CHILDREN'S INSTITUTE INTERNATIONAL
EVALUATION REPORT PROJECT STABLE HOME

by

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NATIONAL CLEARINGHOUSE ON CHILD ABUSE AND NEGLECT INFORMATION

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High Risk Infant, Child and Family Project

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High Risk Infant, Child, and Family Project

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Project Stable Home at Children’s Institute International (CII) was developed to achieve the legislative purposes of the Abandoned Infants Assistance Program (AIA) by developing a comprehensive in-home intervention program designed to prevent the abandonment of infants and young children, ages zero to three years, within the Los Angeles area. Infants and young children targeted for services were prenatally exposed to alcohol and/or drugs or were referred due to a positive diagnosis for the human immunodeficiency virus (HIV). For the past four years Project Stable Home has worked actively to develop and deliver comprehensive services to children placed in shelter care and to their biological and/or foster families.

An integral component of Project Stable Home is the sharing by the community in the prevention effort, through collaborative partnerships, education, and integration of services. Collaboration with community agencies was actively fostered through educational programs, quarterly meetings, resource sharing, and integration of service activities. Project Stable Home provided leadership in coordinating the development of systematic community-wide resources for families enrolled in the program.

Program Design
Intervention strategies were targeted, not only to biological parents, but also to caregivers, foster families and relative caregivers. Not only did the “target” child benefit from the program, but siblings and other family members as well. The service plan was individualized for the family based on assessment information and identified needs. The primary focus of the interventions was successful reunification of the family, and if this was not possible, permanent placement in an adoptive or foster home.

Strategies for intervention focused on treatment of substance abuse through referral to treatment programs, counseling, and supportive services that facilitate the maintenance of clean and sober living. Education on child development, child rearing, and child care activities were provided in the home and at the Center. Service delivery was provided through a team approach, including both professionals and paraprofessionals working with the children and families. Professional staff were responsible for case management, counseling, developmental assessments, health monitoring, and other services. Paraprofessional home visiting staff provided in-home support for the family, demonstrated home-making activities, and monitored the safety and progress of the children. Service activities included weekly case review (rounds), case management activities and case coordination, multi-disciplinary team review, home visits, developmental and health assessments of the infant/child, individual counseling for the
developmental and health assessments of the infant/child, individual counseling for the parent, and linkage to community services.

Evaluation Design
The goal of the original evaluation design was to “document and study the effectiveness of a comprehensive collaborative interagency program to prevent the abandonment of prenatal drug-exposed infants and HIV positive infants”. The design utilized both quantitative and qualitative methodologies to address process and outcome variables based on the program goals and objectives. The quantitative evaluation focused on documenting the process variables, such as the numbers of individuals served and the types of services/activities generated by the program. A variety of instruments were used to assess and monitor the development of the infant/child, the home environment, and the relationship between the caregiver and child. Outcome evaluation addressed outcomes related to adequacy and safety of the placement, and the stability of placement. The qualitative evaluation provided descriptive data of service collaboration; analysis of observations of caregiver interactions with the children and family; and illustrated the effect of interventions through the use of anecdotal stories. A pre- and post-program design, with long-term repeat post measures, as well as comparison groups, was the initial evaluation method developed with the input of Project Stable Home staff.

Statistical Package for the Social Sciences (SPSS) was used to analyze quantitative data. Q.S.R. NUD*IST (qualitative data analysis analysis software) was used to assist in the analysis of qualitative data, specifically case notes and assessments. A Paradox database documented client characteristics (demographics) and components of service delivery, such as the number of individuals served, type of services, resources, participation, and intervention activities.

Description of the Population
Since its inception four years ago, two hundred fifty-five (255) infants were referred for services to Project Stable Home at Children’s Institute International (CII). The majority of the infants (91%) identified for intervention services by child protective services were placed in the emergency residential shelter at CII or in foster care homes. The remaining 9% of the referrals came from a variety of other sources such as drug treatment facilities and hospitals. The number of days a child remained in shelter placement varied from one day to 342 days, depending on the reasons for placement. The average length of time the child resided in the shelter was two months.

There are many risk factors associated with substance abuse in women. These risk factors include economic deprivation, homelessness, social isolation, poor nutrition, physical and/or sexual abuse, and lack of medical/prenatal care. Many substance-abusing women have had children placed in foster care or with relatives. Infants and children
Prenatally exposed to drugs are at risk for multiple behavioral problems, health problems, developmental delays, and neurological deficits. The special needs of these infants and children often make it difficult to achieve permanent placement with caregivers or biological parents who are capable of meeting those needs.

Very little information was known about the biological mothers and birth history of many of the infants. Approximately 50% of the women were not available at the time of referral. Sixty-seven percent were known to have a history of substance abuse. Nine mothers were identified as HIV positive at delivery. Descriptive information for women, for whom data was available, was consistent with the literature on maternal substance abuse and demonstrated similar risk factors associated with drug use, including lack of prenatal care and medical care, the need for housing, and the need for support services. Where information was known, the family reported financial and housing instability, limited access to drug treatment, continued drug use (particularly cocaine), limited family resources, and a previous history of abuse and mental health problems.

The infants were described as mostly term babies of slightly less than average birth weight, approximately 6 pounds. About one third of the infants were considered premature. Three-fourths of the children were classified as ethnic minorities including fifty percent African American, twenty percent Hispanic, six percent Asian, and the remainder Caucasian. Most infants had siblings, many of whom had been previously removed from the home for abuse and/or neglect.

Results
Of the multiple assessments that were initially considered for the evaluation, only a few were used with sufficient consistency by program staff to be included in the evaluation. Developmental instruments used to evaluate children included the Bayley Scales of Infant Development (BSID) and the Receptive Expressive Emergent Language (REEL) evaluation of language. Two-thirds of the 122 children initially assessed, scored at developmentally appropriate levels. In a subsequent evaluation of 41 children, one year later, developmental scores were appropriate for age level for approximately three-fourth of the group. Analysis of language scores utilizing the REEL (for the same 41 children for which both pre- and post-test information was available) indicated an improvement in receptive language scores that was statistically significant (p = .007). Expressive language scores improved also, but not at a statistically significant level. Initial language scores varied with the location of placement. Due to the limited sample size, no conclusions could be drawn at this time from this observation. Continued exploration of the impact of placement and program intervention on the child's development and on language acquisition is needed.
Home environment was assessed using the Caldwell Home Observation/Measurement of the Environment (HOME) and the Parent Need Questionnaire. Scores on the HOME Observation indicate the degree to which the environment is supportive of the child's growth and development. Average age of the child at the initial observation was nine months. Fifty-five children were subsequently reassessed on the HOME. Most of them were in foster care. Home environment scores demonstrated a consistent and steady increase, reflecting an improvement in home environment that was statistically significant. Areas that improved, over time, were caregiver’s emotional and verbal responsiveness; ability to organize the environment and provide outside stimuli; provision and availability of appropriate play material; parental/caregiver involvement with the child; and opportunities for daily stimulation and interaction. The only subscale that did not show an improvement in scores was the use of restriction and punishment for discipline. As children grow older, parents/caregivers are more likely to resort to restriction and punishment as a method to control the behavior of the child. Although staff members focused on providing education and guidance in the area of discipline, it continues to be an area in need of emphasis.

