Development Opportunities. An effective and productive staff development activity was the group process focus of regular staff meetings. These meetings were used for planning project development, decision-making, goal-setting, activity reporting, and progress reporting. The Child Success Project staff met an average of three hours per week for these purposes.

Determining Other Staff Development Needs. External continuing education opportunities were monitored and taken advantage of by each team member as time and money allowed. Each staff member reported her continuing education needs on a monthly basis. Yearly goals were written and progress toward meeting these goals was reviewed on a semiannual basis, during a conference with the Director.

Service Delivery Process

The Child Success Through Parent Training project's service delivery process is summarized in Figure 2. The following narrative elaborates on the steps in this process.

Sources of Referrals

The Child Success Through Parent Training project received its referrals from the following sources: medical, educational, and social service agencies or professionals. Some parents also referred themselves, but the typical means of referral was through the child's pediatrician. In fact, 67% of all referrals came from medical sources with 73% of these directly from pediatricians. These referral sources, especially the medical community, were the primary casefinding agents for the Child Success Through Parent Training project (CSP).

Pre-Admission and Intake Procedures

Each referral was screened to assure that the child was 36 months of age or younger and lived in the CSP's catchment area (Denton, Wise, or Cooke County). A staff member conducted a telephone screening (application for services) and scheduled a home screening. During the home screening, the case manager completed the following:

1. Introduced the parents to the CSP, including location, nature of services, eligibility criteria, and funding source.
2. Administered the *Developmental Profile II* (Alpern, Boll, and Shearer, 1980), a screening tool for determining developmental age across five areas (parent interview format).
3. Gathered pertinent information, e.g., birth history, medical history, family history, parents' primary concerns, transportation, release forms.

The results of the home screening were discussed by the entire CSP team. If the screening indicated that (1) the child was handicapped and/or developmentally delayed or at risk for developing delays and (2) the parents continued to be interested in CSP services, then a comprehensive developmental assessment was scheduled. If the parents were not interested in CSP services and/or if the child was not eligible for CSP services, the family was referred to a more appropriate resource.

Eligibility. The criteria for eligibility were as follows:

1. The family resided in Denton, Wise, or Cooke County.
2. The child was 36 months of age or younger.
3. The parents were willing to participate in individualized parent training activities.
4. The child was significantly delayed in at least two of the following developmental areas: perceptual/fine motor, cognition, language, social/emotional, self-care (feeding, dressing, toileting), gross motor. Or the child was at risk for developmental delay.

The first three criteria were determined during the home screening. The fourth criterion was determined by the results of a comprehensive developmental assessment which was administered by the CSP team in the presence of the child's parents. The instrument used was *Developmental Programming for Infants and Young Children* (DPIYC) (Schafer and Moersch, 1981) which measures the child's skill level in each of the areas listed in the fourth eligibility criterion.

If the child showed delay in a single area of development, the child's parents were referred to an appropriate agency which could provide the specific type of intervention needed, e.g., speech therapy or physical therapy services.

The results of the DPIYC were summarized on a graph which displayed the child's developmental profile. The child's areas of strength as well as areas of delay were visible. These data were shared with the child's parents immediately following the assessment. This *parent conference* was a forum for information exchange in which the child's needs and parents' needs were re-examined.

A typical outcome of the parent conference was the determination of whether to provide specific disciplinary assessments, e.g., physical therapy, speech-language, feeding. The CSP provided for specific assessments, either through a CSP team member, a CSP consultant, or by referring the family to an appropriate agency or resource. Additional outcomes were the identification of the developmental area(s) in which the parents preferred to begin work, the assignment of a permanent case manager, and the establishment of a schedule for home and center visits.

The outcomes of the parent conference were documented in the child's file. After obtaining parental consent, the child's physician received a comprehensive summary of the CSP findings, including the results of the DPIYC assessment, the profile graph, and recommendations. This summary was also sent to agencies which were known to be working with the child and his/her family.

The CSP was sensitive to the needs of both the child and the child's family. The child, for instance, may have been eligible for services, but the parents' primary concerns may have been respite care or perhaps ob-

taining adequate housing. In the case of respite care, the CSP would turn to the Denton State School or the local Association for Retarded Citizens; in the case of obtaining adequate housing, the CSP would contact the Department of Human Resources or the local housing authority. It occassionally was necessary for parents who were facing these types of concerns to concentrate, in the short-term, on these concerns rather than on the child's developmental needs. The alleviation of such concerns may ultimately result in more long-term and beneficial effects on the child than immediate child-oriented intervention could provide. In these types of cases, the CSP and the parents mutually agreed on which direction to take. If the parents chose to concentrate on concerns other than their child for the short-term, they were encouraged to do so.

Development of a Program Plan

The family's case manager was responsible for tracking parent and child needs, discussing these with the parents, helping the parents prioritize them, and finally documenting the methods chosen for meeting them. The case manager had many resources available to help him/her guide the family, specifically the assessment results (including the DPIYC), his/her expertise in child and family development, the expertise of the CSP team, and community resources which offered expertise in areas not addressed consistently by the CSP. The outcome of all this planning and negotiating took the form of an individualized management plan.

The child's goals and objectives were written in behavioral terms, addressed the child's developmental needs, and fit within a 3-month time period. They were selected through a negotiation process between the CSP and parents and reflected the parents' primary concerns. The management plan was kept in the child's file and a copy was given to the child's parents. The plan was reviewed and updated at least quarterly, at the time of the child's reassessment. However, it could be amended prior to the quarterly reassessment as needed.

Those parents in need of assistance in areas unrelated to their child's development had goals written in behavioral terms addressing these needs. Parent goals were determined through a negotiation process between the CSP and parent(s) and reflected the parents' primary concerns. The parents' plan was kept in the child's file and a copy was given to the parent(s) involved. The plan was reviewed and updated at each home visit and/or center visit.

