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AUTHOR Drezek, Wendy
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ABSTRACT

The Infant-Parent Training Program is a model program providing day care, therapy-nursery, and home programs for handicapped children from 0 to 3 years old. Upon intake into the program, both parents and children attend four 1-hour diagnostic sessions during which children are assessed in the areas of cognitive functioning, language functioning, social-emotional functioning, responses to classroom and teaching styles, and motor, neurological, and speech functioning. Parent-child classes are held weekly in which the teacher models specific therapy activities or interaction games, trains the parent, and encourages the parent to elaborate activities to fit his particular interaction style. The day care center program combines elements of "good mothering", traditional preschool activities, and a structured prescriptive approach. Results from evaluations for 1973-74 and 1974-75 show that there were positive qualitative changes in children's behaviors; that children, on the whole, made excellent progress at the preschool level; and that parents' responses were overwhelmingly positive to the program. (SBH)

THE INFANT-PARENT TRAINING PROGRAM

Wendy Drezek, Ph.D.

The Infant-Parent Training Program is a model program of early childhood education for handicapped children. In this paper the history and description of the program and preliminary evaluation data are presented.

History

In November 1972 the Mental Retardation Training Centers of Austin-Travis County Mental Health Mental Retardation Center began a pilot class for children 1- to 3-years-old who were developmentally delayed or high risk for delay. This class served 12 children in the period between November, 1972 and August, 1973. In August, 1972, Developmental Disabilities Act funding became available and an independent program was established. The program furnished day care to children 0-3 years-old. Children were taught one-to-one by rotating teachers (cognitive-language, gross motor, self-help socialization) using Portage program activities. Student social workers from The University of Texas brought Portage activities into the home. In January, 1974 additional funds were made available. A staff of home teachers were hired and vans were acquired for use as mobile classrooms. Consultant physical, occupational and speech therapists assessed each child at intake, and wrote individual therapy programs.

In September, 1974 the program received First Chance funding. Separate day care, therapy-nursery and home programs were organized. Parent-child classes, in which a triad of parent-child-teacher work together, were begun for initiating parent training. Parent counseling and education were also introduced. Special parent groups for young couples and Spanish-speaking

couples were organized by social work students. In 1975-76 the program is being funded by a First Chance grant and Texas Department of Mental Health and Mental Retardation grants-in-aid. While the program model remains similar to that of 1974-75, changes have been made as a result of the 1974-75 evaluation results.

Description

Population. In May, 1975, the children ranged from 2 weeks to 4 years-old with follow-up children ranging from 3- to 5-years-old. The following etiologies were represented: brain damage or cerebral palsy (44%), Down Syndrome (25%), hydrocephalus (7%), blind (3%), unknown problems (11%). In some cases children are referred because of factors relating to parents--child abuse, retardation of parents or siblings, family crisis. In May, 1975, 34% of the families had annual incomes of less than $5,000, 59% had annual incomes between $5,000 and $15,000, and 7% had annual incomes of over $15,000. Forty-four per cent of the children were Mexican-American, 44% Caucasians and 12% Negro.

Program entrance. All children referred to the program are seen at a preliminary intake during which children inappropriate for the program are screened out and referred to other agencies. During a second interview, parents are given preliminary information about program and social services, and assessment instruments are administered. All families are then scheduled for "diagnostic week."

Both parents and children attend the center for four 1-hour diagnostic sessions during the diagnostic week. Parents are given an orientation to the program and program services, and introductory parent training. Parental needs are assessed by the counselor, social worker and home program supervisor who may begin some support activities. Children are seen by two

teams. The teaching team assesses cognitive functioning (Uzgiris-Hunt Scales), language functioning (REEL), social-emotional functioning (Social Competency Checklist, Objectal Scale), and the child's responses to classroom and teaching styles. A team of therapists (occupational, physical and speech) assess motor, neurological and speech functioning.

Friday morning, the information from diagnostic week is presented by different teams; decisions are made about program placement for children and parents. A general outline of the emphases of the individual programs for that family is synthesized from all the material. A home-contact person for the family is chosen. In the afternoon, members of the team meet with staff members who will be involved with the child and family, and detailed curriculum suggestions are discussed. The teaching and therapy teams prepare an individualized curriculum for each child.

Program options. All children and parents are requested to attend a month of parent-child classes upon entrance to the program. These classes meet once a week for 1 1/2-2 hours. At each parent-child session three families and three teachers are present. Each teacher specializes in an area--motor, cognitive-language, or self-help skills. The teacher models specific therapy activities or interaction games, trains the parent, and encourages the parent to elaborate activities to fit his particular interaction style. Teachers also serve as models for positive, valuing attitudes to the child. In the process of working with the parent, the teacher communicates other information--observation techniques, developmental information, the importance of parent-child interaction, and kinds of learning arising in play situations.

All parents are also requested to attend an initial parent-support group evening meeting. At this meeting parents meet other parents of delayed children and explore common concerns. Parents are encouraged to receive

Parent Effectiveness Training, which is used to enhance family communication skills. A range of parent programs are available. Some parents become involved in decision making as members of the advisory board. Others choose individual, group, or marriage counseling. Many parents receive assistance in obtaining social services. In the past special classes dealing with parenting skills, developmental information, and teaching techniques have been offered. The Parent Association sponsors pot luck gatherings and programs with speakers on special topics.