Descriptive data of the initial evaluation of the home environment indicates that the home environment varies based on the area assessed and the placement of the child. Comparison of subscales by placement demonstrated that ‘involvement with the child’ scored lowest for biological father and biological mother when compared to other placements. Provision of play materials appeared to be lowest for the biological father and highest for foster care and the biological mother. Caregiver interaction, emotional/verbal responsiveness, and daily stimulation were consistent among all placements. Statistical comparisons were not made due to the limited number of cases in most categories.

Parent Need Questionnaires were completed when the average age of the child was 7.7 months. Thirty-five parents/caregivers were again evaluated when the child was 21.4 months. Differences in the level of need were reported by relatives/parents vs caregivers of children in foster placement. Parents identified a much greater need for basic care giving information than foster families. They also identified a greater need for support, as well. In general, foster families appear to express fewer needs initially, but the level of need increases as the child gets older. Both initially and at follow-up, parents/caregivers consistently asked for information on the effects of prenatal drug exposure on the child and information on the growth and development of infant. Support was needed to handle stress and have more time for self. Parents needed to have opportunities to talk to other parents and/or the doctor. Foster and biological families both expressed a continued need for child care, referrals for financial assistance, and resources for meeting the child’s special needs.
The relationship between the mother/caregiver and child was evaluated with the Neonatal Perception Inventory (Attachment Subscale), the Mother-Child Relationship Questionnaire, and the Observation of Interaction. The Neonatal Perception Inventory was used to measure the degree to which caregivers/mothers demonstrated proximity behaviors and affective responses in interaction with their infants, i.e., attachment. Other definitions of attachment include a careful review of the context of interaction and emphasized the capabilities of the mother/caregiver to read and respond to cues. The Observation of Interaction was used to measure reciprocal interactions, not only as a measure of attachment, but also as a measure of the caregiver/parent's skill to enhance development and language. This skill can be developed through learning and modeled behavior. Although increased ability to read infant cues does not always result in increased attachment, it does lend itself to a more mutually enjoyable interaction.

Overall scores at both the initial evaluation and subsequent evaluation on the Attachment Subscale were consistently high and a paired t-test indicating no significant difference between scores. The Observation of Interaction evaluates three components of the interactive process between parent/caregiver and child. The first section observes the caregiver's ability to deliberately engage the infant in interaction. The second section evaluates the infant's capability to engage in mutual interaction with the caregiver. The third section focuses on the infant's distress and the caregiver's response to that distress. The average age of the child at the initial assessment was 10 months and, at the subsequent assessment, 21 months. The majority of the infants were in foster placement.

Caregiver scores were high initially and remained high, similar to the attachment scores. The child's interaction score improved over time (t-test = -2.5, p = .015) and demonstrated an improvement in the infant's interactive ability. It is difficult to assess the degree to which the program influenced this change, or if it was a result of the child's growing maturation. The section on infant/child distress demonstrated a decrease in scores over time, indicating the use of more restriction and punishment to control behavior. This was similar to the findings in the HOME Observation. As a child becomes older, caregivers may be more likely to use restriction and punishment as a method of intervening in distressing situations. The group used for the analysis was small, only 34 infants, as not all infants exhibited distress at the time of assessment. Perhaps infants observed in distress had a more difficult temperament or were more irritable? Continued assessment with larger groups may yield additional information relevant for clinical practice. Correlation of caregiver interaction scores with infant interaction scores demonstrated a strong correlation (r = .85, p = .001). Mutually pleasurable interactions tend to foster responsiveness in the infant. This was not affected by age. The strong association between caregiver competence in interaction and infant competence indicates statistical support for the mutuality of response and the importance of evaluating and supporting both partners in the interaction process.
The Mother-Child Relationship instrument assesses positive parenting behavior. In addition to a total score reflective of positive parenting, it can also generate a separate score in the areas of acceptance and non-acceptance. For example, an accepting parent or caregiver would have a high score in acceptance and lower scores in over-indulgence, over-protection, and rejection. Total scores were high with a mean score of 146.

Subscales indicated a generally high acceptance score and lower non-acceptance scores. When scores were analyzed utilizing One-way ANOVA, no significant differences emerged between the biological parent, relative caregiver, or foster parent in either the total score or subscales. Repeat analysis with a larger sample size may provide interesting and different results.

A rich source of information on the interaction between the parent/caregiver and the child came from the comments noted by staff following various observations. These comments have been analyzed using qualitative data analysis software. Staff observed, not only mothers in interaction with their infant/child, but also fathers, grandmothers, aunts, and CII caregivers in the shelter. Qualitative analysis of the staff comments provided a unique opportunity to identify specific behaviors that support positive interaction between child and caregiver. Behaviors noted during infant care activities focused on mutual pleasure in the interaction of feeding, bathing, and holding. Behaviors that fostered infant learning were also noted, including play activities, alertness of the infant and ability of the infant to attend to the activity.

Observations also allowed staff to identify which parent/child combination might be showing the effects of separation. Some parents were attentive and observant, but not directly engaged with the child. Other parents were not able to appropriately moderate their behavior in response to infant cues. The need for continued support, particularly with elderly grandparents, also became evident when observing interactions. Although most of the foster parents were actively involved with the children in their care, responding affectionately and actively promoting development, some foster parents also required intervention and support.

Observation highlighted qualities of the infant that are important in shaping the interaction process. Reinforcement by the parent of the child's interactive attempts was crucial in maintaining the process of communication. Parent and child interaction is a major focus of the intervention efforts of Project Stable Home. The comments during the observations illustrate the staff's attempts to facilitate positive interactions. Observations also provide opportunities for interventions that were directed at providing information on the child's development, growth, health, and nutrition. Observation of interaction, both quantitatively and qualitatively, appears to be an interesting mechanism for staff to focus their attention and their interventions on promoting mutually pleasurable interactions that may facilitate attachment and also provide essential education on child development.
Closure of Services and Placements
Families discontinued services with Project Stable Home for a wide variety of reasons. At this time 206 families have discontinued services or have completed services. Forty-nine families continue active in the program as of October 1997. Age of the child at discharge from Project Stable Home varied from one month to 3 years of age. On the average, the age of the child at discharge was 18 months. Average time in the program was nine months. Placements varied at the time of discharge. One hundred nineteen children (58%) have been placed with parents, family members, or in adoptive homes, while eighty-one children (39%) are in foster homes. Six children are in residential placement.

The most common reason for discontinuing services early was that the family was no longer available for services or children no longer met service criteria. Frequent moves made families difficult to locate and families were subsequently lost to follow-up. Foster families, who no longer perceived a need for services and/or felt that adequate services were being provided by other agencies, also tended to discontinue services. Goldberg, et. al. (1997) also reported that many foster parents indicate that they have generally good support and services through their foster care agencies. This may vary by foster care agency and geographic location.