Program Implementation

The management plan was implemented in two locations: in the child's home and at the activity center which was located on the Denton campus of Texas Woman's University.

Home visits were made between one and four times per month, depending on the needs of the family. The frequency usually decreased after the first 3 to 6 months of CSP involvement. This decrease coincided with the parents' increasing ability to meet the child's needs in the home with less supervision.

Typically, only the case manager made the home visits. This procedure supported the CSP's transdisciplinary team approach to service delivery and, more importantly, helped to limit the number of agency professionals who may have been interacting with the same family. The case manager acted as the liaison between the CSP team and the parents, all of whom were working together for the benefit of the child.

During the home visit, the case manager instructed the parents in specific activities which addressed the child's goals and objectives that were listed on the management plan. The case manager utilized an approach which helped the parents to incorporate the child's activities into their normal, daily routine. This approach prepared the parents for their role as their child's primary teacher.

Center visits occurred weekly for two hours on the Denton campus of Texas Woman's University. Parents and children attended together. Center visits provided another opportunity for parent training. These visits differed from home visits in that the entire CSP team was available at the same time. Each parent was responsible for carrying out appropriate activities with his/her child during the center visit. The CSP team rotated from family to family during the session, helping them with specific portions of the child's plan (and parents' plan, if applicable).

A portion of the two-hour session was often set aside for parent education. Topics for discussion were determined by the parents. The CSP arranged for speakers and/or audiovisual materials according to the desires of the parents. The entire CSP team was present during these discussions, which were led by a CSP team member, a parent, or by a guest speaker.

Center visits also provided an opportunity for the children to interact with each other, for parents to observe other children's behaviors, and for parents to interact with other parents. Center visits were a vital part of the CSP model and helped families discover others from their community who had similar needs and concerns.

Evening parent meetings were scheduled monthly and were conducted by the social worker. These sessions offered a time when both mothers and fathers could meet to share common concerns, as well as benefit from the expertise of various professional presentations.

The *case manager* was responsible for conducting periodic case reviews, home visits, and record keeping for each assigned case. In addition, the case manager coordinated services with each child's physician and with any other agency which was involved with the child. The optimum number of cases per case manager

was determined to be between 12 and 15. Each case actually involved at least two family members—the parent and the child. The CSP model maintained the philosophy that the child was best served by working through his/her parents. Therefore, the CSP model emphasized parent training that was built around the developmental needs of the child.

Review and Discharge

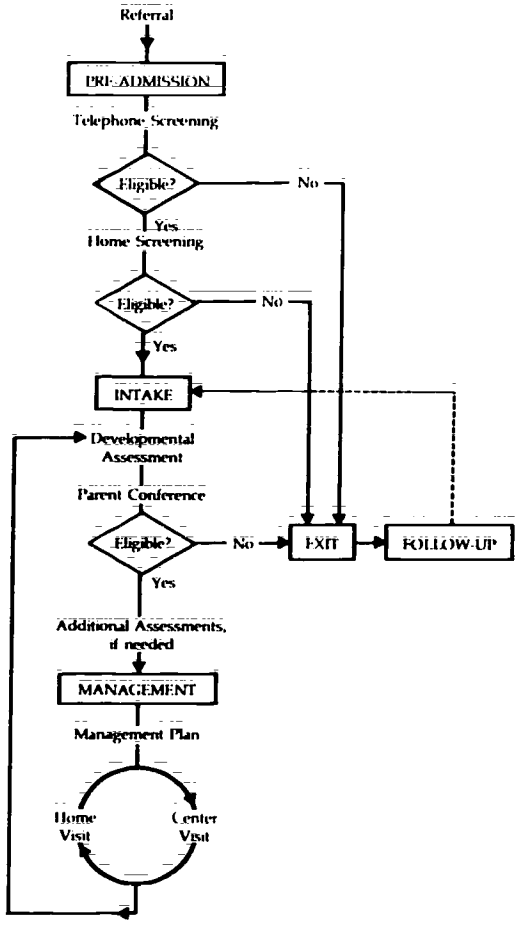
Child progress was reviewed quarterly through the re-administration of *Developmental Programming for Infants and Young Children*. The parents were present for and participated in the reassessment which was usually conducted by the case manager in the presence of the entire CSP team. The results were graphed as before and changes were noted with the parents. The needs of the child and the parents were again evaluated and prioritized. The need for specific disciplinary assessments was determined and planned for. If the parents and the CSP team agreed that the child was still eligible for services and would continue with the CSP, the management plan was revised. The next review date was scheduled and the parent/child cycled back into management for another three months.

Obviously, a child was *discharged* if he/she no longer met the CSP's eligibility criteria. A more common reason for discharge was evidence of the parent's ability to effectively promote his/her child's development with minimal or no supervision by the case manager. In its efforts to promote parental independence, the CSP encouraged parents to gradually wean themselves away from dependence on the CSP for decisions made and actions taken concerning their child's intervention. Families that were exited under these circumstances were able to cycle back into the CSP at a later date, as long as they continued to meet the eligibility criteria.

In either case, the discharge was carefully planned for with the parents. The CSP team assisted the parents in identifying and contacting other appropriate services and continued to coordinate the case until the parents indicated a smooth transition had been accomplished. A three-month *follow-up* telephone contact with the parents was a routine procedure.

At the time of exit, the case manager conducted a final reassessment using the DPIYC, conducted an exit interview with the parents, and documented the results in an exit report, a copy of which was sent to the child's physician.

Figure 2
Flow Chart of Service Delivery



Parent Training

The Child Success Through Parent Training project adopted an ecological philosophy of parent training with the assumption that child change would occur with changes in his/her environment. The parents were targeted as their child's major environmental influence. Thus, the project's goal for parent training was to assist parents in organizing their environment to learn about and influence their child's development.