Children are placed in one of four programs. Children of working parents or those of parents requiring emergency respite care are placed in the small day care program. Children in this program may also receive therapy twice a week. High functioning children functioning at an infant level are placed in the home program; high functioning children functioning at the toddler level are placed in the nursery program. Multiply handicapped children are placed in the therapy program. Children are re-evaluated every six months, at which time new curricula are designed and all placements reconsidered.

Program components for children. The day care center combines elements of "good mothering," traditional preschool activities and a more stuctured prescriptive approach. The daily schedule is designed to provide a balance of restful and active, teacher-directed and child-directed, individual and small group activities. The ratio of adults to children, is generally 1:3. The environment is designed to be easily "readable" by toddlers, and to encourage exploration, movement and socialization by infants and toddlers as well. There is time available for interaction of an individual child and his teacher; large pillows, rockers, plants, and pictures of the children provide a personalized atmosphere. Children receive some formal training or therapy in special areas (physical therapy, self-help

skills, etc.), however free-choice play and preschool activities for the toddlers, and interaction games and stimulation activities for the infant are the major vehicle for learning.

Families participating in the home program generally are visited weekly by home teachers. Teachers work primarily with the mothers. While specific therapy exercises are taught, the emphasis is placed on facilitating existing mother-child interaction. Home teachers use the existing interaction as the basis for incorporating additional kinds of activities into the child's day. The Nissonger and Portage curricula have been used as a source of activities for home visits.

Children in the nursery program attend 1 1/2 hour sessions two mornings a week. The nursery program has a 6:2 child-adult ratio. Some specialized nursery classes have been organized for blind children, high functioning nonverbal children and others. In these classes the specific therapeutic and educational activities for each child are incorporated in such preschool activities as music, art and free play; some children receive individual therapy. In the therapy program, children attend two afternoons a week for 1 1/2 hours. The child-teacher ratio is 2:1. In contrast to the nursery program, the emphasis in this program is on individual therapy activities. However, a preschool model is employed as the framework for the classes of toddler children.

Organizational considerations. Two aspects of organization are considered essential to the success of this program. The first aspect is planning. All teachers are given time for planning and have access to consultants to assist in planning individual curricula. Long-range goals for each child are set every six months. These goals are then translated into specific behavioral objectives which are re-evaluated every one to two weeks, depending on the program. Behavioral objectives are further translated into

specific activities and classroom arrangements. The long-range goals are derived from the curriculum generated from diagnostic week activities. It is the detail of this planning process that allows individual curricula to be incorporated in informal preschool and stimulation frameworks.

The organization of staff roles and relationships is another important aspect of the program. Since both parents and children may participate in several components, a "home-contact person" is selected for each family at the conclusion of diagnostic week. This person is the one who will have the most contact with the child or family. In cases in which the emphasis of services will be in the family area, the social worker or home worker will be the contact person. Similarly, a child participating both in day care and therapy programs, will probably have his day care teacher as his contact person. The role of the home contact person includes--monthly progress reports to parents, referral to social and medical services and coordination of staffings and other meetings related to that child. The role of home contact assures consistency and concern for each family involved in the program.

The staffing pattern is a second means of fostering consistency within the program as a whole. All nine teachers teach nursery (or nursery-therapy) classes. Thus all teachers are involved, part of the day, working together as a single staff. Teachers are "teamed" to provide alternative, complementary teaching styles for the children. In addition each teacher has at least one other, more specialized role in the day care, therapy parent-child or home programs. Teachers also have individual assignments--the toy lending library, Parent-Staff Library, assessment, curriculum development. These specialized roles and assignments allows each teacher to develop her own skills and allows the program to make optimal use of each staff person.

Evaluation

The evaluation design, instruments and results are described in detail elsewhere (Drezek & Shelton, 1975). A brief summary is presented here. Both in 1973-74 and 1974-75, children's test scores on the Denver Developmental Screening Test and Portage Checklist, showed significant changes ($p < .001$) over a six months period. Analysis of video tapes provided evidence of positive qualitative changes in children's behaviors. Programs receiving IPTP graduates reported that the children, on the whole, made excellent progress at the preschool level.

Both in 1973-74, and 1974-75, parents response was overwhelmingly positive to the program. They rated it as very useful to themselves and their children, and as providing all the needed services. Parent-child interaction, at the end of the 1975 school years, coded on the ABC instrument was similar to the interaction of "expert" teachers of infants. A community survey revealed a positive image of the program by professionals in the community.

Conclusion

The history of the Infant-Parent Training Program reflects the overall trend of infant education--from informal programming, to prescriptive programs, to a reasoned combination of the two. The Infant-Parent Training Program attempts to employ the systematic methodology of prescriptive teaching and therapy techniques with an emphasis on the importance of natural adult-child interaction and play. The program recognizes the diversity of child and parent needs in the diversity of program options. The preliminary evidence indicates that this approach is successful for both children and parents.

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