An area of both national and program concern is the impact of the number of changes in placement on the infant. The literature substantiates that frequent changes in placements are often detrimental to the child’s growth, development and overall well-being. Infants with multiple placements are considered to be at much greater risk for subsequent emotional and behavioral problems. The majority of infants referred to Project Stable Home were already in protective custody and many had at least one previous shelter and/or foster care placement. Nine percent of the total number of infants referred to the program had multiple placements of 3 or more. Project Stable Home staff worked actively with child protective services caseworkers to identify appropriate placement for children in the shelter and to continue to evaluate the placement throughout the enrollment of the child in the program. Anecdotal stories support the efforts of the staff to identify permanent placements for the infants/children and to maintain placements, whether in the home of the biological parents or in foster care. Based on the initial high risk status of these children for abandonment, the small number of infants with multiple placements was reflective of the program’s on-going efforts in this area.

Although much effort was expended on the evaluation, the small sample size, variability in administering the instruments (both in timing and the staff members who assessed the family) impacted the availability and reliability of the measurements. Changes in child placements added additional complexity to the evaluation effort. The evaluation findings, although not conclusive, provide insight into possible effective intervention strategies. Some of the results are provocative and point to increased areas of exploration and investigation in future evaluations.
INTRODUCTION

Statement of the Problem

National concern has grown over the past 10 to 15 years over the increase in the number of women who are using illegal drugs and/or alcohol during their pregnancy. This usage creates the potential for adverse consequences for their infants during prenatal development and following delivery. In particular concern has focused on the link between female intravenous drug users and the transmission of the human immunodeficiency virus (HIV). AIDS was the fifth leading cause of death for women in 1990. Public Law 100-505, the Abandoned Infants Act of 1988, was signed into law to address the potential increase in orphaned, abandoned and HIV positive children and their concomitant impact on the health and welfare systems. Since the problem of HIV/AIDS is closely connected with substance abuse, Public Law 100-505 also attempted to reduce the impact of perinatal substance abuse on the infant and developing child.

There are many risk factors associated with substance abuse in women. These risk factors include economic deprivation, homelessness, social isolation, a lack of medical and prenatal care, poor nutrition, and a history of physical and/or sexual abuse. Many substance-abusing women have had children placed in foster care or with relatives. Infants and children prenatally exposed to drugs are at risk for multiple behavioral problems, health problems, developmental delays, and neurological deficits. The special needs of these infants and children often make it difficult to achieve permanent placement with caregivers or biological parents who are capable of meeting those needs.

Project Stable Home at Children's Institute International (CII) was developed to achieve the legislative purposes of the Abandoned Infants Assistance Program (AIA) by developing a comprehensive in-home intervention program designed to prevent the abandonment of infants and young children, ages zero to three years, within the Los Angeles area. Infants and young children targeted for services were prenatally exposed to alcohol and/or drugs or were referred due to a positive diagnosis for the human immunodeficiency virus (HIV). For the past four years Project Stable Home has worked actively to develop and deliver comprehensive services to children placed in shelter care and to their biological and/or foster families. The program utilizes both in-home and center-based components. An integral component of Project Stable Home is the sharing by the community in the prevention effort, through collaborative partnerships, education, and integration of services. Project Stable Home, in addition to providing direct services to infants and families, has focused on developing a consortium of public and private organizations that work together to assist infants and families.
Goals and Objectives of the Program

The initial goals and objectives of the program were modified and condensed to more closely reflect the implementation of the program, while still preserving the original intent of the program. The goals are to:

1. Prevent the abandonment of infants, ages 0 to 3, who have been prenatally exposed to drugs, alcohol, and/or to the HIV/AIDS virus by providing early identification and case management services to children in residential shelter care, foster care, placement with relatives, or in the care of their biological parents.

2. Prevent the subsequent abandonment of infants and young children, ages 0 to 3, due to substance abuse and/or AIDS by developing a program for in-home intervention directed at children in placement with relatives or in the care of their biological parents.

3. Prevent the abandonment and/or multiple placements of children, ages 0 to 3, who cannot be placed with biological parents or relatives through the development of a comprehensive foster care and adoptive services support system and permanency planning in conjunction with child protective services.

4. Establish an interagency, interdisciplinary collaborative model to address the multi-faceted needs and maintain comprehensive service delivery to infants and young children, ages 0 to 3, at risk of abandonment who have been exposed prenatally to drugs/alcohol and/or the HIV virus.

5. Improve the medical, developmental, and psycho-social health of targeted children.

The proposal identified the following objectives and planned activities in support of the goals, specifically to:

- Develop an outreach program aimed at pregnant women in high risk populations.
- Provide supportive services to women at risk for abandoning their infants.
- Implement an outreach and in-home visiting program for parents and caregivers.
- Develop a comprehensive family-assessment protocol.
- Provide a comprehensive range of in-home and center-based family preservation services to parents, relatives and caregivers.
- Monitor the physical, developmental, and psychological well-being of infants and children referred for services.
- Identify and evaluate foster placements for infants/children at risk of abandonment.
- Provide comprehensive and on-going training/education for parents, caregivers, adoptive parents, and foster parents.
- Develop collaborative relationships with community agencies.
- Provide cross-discipline training in the area of perinatal substance abuse, pediatric AIDS, abandonment prevention, and interagency coordination.
Case Management

The case management component of the program was implemented by referral. Many of the infants and children entered Project Stable Home through referral to the residential shelter care following removal from the home or as a direct placement from the hospital. This was a change from the original program design which focused more on in-hospital case management and treatment of pregnant women. Project Stable Home clients were almost exclusively infants and young children in protective custody. Case management activities included initial assessment of the child and family, case planning, and monitoring of the infant/family while in placement. Project Stable Home worked closely with residential treatment staff and the Department of Children and Family Services (DCSFS) to identify appropriate placement for the child either with biological parents, relatives or in foster care. Referrals were made to families for services, particularly drug/alcohol treatment, child care, and housing. Services of on-site programs were identified when possible, as well as community resources. Case conferences, weekly team rounds, and interdisciplinary conferences served to coordinate intervention activities.

Once a child was placed with a family, staff continued to focus on the development of a permanent placement for the child. Family needs and/or caregiver needs continued to be assessed. Appropriateness of the placement and general well-being of the child was closely monitored. Staff provided support and advocacy with the courts when needed. Case reviews and conferencing continued throughout the intervention effort.

Intervention Strategies

Strategies for intervention focused on treatment of substance abuse through referral to treatment programs, counseling, and supportive services that facilitate the maintenance of clean and sober living. Knowledge of child development, child rearing, and child care activities were provided in the home and at the Center. Staff worked diligently to improve home environments for children by addressing issues of safety, housing, and general activities of daily living. In-home teaching and homemaker instructions served to improve household management and budgeting. General support by paraprofessional staff was an important strategy that served to engage families in services.

Intervention strategies were available not only to biological parents, but to caregivers, foster families and relative caregivers. Not only did the “target” child benefit from the program, but siblings and other family members as well. Families were involved in the
development of goals and activities for families, participated in decision-making, and generally, partnered with the staff in directing the interventions. The primary focus of the interventions continues to be successful reunification of the family, and if this is not possible, permanent placement for the "target" child.