The project's general objectives were to facilitate the parents' abilities to (1) enjoy interactions with their child, (2) become aware of their child's as well as their own strengths and weaknesses, (3) participate in planning and prioritizing child management decisions in relation to their own needs, (4) implement their child's management plan in their normal daily routine, (5) participate in evaluation of these activities and (6) ultimately achieve independence in decision-making in behalf of their child.

Procedures for parent training gradually evolved over the first two years of the project until parents were involved in every step of the service delivery process.

Determining a parent's needs became an important, ongoing function. The intake process, for example, gave at least three opportunities for parents to verbalize their perceived needs. The developmental assessments proved to be the best time to prioritize the parents' needs and to relate them to the needs of the child. The parents were not only present but participated in the testing along with the entire team.

The parent conference, which followed the testing, provided the parents with an immediate analysis of the child's needs. The parents were once again asked to help verbalize their needs by choosing the area(s) of programming which were of the most concern to them.

And finally, during the implementation phase the case manager consistently monitored the parents' immediate needs and helped them adjust their child's program plan accordingly.

Thus, the parent training component of the Child Success Project was a highly individualized process which required that parents commit to being involved. This expectation was clearly articulated throughout the service delivery process which allowed for flexible exit and re-entry based on the needs of both the parents and their child (see Figure 2).

Parent Training strategies revolved around informing and sharing knowledge and/or skills based on parental needs. These strategies were implemented according to the parent's interest, availability, capability, and motivation. The following list includes the most successful strategies used by the Child Success Project:

- Include parents in all program processes.
- Interpret child assessment results immediately after testing.
- Provide multiple opportunities for learning, both individual and group.
- Have all the "experts" available to the parent at least on a weekly basis (e.g., during center visits).
- Listen to parents and hear what they are saying.
- Respect parents' decisions even if you don't agree with them.
- Provide training materials at the parents' levels of understanding.
- Establish a toy and book lending library.
- Interpret medical jargon so parents can better understand what they are reading or hearing from others.
- Encourage parents to keep a personal file which includes all their child's records. This procedure facilitated communication between parent and the Child Success team as well as between parents and other professionals, e.g., physicians.
- Help parents organize their concerns so they can more easily address them directly to their child's physician.
- Give parents feedback on their progress, at least quarterly.
- Help parents meet other families with similar concerns, e.g., parent support groups.
- Be flexible.

Demonstration and Dissemination Activities

Demonstration activities were conducted on site at the Child Success Project's offices which were located on the Denton campus of Texas Woman's University. The facilities were renovated early in the first year of funding which resulted in the installation of a large viewing window through which all project activities could be observed. These facilities were also adapted to include videotaping capabilities.

Over 1,000 people participated in a variety of demonstration activities which the project conducted. Two open houses and a Christmas toy fair were the major large events sponsored by the Child Success Project. The most popular activities, however, were the weekly center visits, which were attended by both parents and children, and the regularly scheduled team assessments of project children. Visitors observed these activities through the specially constructed viewing window. In many instances the observer became actively involved in these activities.

These weekly activities demonstrated the three major components of the Child Success model, i.e., child service procedures, parent training procedures, and transdisciplinary team interactions. Each observer's personal objectives were negotiated with the Project Director, thus making all observations (demonstrations) fit their individualized needs.

Since the project was located on a University campus, it was utilized by students from a variety of disciplines who had an interest in the work of the project. A student's involvement with the project depended on his/her personal or course objectives. These objectives were carefully screened by the Project Director to assure that the client's needs would not be interferred with by the involvement of a student. By participating in demonstration activities, students from the following disciplines became aware of the project's goals and objectives: adaptive physical education, child development, communication science, dental hygiene, education, library science, music therapy, nursing, nutrition, occupational therapy, physical therapy, psychology, social work, and special education. The diversity of disciplines represented reinforced the project's philosophy that young handicapped children and their families require the combined efforts of numerous specialty areas.

The project also attracted local, regional, and national professionals from these same disciplines. Early intervention personnel throughout the State of Texas, for example, have contacted the Child Success Project in recent months for assistance in enhancing their service delivery approaches. Response to these requests will continue into the months and years to come.

Dissemination activities began as soon as notification of funding was received. Since the Denton community had no services available for handicapped infants and their parents like those proposed by the Child Success Project, dissemination activities concentrated initially on community awareness of Child Success services. An overall dissemination plan was conceived during the first year of the project.

The major objective of these demonstration years was to generate referrals of very young children in need of early intervention services. Three segments of the community at large were targeted as potential referral sources, namely the medical, educational, and social service agencies. The dissemination plan was to educate these segments of the community to the services that Child Success could provide for very young children and their parents. Special attention was given to the medical community since this group was the most likely to identify appropriate children at the earliest time in their lives.

By the end of year one, 23 referrals had been received, 3 (13%) from the medical community and 13 (57%) from educational agencies. During year two, 49 (67%) of 73 referrals that year came from the medical community and 10 (14%) from educational agencies. By the end of the third year 97 additional referrals were received with the medical community accounting for 73 (76%) of them.

Success in these dissemination efforts were in part due to the following factors: (1) identification and continued dialogue with key medical personnel, especially pediatricians; (2) provision of clear information regarding Child Success' eligibility criteria; (3) definition of Child Success services in terms that were common to medical and developmental specialists; (4) provision of regular feedback on all referrals received; (5) establishment of regular staffings with physicians; and (6) inclusion of physicians in decision-making which also involved the child's parents.

Some dissemination activities resulted in written products such as a project brochure, newsletters, slide-tape presentation, fact sheet, and a parent information packet. Other dissemination activities took the form of presentations made by the project staff to local, regional, and national audiences.

Coordination With Other Agencies

The Child Success Project's comprehensive approach to service delivery necessitated coordination with agencies from all aspects of the community, i.e., agencies which focus on child and/or parent (family) needs. The Child Success Project established a system for tracking its contacts with other agencies and for updating this system at regular intervals. All contacts were put on the project's mailing list to receive Child Success' publications. The project freely shared its resources with any agency or individual that could benefit from them.