**Interagency Collaboration**

Coordination of community resources is an important activity of Project Stable Home. Collaboration with community agencies was actively fostered through educational programs, quarterly meetings, resource sharing, and integration of service activities. Project Stable Home provided leadership in coordinating the development of systematic community-wide resources for families enrolled in the program. As part of the educational effort other agencies became involved and supportive of the goals of the program. Quarterly progress reports by the Project Director clearly document both the scope and type of collaborative and interagency activities promoted by the program.

**Staffing**

The original program model and design was to be implemented by professional staff. Early in the development of the program, staffing was modified to more closely reflect the community. Service delivery was provided through a team approach, including both professionals and paraprofessionals working with the children and families. Each staff position had discrete responsibilities and it was expected that both the professional and paraprofessional staff would provide services for each family enrolled. The Director, Assistant Director (child development specialist), Case Manager, Nurse and Child/Family Therapist were professionally trained staff. Professional staff were responsible for case management, counseling, developmental assessments, health monitoring, and other services. Paraprofessional home visiting staff provided in-home support for the families, demonstrated home-making activities and monitored the safety and progress of the children.

A number of difficulties were encountered with the staffing model, which was modified several times throughout the four-year grant period. Use of a team approach was very effective, but without inter-disciplinary training, vacancies in team members create difficulty with service delivery and continuity of care. Vacancies in positions, particularly the nurse position, resulted in gaps in the documentation of assessments and limited information on the health, growth and the nutritional status of the children. Other
positions were vacant for several months creating similar difficulties in collecting data, maintaining records, and continuity of services. This impact was most acutely felt in the evaluation effort and affected both the design and the reliability/validity of the assessment data.

Services

The services that comprised the core components of Project Stable Home were:

- **Multi-discipline intervention teams** consisting of professionals and paraprofessionals from the community providing outreach, education, referrals, assessments, and counseling services.

- **Home-based community services** as well as Center-based services.

- **Interagency collaboration** for service coordination and service development as well as general education on the needs of the target population.

- **Culturally sensitive and appropriate interventions** consistent with the cultural and ethnic make-up of the community.

- **Case management** and coordination of services to provide comprehensive service delivery and continuity of care.

- **Legal advocacy and counseling** to facilitate placement of the child with the biological family, if possible, or stable foster/adoptive placement.

- **Referrals to other CII programs for essential services such as child care and drug treatment** as well as to other community service agencies.
Program Theory and Logic Model

The purpose of the evaluation is to examine the effectiveness of Project Stable Home in achieving the goals of the program and addressing the outcomes of Abandoned Infants Assistance Act. Each program has a theory or organizing device that states that the program’s activities will have a certain specified result, either through its direct accomplishments or through some intermediate events. As a result of the program’s activities, certain elements of the problem will be changed or modified. The effectiveness of a program is generally measured by how well it accomplishes its stated objectives. Program effectiveness can be determined by monitoring its activities and testing the program theory.

Many social programs, either implicitly or explicitly, utilize an organizing framework to define the problem and the activities that will result in resolution of the problem.

**ORGANIZING FRAMEWORK**

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Another way of describing the organizing framework for the program would be to develop a Logic Model that looks at the characteristics of the participants, the services, measures of service implementation, and the impact of the services on the clients.

**INPUT \( \Rightarrow \) PROCESS \( \Rightarrow \) INTERMEDIATE OUTCOMES \( \Rightarrow \) IMPACT**

\((ACTIVITIES)\) \(\Rightarrow\) (ULTIMATE OUTCOMES)

An outcome is the result of an activity by program personnel. An activity is simply an effort exerted by program personnel that is then linked to the changes the activities are intended to produce. Program impacts are evaluated by measuring outcomes. An outcome line runs from the basic program activities on the left to the ultimate benefits or outcomes on the right.

The use of a Logic Model assists the program to identify both the process variables and potential outcomes of the program. It provides a graphic summary of how the program
components relate to the whole and makes explicit the program theory, or underlying organizing framework of the program.

Outcomes generally include beneficial outcomes, which are the desired effects and lead to resolution of the problem. Some beneficial outcomes are inherently valued. For example, if drug addiction is reduced then other beneficial outcomes will follow such as employment, housing and/or appropriate parenting. Reduction of drug addiction, therefore, is seen as inherently valuable. In addition to the anticipated beneficial outcomes, the program can have unanticipated outcomes. If these are considered detrimental or undesirable they are usually identified as side effects.

Scaling of program effectiveness redefines impact. It does so in several ways by:

1. comparing of what happened after the program was implemented with what would have happened if there had not been a program. Prevention of the problem is difficult to document quantitatively. Anecdotal stories illustrate the prevention component of Project Stable Home.

2. developing an effectiveness ratio, such as comparing the actual impact of the program to the planned impact of the program.

3. determining an adequacy ratio, i.e. the proportion of the problem eliminated by the program. Placement of children in homes that promote their safety and development and maintaining that placement is the most direct measure of the program’s progress toward eliminating the problem.

Most systematically evaluated social programs have difficulty demonstrating their effectiveness or impact. Often the intervention appears to be too limited within a complex situation to produce a change that is of such magnitude that it is statistically significant. Varied participation in program activities as well as the small number of participants who complete the full program, frequently hampers evaluation efforts to determine effective interventions. Interventions, particularly if based on family needs, will vary dramatically within the same program and the intensity of the intervention effort is difficult to quantify within many service delivery models. Finally, interventions that are demonstrated to be effective may not be able to be generalized to a larger population or may be difficult to duplicate in other locations with different participants. Finally, the strength of an experimental evaluation design based on comparison groups and randomization are often impractical or impossible to execute in most program evaluations.
Many of the concerns mentioned above as being typical of social program evaluations also needed to be addressed in the evaluation design for Project Stable Home. Although the number of participants subsequently enrolled in the program constituted an adequate sample size, the implementation of the program varied based on child and family needs.

**Design and Methodology**

The goal of the original evaluation design was to “document and study the effectiveness of a comprehensive collaborative interagency program to prevent the abandonment of prenatal drug-exposed infants and HIV positive infants”. The design utilized both quantitative and qualitative methodologies to address process and outcome variables based on the program goals and objectives. The quantitative evaluation focused on documenting the process variables, such as the numbers of individuals served and the types of services/activities generated by the program. The qualitative evaluation provided descriptive data of service collaboration, interaction of care providers with the children and family, and illustrated service delivery through the use of anecdotal stories. Outcome evaluation addressed the ultimate outcomes related to infant placement, adequacy and safety of the placement, and the stability of placement. A pre- and post-program design with long-term repeat post measures, as well as comparison groups, was the initial evaluation method developed with the input of Project Stable Home staff.

Based on the goals and objectives of Project Stable Home, a logic model was designed (see Appendix A) describing program theory and planned implementation of intervention activities. The logic model was based on the original program and evaluation design and has been subsequently modified to reflect program changes. The model describes the participants, program services, interventions, and intermediate as well as ultimate outcomes. Input characteristics of the participants of the program, not described in the logic model, included such variables as the initial identification and assessment of the children and families served; child, maternal and family histories; Department of Child and Family Services (DCFS) status; drug use and drug treatment history; and baseline assessments of the child’s development, health and psychosocial status. Program implementation is documented in the model and includes information on program services and participation. Examples of some of the variables tracked include the types of services provided, numbers of families referred, assessments, numbers of case plans developed, numbers of foster families recruited and trained, and numbers/frequency of interagency case management meetings.

In addition to describing the participants and tracking program implementation, a longitudinal design was utilized to document change over time. The initial assessment and evaluation of each infant and family served as baseline data against which repeat measures could be compared. Quarterly monitoring and assessment of the child reflected
the child’s health, development, growth parameters, interaction abilities, and language skills. Evaluation of the child’s progress over time needs to incorporate both the natural development and growth of the child, as well as improvement due to program participation. Initial and repeat assessments serve to establish a trajectory of growth and development against which positive or negative variation from an established trajectory can be evaluated to determine causal relationships. Potential variances from the norm could reflect program intervention efforts, or health status such as illness or hospitalization, or environmental changes such as mother’s return to drug use or entry into drug treatment.

Part of the initial evaluation design also included group comparisons to assess differences in outcomes based on individual or treatment characteristics. Proposed comparison groups initially included mothers and infants in residential treatment versus outpatient treatment; foster placement versus in-home placement; and medically fragile versus term infants. External groups were not available for comparison and the design was modified to explore internal group comparisons only. Internal grouping and comparisons provided opportunities to compare process outcomes of children placed within different family situations, such as biological families, relative care, and other placements. Assessing the impact of program interventions within different family constellations enhances the ability of staff to evaluate the effectiveness of the intervention modality in a variety of natural settings.

The ultimate outcomes or effectiveness of the program is evaluated based on the impact the program had on reducing or ameliorating the problem. Outcome data was collected on the:

- number and length of time of foster placements;
- number of infants reunified with their biological parents/family; and
- the degree to which infant/family needs were addressed by Project Stable Home services.

**Instrument Selection**

In the first year of the Program, extensive meetings with the Program Director and other staff were held to discuss service delivery and data collection. Instruments were selected and protocols established for data collection. Responsibilities for services and assessments were assigned to staff members based on their level of training, for example, the child development specialist completed language and developmental assessments; the nurse assessed health and nutrition; and the home visitor evaluated caregiver-child interaction and the home environment. Assessments were initially to be completed at entry and then on a quarterly basis.
Instruments were selected through a careful review of the literature and other in-home and infant programs. Detailed descriptions of the instruments utilized in the evaluation are included in the section on evaluation results. Instruments predominantly focused on the interaction between infant and family, observation of the home, documentation of family needs, and monitoring of the growth/development of the child.

Multiple assessments and repeat measures were utilized in each domain to measure the dimensions of the concepts and to determine the validity of the findings through repeat measures. Included in Appendix B is a copy of the protocol and the following forms/assessments:

- Initial Screening Form Entry Data (AIA evaluation)
- Six Month Reporting Form (AIA evaluation)
- Newborn Risk Assessment
- Emergency Shelter Care - Infant Behavior Form
- Monitored Parent-Child Evaluation Visit
- Parents Needs Assessment (Spanish and English)
- Mother-Child Relationship Evaluation (Spanish and English)
- Caldwell Observation of the Home Environment
- Attachment Scale (Neonatal Perception Inventory)
- Receptive-Expressive Emergent Language Scale
- Children’s Engagement Questionnaire
- Infant Nutrition Screening
- Home Visit Report
- Observation of Interaction
- Bayley Scales of Infant Development

Evaluation tends to be staff and resource intensive requiring staff time for planning, instrument development, data collection and program modification. Clerical support for tracking essential program information, such as chart organization and services, is essential. To reduce the number of data items to be collected, assessments relevant to clinical management of the cases would also be used for evaluation. Case records, observations, surveys, and assessments of children, families, and of the environment are included.

In order to maximize the degree of accurate information derived from a data collection instrument, efforts were made to identify assessment instruments for which validity and reliability information was available. The development of a protocol for data collection would improve the consistency of the case record. The appropriateness of the instruments used by Project Stable Home for the population to be served was an
important concern in the selection of the instruments. Several of the instruments were available or translated into Spanish. Additional criteria for instrument selection for data collection were that the instrument had to be useful to staff in making clinical decisions and had to facilitate staff’s understanding of the family and their needs.

Data Analysis

Statistical Package for the Social Sciences (SPSS) was used to analyze quantitative data. Q.S.R. NUD*IST (qualitative data analysis software) was used to assist in the analysis of qualitative data, specifically, interviews, case notes, and assessments. A Paradox database documented client characteristics (demographics) and components of service delivery, such as the number of individuals served, type of services, resources, participation, and intervention activities. The evaluation design allows for the assessment of different aspects of the environment and of the parents’ progress in developing parenting skills, the stability and safety of the home, and the degree to which the family environment supports the optimal health and development of the child.

Program Modifications: Effect on the Evaluation Design

Programs need time to establish themselves following funding. It usually takes time to refine the setting, the intervention approach, select the instruments for evaluation, and establish a client base. Collaboration with other agencies also has a normal developmental cycle. In evaluating many collaborative efforts, it is clear that a cohesive and effective approach to services is not established until several years into the program’s development. The process of program development and refinement usually hampers evaluation efforts, particularly during the first two years.

Project Stable Home encountered similar difficulties in the establishment of their services as many other programs. During the four-year grant period many changes occurred, both in program design and implementation, which affected Project Stable Home staff, the clients and the evaluation component. Program modifications occurred particularly in the areas of referral, enrollment, staffing, and service delivery. Based on program needs, the evaluation design was adjusted and simplified. Specific difficulties encountered by Project Stable Home that resulted in program modifications were:

- the selection of clients for enrollment;
- placement of clients for extended periods in the shelter and foster care;
- limited number of children reunified with biological families;
- staffing changes and vacancies;
- chart organization and documentation.
Referral and Enrollment
The Project's original intent was to provide extensive support services in the hospital for biological mothers before and immediately following the delivery of the infant. The purpose of the interventions was to help with the birth recovery process, to address the need for treatment for substance abuse, and to assist the mother to develop her parenting abilities. However, most of the children referred to Project Stable Home, were placed in the emergency residential shelter facility and were not identified in the hospital. Most of the hospital-related information was unavailable at referral. Hospital and pre-delivery interventions were not implemented and were removed from the evaluation design.

Infants enrolled through CII's emergency shelter program also impacted the amount of demographic information available to Project Stable Home. Children were placed in shelter care with little information regarding their birth process or their biological parents. Often the child's and the mother's medical history were not available. Prenatal HIV and/or substance abuse exposure could not be initially verified for all infants. Most infants met the enrollment criteria, but basic referral and demographic information available to staff was limited. If family members were not accessible or willing to engage in the reunification process the program, as initially designed, could not be fully implemented. The enrollment policy was modified and currently Project Stable Home has increased the emphasis on identifying and enrolling children whose parents and/or family are interested in reunification.