An abbreviated outline of the project's primary contacts is provided below along with examples of the type(s) of coordination.

I. Coordination with Educational Agencies
- Texas Education Agency's Region XI Education Service Center (participate in state-wide tracking system; serve on their advisory board)
- Local School Districts (participate in admission, referral, and dismissal meetings; coordinate transition of children into early childhood programs)
- Other Educational Agencies, e.g., United Cerebral Palsy, Dallas Society for Crippled Children, Fort Worth Child Study Center, and other early intervention programs

II. Coordination with Medical Services
- Texas Department of Health, Public Health Service (consult for SSI eligibility; coordinate home visits with public health nurse)
- Local Public Health Departments (refer families to W.I.C. program; accept referrals from well/sick baby clinics)
- Other Medical Services (provide regular feedback to referring physicians; coordinate services with local home health agencies)

III. Coordination with Social Services
- Texas Department of Human Resources (accept referrals from Children's Protective Services; refer clients to social service programs, e.g., food stamp services, Aid to Families with Dependent Children)
- Other Social Service Agencies (e.g., community food center Women's Shelter, poison center, agencies providing transportation services)

IV. Coordination with Mental Health/Mental Retardation Services
- Texas Department MH/MR Units (refer clients to state school community service program; exchange ideas with professional staff)
- Other MR Agencies (serve on board of Association for Retarded Citizens)

Continuation and Replication

The Child Success Project's conceptual framework for dissemination strategies culminated in continuation of early intervention services in the Denton area. This model required that the project simultaneously explore the fiscal as well as programmatic feasibility for its continuing services in Denton.

Although the Child Success Project was funded for a short time by the newly-established Early Childhood Intervention Program of Texas, State priorities shifted for the 1983-85 biennium and left the project without a stable funding source. After examining all other potential fiscal resources, it was determined that the total Child Success model would not be able to remain intact at the original project site. Therefore, the demonstration site at Texas Woman's University was phased out at the end of the 1983 calendar year.

Continuation efforts typical of previously-funded Handicapped Children's Early Education Programs are not planned for the immediate future. Alternative continuation efforts, however, through publication of project findings, are projected as the next course of action. These publications may assist other early intervention programs across the country to consider replication of all or parts of the Child Success model.

Evaluation

The Child Success Through Parent Training project used the CIPP (context, input, process, product) model of evaluation developed by Stufflebeam et al. (1971). The project applied the CIPP strategy to six major components, i.e., child services, parent services, team development, dissemination (demonstration and continuation), administration, and evaluation. These components were identified for tracking during the first three months of funding.

Quarterly project goals were developed in each of these six areas; thus, a built-in mechanism for program review went into operation every three months. This method of formative evaluation proved extremely helpful in keeping the project on its timeline and in relating the six project components to each other.

Participants in the process of formulating project goals were the Director and all team members. All staff were supportive of this approach and recognized that it allowed them to have input into planning and implementing the project's goals and objectives. In addition, the process reinforced the project's philosophy of transdisciplinary team development.

An external evaluation consultant met with the staff on a quarterly basis throughout the funding period to guide the project in implementation of the CIPP process. His objectivity provided the project staff with the necessary input to make the best decisions for the subsequent quarters.

Tracking Child Services

The Child Success Project's purpose was to establish a comprehensive service delivery system for handicapped and or developmentally delayed children between the ages of birth and 36 months. The first six months of the project were set aside to establish the service delivery system for children. This system was repeatedly tested and refined throughout the funding period. The resulting process is detailed in a previous section of this report.

Tracking each child's progress through this system required (1) creation of a systematic approach for processing and filing child records and (2) development of a systematic means for tracking each child's progress through the project.

Child records: Each child's record not only served as a depository of forms, but was also designed to facilitate usage by all project team members. The child's records became a major communication link among the team members, since it contained documented information about child needs, plans, and progress.

A major challenge was to develop a system of documentation which was both adequate for decision-making and easy to use. The project settled on a modified problem-oriented medical record approach (Weed, 1971). This approach allowed project staff the means for systematic examination of all existing and potential problems (both child and parent) which could impact the child's individualized program plan. The master problem list was extremely helpful in the decision-making process and the progress notes were invaluable in enhancing the communication among staff regarding all project interactions with the child, his/her family, and significant others.

Tracking progress through service delivery process: The Director conducted monthly client reviews in which the status of each child in the project was accounted for and documented in a cumulative log. These reviews served several purposes: (1) quantified the number of clients served in each phase of the project on a monthly basis, (2) allowed for development of projections of service delivery capacity in subsequent months, (3) reinforced the team development philosophy of the project, and (4) prevented clients from slipping from the attention of the project.

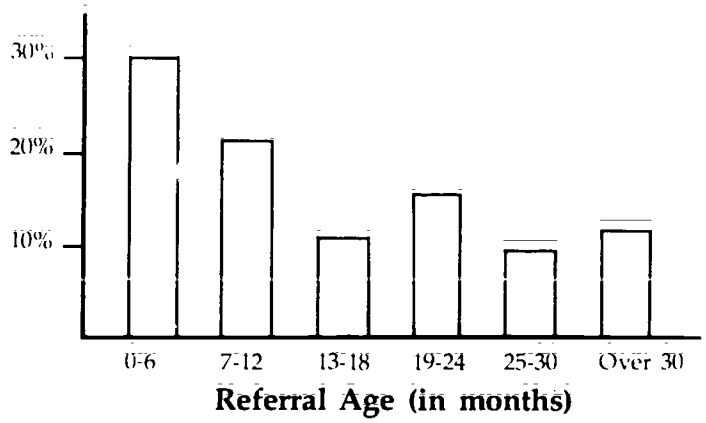
The project team extended this process to serve their day-to-day requirement for keeping track of client progress through the service delivery system by establishing a client board. This board listed the team members along one axis and the service delivery components along the other. Clients were moved from one coordinate to another as necessary. This process was updated on a weekly basis.