Discharges
At discharge, following shelter placement, many of the families in Project Stable Home were not ready for the infant's return and/or could not be located. Many children were moved from shelter placement to foster care. The original program plan included an active service delivery component for foster families. Both the location of the foster homes and the use of foster homes not affiliated with CII's foster care agency hampered implementation of the service component for foster families. Foster families from many different agencies, both within and outside the general service area of Project Stable Home, were used for placement by DCFS. Each individual foster agency offers some training and support for their families. Although extensive services were provided to some of the foster families and children in foster care, most foster families either lived too far away or were actively involved in multiple activities related to both the target child and other children in the home. Relative caregivers were much more receptive to Project Stable Home staff and to services. Many foster families discontinued services early and baseline demographic data, as well as follow-up information, was not routinely collected.

Staffing
The extensive number of assessments identified by the staff initially required both a
significant amount of staff time and the ability to assess/evaluate clients in a reliable and consistent manner. Recruitment of staff for vacancies and subsequent difficulties in filling positions resulted in decreased availability of professional staff for in-home assessment and documentation. The establishment of uniform charting protocols and organization of the chart was an evolving process, made more complex by staffing and organizational changes. Several methods were tried before a complex clinical model was adopted at the end of the second year of program services. Evaluation protocols were subsequently modified and simplified to minimize the amount of demographic information requested at enrollment and to reduce the frequency of comprehensive assessments data to semi-annual, rather than quarterly. Staff was routinely trained on the collection of data and on assessment protocols, to increase the reliability of the data.

Documentation and Chart Organization
Data collection for Project Stable Home was also impacted by policies in other programs within the agency. Each program has its own requirements for confidentiality, protocols for client assessment, and data collection instruments. Information acquired by other programs, such as drug treatment or counseling, was not readily accessible to Project Stable Home staff. CII programs worked actively to address the problem by attempting to develop forms that would allow uniform collection of demographic data and assessment information across agency programs and by developing shared confidentiality agreements. This continues to be a goal and an on-going effort of the agency.

In addition to individual program requirements, professional differences also contributed to an increasingly complex documentation system. Professional and paraprofessional staff, responsible for direct client services, often developed their own methods of recording and tracking information. Most of this was in the form of progress notes. Use of the entry and six-month follow-up forms were considered to be a duplication of effort. These forms underwent multiple revisions and simplification in order to encourage staff usage. Because of the extensive information that was needed for AIA reporting, every effort was made to minimize additional information and concentrate only on collecting the most essential information for the evaluation effort. Forms and schedules, which were not useful to program staff, were revised.

Project Stable home has, as illustrated in the evaluation report and the case study examples, provided intervention services to a large number of families, provided case management, facilitated referrals, encouraged drug treatment and carefully followed the growth and developmental progress of the child. The continuity of care and education that Project Stable Home offers to mothers, fathers, grandmothers, and foster parents promotes understanding of child development and parenting skills. Safety of the child, stability of placement and support for the parents and caregivers are program goals that facilitate positive outcomes for children, parents and families.
Since its inception four years ago, two hundred fifty-five (255) infants were referred for services to Project Stable Home at Children's Institute International (CII). The majority of the infants, 232 (91%) were identified for intervention services by child protective services. Over 80% were placed in the emergency residential shelter at CII, South County Facility and another 11% were placed in foster care homes. The remaining 9% of the referrals came from a variety of other sources such as drug treatment facilities and hospitals.

Infants placed in a shelter facility due to abandonment, abuse and/or neglect, frequently arrive without documentation regarding their birth circumstances or information about the parents. Without access to medical records, it is difficult to obtain information about the child and/or the mother's medical history. Although the following section will briefly describe the children and their parents, the information is limited and much of the data was not retrievable at the time of referral. The families that are described, however, are illustrative of the children and families served by Project Stable home. Their profile is consistent with the literature description of families involved in drug and/or alcohol abuse.

Description of Infants and Families

Infants

Little birth information was available for infants referred to Project Stable Home. The gestational age at birth was unknown for 153 (60%) of the infants and children. Of the remaining 102 (40%), the gestational age ranged from 24 to 43 weeks. One hundred and two infants, 70 (69%) were delivered at term (37 to 41 weeks). Twenty-three infants (30%) were identified as premature (less than 37 weeks) and one infant was post term.

Birth weights were known for 87 infants and ranged from 2 to 11 pounds, with the average weight close to 6 pounds. Nine mothers were identified as HIV positive at delivery, but only three infants were positive for HIV at birth. These children continued to remain positive when their HIV status was reassessed at 15 months. The predominant ethnicity of the children served by the program was African American (51%), followed by Caucasian (24%), Hispanic (20%), and Asian (6%).
Biological Mother

Very little information was known about the biological mothers of many of the infants. Many of the women were not available at the time of referral. Women, for whom descriptive information was collected, constituted approximately 50% of all the referrals. Many of the findings were found to be consistent with the literature on maternal substance abuse and the risk factors associated with drug use. Much of the information reported below is based on historical information gathered from 125 women in the program.

Although a few women were teenagers, most of the mothers were older. Maternal age at referral ranged from 13 years to 47 years, with an average age of 29. Education level varied but usually included some high school. The majority of mothers were unemployed and receiving financial assistance. Income came from predominantly government sources such as SSI, AFDC, or General Relief. A few indicated no source of income, or they relied on relatives and/or their partner for financial support.

Medical care was difficult to obtain for many of the women. Information on prenatal care was available for only forty-one women. Twenty-one of these (approximately half) received some type of prenatal care, but the frequency of care was not known. Only one woman reported receiving prenatal care at the beginning of her pregnancy in the first trimester. Sixteen women indicated that they did not seek prenatal care.

The living situation of the women varied widely. Approximately eighteen women (7%) lived alone and another forty-six (18%) were living with a partner or relative. Forty-one women (16%) were living in some type of institutional setting, such as jails, hospitals for the mentally ill, or in residential drug treatment facilities. Another eighteen women (7%) were homeless.
Although information on the biological mother was often incomplete, the majority of women, one hundred seventy-one (67%) were known to have a history of substance abuse. The following information is based on the 171 women for whom substance abuse information and drug treatment history was available. Additional information was limited regarding the drug of choice and/or the abuse of other drugs, such as prescription drugs, alcohol or tobacco. The women identified a variety of legal and illegal substances, but by far the largest number (54%) indicated that cocaine was their drug of choice. Other drugs identified included amphetamines (17%), heroin or opiates (9%), alcohol (9%) and marijuana (7%). Only 3% reported use of PCP, methadone, barbiturates and/or codeine. Twenty-seven percent of the women were known to be polydrug users and 9% were identified as using alcohol excessively in addition to illegal substances. The findings are consistent with previous descriptive reports published by AIA of the women served. Substance use and abuse are generally underreported.

Treatment status was known for one hundred and twelve women. Eighty-seven women (34%) indicated that they had participated in some type of drug/alcohol treatment but the length of treatment and the type of program was unknown. Twenty-five women (10%) were currently receiving drug/alcohol treatment. Ten were in residential treatment. Overall the length of treatment for women varied greatly, ranging from less than one month to approximately one year. In addition to drug treatment, twenty-five women (10%) reported a history of mental illness, thirty-six (14%) had been physically abused, and thirteen (5%) had been sexually abused.
There were other children in the home, besides the target child, in over two hundred and twenty-five (88%) of the families. The number of siblings ranged from one to twelve, with an average of three children in the home. Prior to being referred to Project Stable Home, other children had been previously removed from the family due to abuse or neglect in 84% of the cases.

Although many of the referred infants had little information available regarding both their medical and family history, where information was known, the family reported financial and housing instability, limited drug treatment, continued drug use (particularly cocaine), limited family resources, and a previous history of abuse and mental health problems. The infants were described as mostly term babies of slightly less than average birth weight, approximately 6 pounds. About one third of the infants were considered premature. Most had siblings in the home. Many of the siblings had been previously removed from the home for abuse and/or neglect.

**Reason for Referral to Project Stable Home**

Multiple reasons were given for placement of the infants in the shelter and for subsequent referral to Project Stable Home. The most common ones included maternal substance abuse (67%), caregiver absence and/or child abandonment (22%), abuse/neglect of the child and/or other children in the home (21%), and voluntary placement of the infant by the mother (18%). Additional reasons for referrals included medical/health problems of the infant (12%), incarceration of mother (9%), residential drug treatment (4%), and maternal HIV status (3%). A small number of infants and young children (9%) had been in foster care homes and had encountered difficulties in foster placement.

At the time of referral to Project Stable Home, the children ranged in age from birth to three years of age, with an average age of 7.5 months. Requests for in-home services for children, who were three years old, were carefully evaluated and referred to other resources as appropriate.

The majority of infants (80%) were enrolled in Project Stable Home while in residential shelter placement. The number of days a child remained in shelter placement varied from one day to 342 days, depending on the reasons for placement. The average length of time the child resided in the shelter was two months.
Graph 3. Reason(s) for Referral for Services

![Graph showing reasons for referral for services]

Services

Project Stable Home initiated services for the infants while they were in the shelter placement. In addition to residential shelter care, a broad range of intervention services was available to infants to facilitate return to parents and/or relatives or placement in foster care. The frequency and type of services provided to infant/children in shelter care are briefly described below. Unless identified differently, all families received at least one of the following services.

Service activities included weekly case review (rounds), case management activities and case coordination, multi-disciplinary team review, home visits, developmental and health assessments of the infant/child, individual counseling for the parent, and linkage to community services. Monitored visits, as well as home visits, were provided for biological parents, relatives, and prospective adoptive or foster parents. Therapy was available for families, including individual counseling, family counseling, and/or marital counseling. Drug treatment services were available through referral to the on-site drug treatment program or to community services. All infants in the shelter received health care on-site provided by the physician and the nurse. Child care was provided on-site, to those who met the criteria for the child care programs, or families were referred to community programs for services. The service plan was individualized for the family based on...
assessment information and identified needs. As a result of developing individualized
service or case plans, there was a significant amount of variation in the type of services
received, as well as the intensity and frequency of services delivered.
A brief summary follows of the services families received. Unless indicated differently, the
following summary reflects the case activity on 255 children.

- Weekly case reviews ranged from one to twenty-three per infant/child, with an average
  of six reviews per child.
- Case management services ranged from one to fifteen, with an average of four per
  child.
- Case coordination activities with other agencies ranged from one to sixty, with an
  average of five case coordination activities per family.
- Multi-disciplinary team reviews of the selected cases were initiated during the last
  year, in addition to case conferencing and weekly reviews, and 37 cases were
  reviewed.
- Case conferences and team meeting were held on a weekly basis to review active cases
  and discuss problem situation.
- Monitored visits ranged from one to forty-five with an average of seven monitored
  visits per case. Monitored visits, which were usually held at the shelter facility, were
  recorded for seventy-seven cases.
- One hundred and twelve families received home visits. The number of home visits to
  families varied from one to twenty-five visits, with an average of eight home visits per
  family.
- In addition, nine mothers had extensive therapy needs and received from one to forty-
  four therapy sessions with an average of thirteen sessions.

Referrals

Assessing both the frequency and number of referrals for clients gives one a sense of the
complexity of the family situation. Over thirty-three different types of referrals were made
for caregivers of the infants/children in Project Stable Home. Depending on family need,
referrals ranged from zero to twelve per family. Some of the more common type of
referrals are described below (see Table I). Referrals were generally based on assessments
such as the Parent Need Questionnaire, the Home Inventory, the Attachment Scale, and
the Observation of Interaction evaluations. Many of the services provided on-site to
Project Stable Home families would not be reflected in the referrals.
### Table I. Referrals

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Care/Day Care</td>
<td>12.0%</td>
</tr>
<tr>
<td>Counseling</td>
<td>6.3%</td>
</tr>
<tr>
<td>DCFS Referral</td>
<td>2.0%</td>
</tr>
<tr>
<td>Developmental Testing/Services</td>
<td>12.6%</td>
</tr>
<tr>
<td>Drug Treatment</td>
<td>10.2%</td>
</tr>
<tr>
<td>Family Support Services</td>
<td>5.0%</td>
</tr>
<tr>
<td>Financial Assistance</td>
<td>1.0%</td>
</tr>
<tr>
<td>Foster Care</td>
<td>11.0%</td>
</tr>
<tr>
<td>Health Care</td>
<td>6.0%</td>
</tr>
<tr>
<td>Housing</td>
<td>2.4%</td>
</tr>
<tr>
<td>Mental Health Evaluations</td>
<td>2.0%</td>
</tr>
<tr>
<td>Parenting Groups</td>
<td>3.0%</td>
</tr>
<tr>
<td>Preschool/School District</td>
<td>2.0%</td>
</tr>
<tr>
<td>Twelve Step/AA</td>
<td>1.0%</td>
</tr>
<tr>
<td>WIC</td>
<td>4.0%</td>
</tr>
</tbody>
</table>
One of the more challenging aspects of the evaluation was arriving at an assessment protocol that was both clinically relevant for the paraprofessional staff, as well as the professional staff, and could also address the outcome components of the evaluation. In addition to the clinical relevance of the assessment, three major factors influenced the consistent implementation of the assessment protocol. These factors were 1) the level of instability and/or crises in the family, 2) multiple placements of the child, and 3) staffing.

Family Situation
Assessment of the child and family was time consuming and required some stability of the family situation. The staff member, who entered the home, was often faced with multiple demands that competed for their attention. Implementation of the assessment protocol in a consistent manner was difficult when the initial purpose of the home visit could be dramatically changed based on the family situation, behaviors or health concerns of the child, and/or the presence of an acute crisis. There were times when either the family and/or the child were not available for the necessary evaluation. Frequent illness of the child, unavailability of parent, frequent moves, or competing family demands necessitated both flexibility and persistence on the part of the home visitor in order to complete assessments.