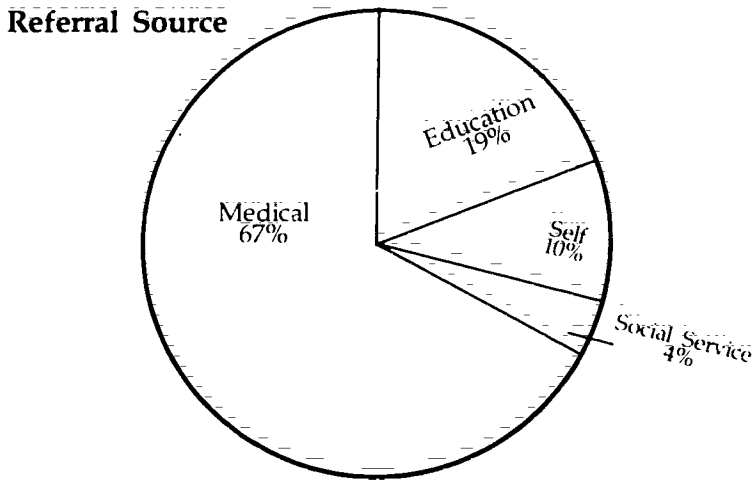
Service Delivery Results

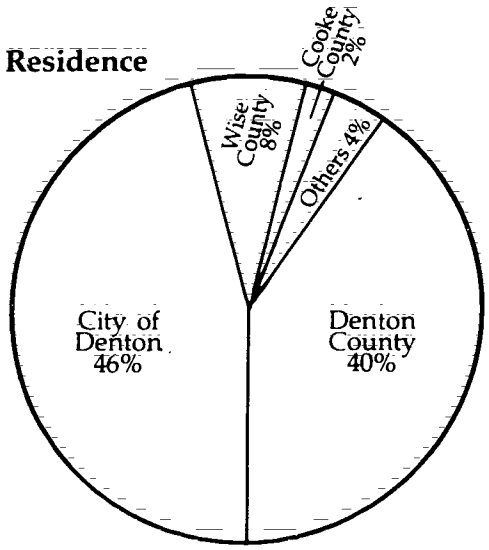
The Child Success Through Parent Training project received a total of 193 referrals. Some demographic data about this population include the following:

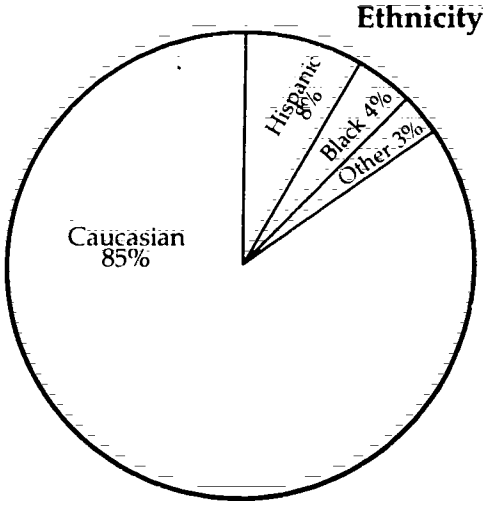
Sex

Male	Female
53%	47%









These data verify that the Child Success Through Parent Training project did indeed reach the birth-to-36 month population and that it was successful in promoting the concept of early intervention as evidenced by the fact that over 50% of its referrals were of children under 12 months of age.

The clinic makeup of this population was consistent with the population statistics of the north Texas region covered.

Assessment of Child Progress

One hundred forty-two children completed the intake process and received a comprehensive developmental assessment. Schafer and Moersch's (1981) *Developmental Programming for Infants and Young Children* (DPIYC) was used for this purpose. One hundred fifteen children entered the management phase of the project after receiving the initial developmental assessment.

Child progress was measured several times during the year by re-administration of the DPIYC. The DPIYC was selected for several reasons: (1) it was designed for administration by a team of allied health professionals such as those represented on the Child Success team, (2) it covered a broad spectrum of developmental areas including a Piagetian-based cognition section, (3) it was designed to be used for developing individualized development plans, and (4) it had been tested against other published tests as reported by Moersch and Wilson (1976).

Eighty-five children received at least one reassessment during his/her time with the project. Progress in each of the scales of the DPIYC was determined separately. The scales included skills in the following developmental areas: perceptual/fine motor, cognition, language, social/emotional, self-care (feeding, dressing, toileting) and gross motor. A developmental age for each scale was calculated according to the method of Rogers and D'Eugenio (1977). The developmental score was useful in completing the profile graph, but was converted to a ratio score (developmental age divided by chronological age) when used to pool the data set. The ratio score allowed the interpretation of results to rule out normal maturational gains.

Table 1 summarizes the analysis of the pre- and post-test mean ratio scores of 83 children who were enrolled in the Child Success Project.

Table 1

Child Success Through Parent Training
Child Progress Results

DPIYC[a] Scale	N	Mean Ratio[b] Test Score Pre	Post	Mean Difference	SD	SE	T Value
Perceptual Fine Motor	83	.705	.824	.119	.245	.027	4.42***
Cognition	83	.718	.870	.152	.273	.030	5.07***
Language	83	.748	.765	.017	.265	.029	0.58
Social	82	.927	1.030	.103	.312	.034	2.99**
Self-care (Feeding)	82	.730	.870	.140	.292	.032	4.34***
Gross Motor	83	.728	.773	.045	.220	.024	1.86*

[a]DPIYC = Developmental Programming for Infants and Young Children (Schafer and Moersch, 1981)

[b]Ratio score derived by dividing developmental age by chronological age

*$p = .067$

**$p < .01$

***$p < .001$

Positive gains were seen in all DPIYC scales. Significant increases were seen on the following scales: perceptual/fine motor, cognition, social, feeding, and gross motor.

These data clearly support the project's ability to provide effective intervention across a broad spectrum of developmental skills. Further evaluation of these data is planned through a research grant received by the Director for 1983-84.

Parent Curriculum

The Child Success Project's parent training procedures (see Parent Training section) represent a compilation of strategies derived from project case studies.

A comprehensive assessment of parent needs was identified early as a major component of the evolving parent "curriculum." The project studied numerous existing assessment instruments and found none to be totally satisfactory. Child Success stopped short of developing its own assessment tool, a task determined to be outside the scope and timeline of the project. In retrospect, however, it was determined that parent needs fell into three general categories: (1) basic information and skills in child rearing, (2) supplemental information and skills in child management related to the child's primary area(s) of delay, and (3) consumer information related to community services available for their family or handicapped child.

As particular parent needs consistently recurred, a file of previously published training resources was established. A bibliography of these resources appears in another section of this report. In addition, a toy, equipment, and book lending library was established and used extensively by project parents.

The child's quarterly re-assessments were a major parent training opportunity. These sessions turned out to have tremendous impact in the following ways:

1. Broadened parents' scope of child development.
2. Taught parents to watch for changes which could signify the presence of a problem, i.e., knowing when to ask for help.
3. Helped parents understand the concept of developmental rate and how it applied to their child.

Parent involvement was documented in the child's records and became an integral part of the project's service delivery process. Although the project tested the idea of parent contracting, an approach integrating the child's and parent's management plan was preferred by both the staff and the parents.

Thus, the Child Success Through Parent Training project successfully incorporated parents into all aspects of the service delivery process. This approach, which provided continuous opportunities for parent/child/staff interactions, was successfully used by the Child Success Project to train parents to become their child's primary care providers.

Assessment of Parent Progress

The stated purpose of the Child Success Through Parent Training project was to develop an innovative method by which parents of handicapped/developmentally delayed children could become the implementers of their child's management plan. As the philosophy of the project was operationalized, it became apparent that parents, by virtue of their being parents, had already assumed the role of their child's primary implementer. The challenge facing the project was to develop methods by which parents could *remain* the primary caregivers of their child rather than handing over this responsibility to a group of professionals whose contact with the child would be, at best, a few hours a week.

The project solved this problem by involving the parents in all aspects of the service delivery process (see Parent Training section for details). During this process the parents were expected to improve their abilities in (1) recognizing their child's developmental abilities, (2) selecting appropriate child goals, and (3) implementing their child's developmental plan.

It took two years to stabilize the project's parent training component and evaluation of its effectiveness was not possible until the third year had been completed. However, the project director received a separate research award during the third year (1982-83) to conduct a preliminary investigation of how to measure differences between clinician and parent perceptions of child change over time. The following section is a preliminary report of this research.

Clinical vs. Parental Judgment of Child Change: A Preliminary Report

by D. Sue Schafer and A. Polly Boll

A major feature of the Child Success Through Parent Training project was teaching parents to become effective managers of their developmentally delayed child's program plan. One step in this training process involved improving a parent's ability to report child change, i.e., to move the parent's perceptions to be in line with the clinicians' perceptions.

Concurrent validity. The Child Success Project used *Developmental Programming for Infants and Young Children* (Schafer and Moresch, 1981) to measure the clinicians' perceptions of child change across several areas of development. This instrument was designed to be clinician-scored rather than parent-scored. Therefore, a second tool, *Developmental Profile II* (Alpern, Boll, and Shearer, 1980), was selected for measuring parent perception of child change since it was designed to be parent-scored.

Before these tools could be used to compare clinician vs. parent perceptions of child change, the instruments had to be shown to be compatible across all areas of development. Therefore, the first objective of this study was to demonstrate the concurrent validity of the selected developmental assessment tools in each of five areas of development ($r > .80$).

The five scales of *Developmental Profile II* (DP) were consistently used throughout the study. The six scales of *Developmental Programming for Infants and Young Children* (DPIYC) were grouped as follows:

DP	DPIYC
Physical	Perceptual/Fine Motor and Gross Motor
Self-help	Self-care
Social	Social/Emotional
Academic	Cognition
Communication	Language

The perceptual/fine motor and gross motor scales of the DPIYC were combined, i.e., the two scores were averaged to match the single score of the physical scale of the DP.

During a three-month period, 30 clients enrolled in the Child Success Project were tested using both the DPIYC and the DP. The time elapsed between administration of the two tests for any client was no more than two weeks. Each test was concensus-scored by at least two clinicians. Clinician assignment was not controlled for except that different clinicians scored each test for any one child.

Resultant data were analyzed by calculating the Pearson product-moment correlation coefficient for each scale and are shown in the following table.

Table 2

Correlation Between Clinician-scored Scales of Developmental Programming for Infants and Young Children (volume 2) **and Developmental Profile II**

Scale	N	Pearson r	95% Confidence Interval
Physical	30	.912*	.822 to .958
Self-help	30	.919*	.834 to .961
Social	30	.897*	.793 to .950
Cognitive	30	.932*	.861 to .968
Language	30	.934*	.865 to .968

*$p < .001$

These data clearly show that each of the DPIYC and DP scales measure the same child behaviors, i.e., they demonstrate concurrent validity.

Clinician vs. parental scores. The next objective of the study was to pilot test the question: Is there a difference between parents' observations of their children's behaviors as scored on *Developmental Profile II* and clinicians' observations as scored on *Developmental Programming for Infants and Young Children* over time?

Thirteen subjects were tested three times at approximately three-month intervals. The data from each scale (5) and for each testing period (3) were treated separately, resulting in 15 separate analyses. T-tests, which compared parent mean scores with clinician mean scores, were run on each of the 15 situations. No significant differences were found at any testing period for the physical, social, or language scales. Significant differences were found in the first testing period for both the self-help and cognition scales ($p < .05$) and in the second testing period for the cognition scale ($p < .01$). No differences were found at the third testing period for either the self-help or cognition subscales.

Summary and conclusions. First, concurrent validity between two infant assessment tools in each of five developmental areas (gross/fine motor, self-help, social, cognition, and language) was established ($r > .90$ in each area; $n=30$).

Then these tools were used to pilot test the question: Is there a difference between parents' observations of their children's behaviors as scored on *Developmental Profile II* and clinicians' observations of these same children's behaviors as scored on *Developmental Programming for Infants and Young Children* over time? Significant differences between parents and clinician observations were found in the first testing period of the self-help and cognition scales ($p < .05$) and in the second testing period of the cognition scale ($p < .01$).

These findings support the assumption that the selected assessment tools are capable of quantifying differences between parent and clinician judgment of child change. Even though the sample size was small, these differences appear to be decreasing over time, most significantly in the cognition and self-help areas. These preliminary results suggest that the parent training strategies used by the Child Success Project were successful. This research is continuing and will be reported in the early intervention literature in the near future.

Team Development

Transdisciplinary team development was operationalized immediately and reinforced throughout the life of the project. This approach (explained in the Team Development section of this report) required constant monitoring.

The essence of the transdisciplinary approach was to produce team members who could easily interact with the other team members (including parents) both as a teacher and as a learner. The following observations were made regarding Child Success team development:

1. An open office allowed spontaneous team interaction to occur, but the "proper" room arrangement was the critical element for making this work. A team member's need for private times had to be consciously guarded for, and it took time for the team to read each others' signals accurately.
2. Set backs in team development occurred whenever the team composition changed, but overcoming these changes became less of a problem as the service delivery procedures became more clear and uniformly implemented.
3. Including the team in regular planning sessions was critical. These sessions provided a forum for understanding the entire project's goals and objectives rather than focusing on specific team member concerns.
4. Personality traits and level of expertise of each team member had marked effects on the success of transdisciplinary teamwork. The most successful combination was a person (1) who was well developed and confident in his/her disciplinary skills and (2) who had well developed interpersonal skills. Screening for these factors during the interview process, which was also a team responsibility, became a very important part of the hiring process.
5. The Child Success Through Parent Training project was able to demonstrate the application of the transdisciplinary philosophy throughout its service delivery process. This approach appears to have facilitated the difficult process of incorporating parents' needs with the child's needs. The disciplines represented on the team were primarily from child-focused professions (physical, occupational, and speech therapies) and had to actively work to change their focus to parent training. The addition of a social worker to the team during the third year proved to be extremely useful in helping the total team shift the focus from child to parent.
6. The quality of the interactions between the parents and their case manager was the most important factor in being able to correctly identify the parents' needs.

Tracking Staff Development

The Child Success Project's emphasis on team development is demonstrated in a summary of staff development activities presented in Table 3. Hours spent in staff development were subdivided into six program components. Each component consisted of identifiable blocks of time, such as time spent with consultants, workshops attended, and inservice activities. The data clearly reflect the project's emphasis on team development and parent services.

Table 3

Distribution of Staff Development Hours Across Six Project Components

		Child Success Pro Component						
		Service Delivery			Support Services			
Year	At No Staff	Team Development	Parent Services	Child Services	Evaluation	Administration	Dissemination	Total
1980-81	3	317	205	201	156	61	55	995
1981-82	4	319	328	23	153	46	54	923
1982-83	5	477	131	244	160	105	84	1201
	TOTAL	1113	664	468	469	212	193	3119
	% of Total	35.7%	21.3%	15.0%	15.0%	6.8%	6.2%	100%
		72%			28%			

Team development. By far, the largest number of staff hours was spent in team development. This included scheduled staff and team meetings, but did not include the numerous informal interactions in which a transdisciplinary team routinely engages. Interestingly, the Project Director was the only staff member who had had prior experience on a transdisciplinary team. Therefore, any time a Program Instructor was added or left the project, the change required that the team members "relearn" how to interact effectively with one another. In addition, a long standing team needed periodic feedback on its success at moving toward becoming transdisciplinary. Thus, team development activities consistantly remained a high priority throughout the project's three years. This high level of team interaction assured consistant interactions between any team member and any parent, i.e., facilitated communication among all persons who were working together in behalf of a child.

Parent Services. Discovering the best way to incorporate parents into the transdiscipinary team process was a major goal of the Child Success Project. Table 3 indicates the project's emphasis on this component during the first two years. Indeed, staff development time spent in parent services exceeded time spent on team development during the second year. Major decisions regarding the parent component were made during this period and were operationalized during the third year.

Child Services. As seen in Table 3, the ability to provide for staff development in areas related to child services diminished significantly between the first and second years. The reasons for this occurrence were: (1) major decisions about the process of child service delivery were determined during the first year so they could be operationalized during year two; and (2) staff development shifted to the parent component during the second year since child service delivery patterns had been established and required only minimal attention.

Once the parent component procedures had been established, staff development in child-related areas rebounded during the third year to the levels of the first year. During this time, staff participated in various child service activities related to their own disciplines, but just as frequently chose to participate in activities outside their own disciplines. This phenomenon may be attributed to the influence of the transdisciplinary process.

Support Services. Evaluation was considered an important component from the inception of the project. Table 3 clearly shows its consistent emphasis through the life of the project. The CIPP evaluation model proved to be appropriate for this type of project because it allowed for flexibility of design in each project component and for easy review of interactions among project components. To implement the CIPP model, however, plans for documentation of progress across all project components required early formulation and constant monitoring.

The dissemination component, which focused on relating project activities to the general public, turned out to be an administrative function, along with routine fiscal and management responsibilities. These components were managed primarily by the Project Director. The 13% of all staff development time consumed by these components included workshops and seminars provided by the funding agency.

In summary, the distribution of staff development hours accurately reflects the priorities of the Child Success Through Parent Training project in the following ways:

1. The project was a service delivery model, i.e., 72% of all staff development focused on service delivery components.
2. The project placed special emphasis (35.7%) on transdisciplinary team development.
3. The project emphasized parent training (21.3%).
4. The project incorporated program evaluation as a major component (15%).

Summary and Conclusions

The Child Success Through Parent Training project successfully demonstrated an early intervention model which incorporated parents into the team process. The parents remained in charge of their child's intervention; gained skills in observing, planning, implementing, and evaluating their child's needs as well as their own; and learned how to utilize an early intervention team as consultants rather than as the primary providers for their child.

The project successfully transformed a multidisciplinary group of professionals, which were composed primarily of representatives from traditionally child-focused disciplines (physical therapy, occupational therapy, speech-language pathology), into a team which focused on the parents as well as the child. The transdisciplinary philosophy, which was the common theme throughout the project, facilitated this transformation. Each team member moved through this process, some faster than others, and ultimately recognized (and operationalized) the parent's role on the team. Releasing control to the child's parents was the most difficult task for these traditionally "hands on" professionals. But the benefits of assured carryover into the home eventually became their overriding concern.

Parent involvement has been recognized as an essential component of early intervention programs for many years. However, the level or type of involvement has never reached concensus. One of the reasons for this may be that early intervention has been approached from at least two schools of thought: the education and medical perspectives, neither of which focuses directly on the impact that parents can have on their child.

These child-focused approaches, however, can be blended together to produce an effective parent training program. The Child Success Project has successfully demonstrated this approach for the birth-to-36 month developmentally delayed population. The success of the project can be attributed to the following key components:

1. Use highly trained child-focused professionals as direct parent instructors.
2. Give parents multiple and continuous opportunities for instruction, e.g., in the home, at a training center, through reading materials.
3. Allow parents access to a variety of professional staff on a regular basis, including those trained to be parent-focused, e.g., social work.
4. Involve parents in the assessment and planning processes for their child.
5. Review parent/child progress with the parents at least quarterly.
6. Emphasize flexible entry and exit from the program, based on parents' needs.

If another program were to replicate all or part of the Child Success model, a prerequisite should be that staff and administration be committed to a high level of parent involvement and be able to reinforce the team effort necessary to make the model work.

Increased services for developmentally delayed infants from the time of birth will likely continue to be a priority of national and state agencies. Thus, the Child Success Through Parent Training model has been completed at an opportune time. Data collected over the 3 years duration of the project indicate successes in the following areas:

1. Reaching children early (51% of all referrals were under 12 months of age).
2. Communicating with the medical community (76% of all referrals came from this component of the community during the third year).
3. Demonstrating significant child gains across a broad spectrum of developmental areas.
4. Reporting preliminary data which demonstrate parent gains in understanding their child's development.
5. Implementing transdisciplinary teamwork.
6. Increasing awareness and acceptance of early childhood services in the north Texas area.
7. Demonstrating the first comprehensive service delivery system which includes parents as team members in the State of Texas.

Finally, the pre- post-test data generated by using Schafer and Moersch's (1981) *Developmental Programming for Infants and Young Children* (DPIYC) has begun the process of validating the use of this instrument as a measure of child progress. These results invite replication by other users of this instrument.

The DPIYC has also been demonstrated to have concurrent validity with *Developmental Profile II* (Alpern, Boll, and Shearer, 1980). Studies comparing clinician vs. parent perceptions of child change, such as the preliminary report provided earlier, also invite replication.

A third research effort, cost analysis of the Child Success model, is also underway. All of the above research studies will appear in the early intervention literature in the near future.

The Child Success Through Parent Training project has brought the early intervention state-of-the-art a few steps closer to understanding how to keep parents involved with their young, developmentally delayed children. More research studies in this area need to be undertaken so that handicapped children everywhere can have the best chance for achieving CHILD SUCCESS.

Personnel and Consultants

Director

D. Sue Schafer, MA, LPT	July 1, 1980 to Dec. 31, 1983

Program Instructors

Linda A. Ryan, MS, CCC	July 1, 1980 to Aug. 31, 1982
Mary Jane Palasciano, LPT	July 1, 1980 to Sept. 30, 1981
Larry Hagat, OTR	July 13, 1981 to Apr. 15, 1982
Cheryl Keaveney, MS, CCC	Jan. 4, 1982 to July 9, 1982
Pat Deligans, MEd, LPT	May 24, 1982 to June 3, 1983
Allison Nelson, MS, CCC	July 1, 1982 to June 30, 1983
Judy Spalding, MSSW, CSW	Sept. 1, 1982 to Dec. 31, 1983
Cyndy Johnson, OTR	Jan. 1, 1983 to Dec. 31, 1983
Kathy Shearer, LPT	June 13, 1983 to Dec. 31, 1983

Graduate Research Assistants

Sherril York	Sept. 1, 1980 to June 30, 1981
Polly Bell	Sept. 1, 1982 to Dec. 31, 1983

Secretaries

Susan Rains	June 2, 1981 to June 11, 1982
Amanda Powell	June 14, 1982 to Aug. 31, 1983

Student Assistants

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Martyn O. Hotvedt, Galveston, Texas (Evaluation Component)

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American Dental Association
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Down's Syndrome Congress
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Ft. Worth, TX
McNeil Consumer Products Company
Ft. Washington, PA
Parents of Prematures, Inc.
Proctor & Gamble
Ross Laboratories
Scott Paper Company
Spina Bifida Association of America
Texas Department of Health
Texas Department of Mental Health and Mental Retardation
U.S. Department of Transportation