Placements
Another factor that influenced implementation of the assessment protocol was the placement of the child. If the child was moved from one environment to another, particularly if there were multiple foster placements, some of the family and/or environmental assessments could not be compared longitudinally. Families with foster children also had different needs than the biological parents or adoptive parents. Placements with relatives, such as grandparents, frequently required some modification of follow-up services as well. Many foster parents received services from their foster agencies and had access to health care and information. For example, home making assistance was not needed in foster care families in the same way it was with the biological families. Not only the interventions, but the frequency and type of assessments performed by the staff, varied with the placement and with family circumstances. Based on staff observations, both program implementation and assessments were modified based on the differing needs of foster families and biological families.

Staffing
Changes in staffing influenced protocol implementation, which affected program outcomes. This is not uncommon in program evaluation, particularly when a program is
implemented over a long period of time. Even with repeated staff training on assessments, reliability and validity are influenced by staff changes. Staff preparation also influences the type of interventions and assessments performed. Many of the paraprofessionals had little formal training and none had completed college, although some were enrolled in courses. The professional staff provided supervision and evaluation, but paraprofessional staff performed the majority of home contacts and assessments.

Difficulty in filling some of the vacant positions, particularly the registered nurse position, resulted in modifications of the evaluation. The registered nurse was responsible for many of the home visits and health monitoring information. When the position was not filled, health care services were either provided by the nurse in the shelter or were referred to community services. Health information was recorded, when available, for clinical intervention but was too limited to be utilized in the evaluation.

Focus of the Assessments
Following program implementation, three areas of intervention were consistently assessed and monitored. These areas are:

1. development of the infant/child;
2. home environment and caregiver needs;
3. relationship between the caregiver and child.

Of the multiple assessments described in the evaluation design, that were initially considered for the evaluation, only the following were found to be useful by program staff and were utilized with sufficient consistency to be included in the evaluation.

- Developmental assessments included the Bayley Scales of Infant Development (BSID) and the Receptive Expressive Emergent Language (REEL) evaluation of language.
- Home environment was assessed using the Caldwell Home Observation and Measurement of the Environment (HOME Inventory) and the Parent Need Questionnaire.
- The relationship between the mother (caregiver) and child was evaluated with the Neonatal Perception Inventory (Attachment Subscale), the Mother-Child Relationship Questionnaire, and the Observation of Interaction.
The initial design called for repeat assessments at quarterly intervals. Staff members were only able to consistently evaluate clients at two points in time. Longitudinal analysis was, therefore, not performed and only a baseline and one comparison point were utilized in the analysis. Quantitative data was analyzed utilizing SPSS software and the qualitative data analysis was performed with Q.S.R.NUD*IST software.

Assessment Instruments

The following table describes both type and the frequency of the assessments performed. Detailed description of each instrument and analysis of the results follow this section.

Table II. Frequency of Assessments

<table>
<thead>
<tr>
<th>Development:</th>
<th>Number of Children Assessed (N)</th>
<th>Average Number of Assessments per Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bayley Scales of Infant Development</td>
<td>122</td>
<td>1.4</td>
</tr>
<tr>
<td>REEL (Language)</td>
<td>103</td>
<td>1.9</td>
</tr>
<tr>
<td>Home Environment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caldwell HOME Inventory</td>
<td>106</td>
<td>3.0</td>
</tr>
<tr>
<td>Parent Need Questionnaire</td>
<td>94</td>
<td>1.6</td>
</tr>
<tr>
<td>Parent/Caregiver-Child Relation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attachment</td>
<td>102</td>
<td>2.8</td>
</tr>
<tr>
<td>Mother-Child Relationship Quest.</td>
<td>57</td>
<td>1.3</td>
</tr>
<tr>
<td>Observation of Interaction</td>
<td>117</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Developmental Assessments

Bayley Scales of Infant Development (BSID)

The Bayley Scales of Infant Development is a norm-referenced measure, which provides a measure of the child's developmental status at a given point in time. It provides a comparison of the child's performance with a normative population of children from two
to thirty months of age. The scales have been utilized since 1969 to quantify an infant’s or child’s abilities. Raw scores on the Mental and Motor scales are converted to a Mental Development Index (MDI) and a Psychomotor Development Index (PDI). Both are based on the child’s chronological age. The administration of the instrument also includes a behavioral record of infant or child’s behavior in the testing situation. The MDI, the PDI and the behavioral record are part of the total evaluation of the infants and young children by Project Stable Home staff. Sechrest et al. (1996) has utilized repeat assessments to establish growth curves and determine the increment of change as a component of outcome analysis. Insufficient numbers of assessments per child in the program, as well as the wide variation in the home environment at the different assessments, has resulted in the use of the development scales as a clinical and descriptive instrument rather than as a method to assess program impact.

Development Scores
The BSID was conducted on 122 children initially and, for 41 children, the assessment was repeated approximately a year later. Twenty children were evaluated one additional time between the initial and repeat evaluation. (The result of the interim evaluation has been reported graphically only, due to the limited sample size). The median age of the infants and children at the time of the initial assessment was 8 months of age and 22 months at the last assessment. When initially assessed, seventy-two children (66%) were in emergency shelter care, twenty-one children (19%) were in foster placement, nine children (8%) were with relatives and the remaining eight children (7%) were with their biological mothers. At the later assessment, only one child was in the emergency shelter, twenty-four children were in foster care, nine children were with relatives, and seven children were with their mothers.

Scores on the initial MDI ranged from 50 to 118, with a mean score of 91. The initial PDI scores ranged from 50 to 117, with a mean score of 93. Scores from 85 to 114 are considered to be within normal limits on the BSID. Most of the children were within this range on the MDI (68%) and the PDI (72%). On the initial MDI, 32 children (28%) scored within the mildly delayed range and 4 children (4%) were significantly delayed. On the initial PDI, 28 children (25%) were assessed in the mildly delayed range and 3 children (3%) were significantly delayed.

In subsequent assessments, the MDI scores ranged from 64 to 118, with a mean score of 95. The PDI scores ranged from 60 to 123 with a mean score of 104. BSID assessments indicated that the majority of the children tested continued to be within normal limits on the MDI (71%) and PDI (76%).
Receptive Expressive Emergent Language Scale (REEL)
The Bzoch-League Receptive Expressive Emergent Language Scale (REEL) has been used as a screening tool for language with infants and young children since 1971. It utilizes both parent or caregiver report, as well as observation. It is a relatively simple instrument to use that is suitable for very young children. The test is divided into two-month age-spans with three receptive and three expressive language items in each age range. The child receives a score in receptive language and in expressive language. Receptive language skills, on the average, are usually somewhat better developed than expressive skills.

Language Scores
The REEL Language assessment was conducted on 94 children initially, and for 62 children the assessment was repeated at a later time. The mean age of the infants and children at the time of the initial assessment was 7 months of age and 18 months at the later assessment. When initially assessed, fifty-seven children (64%) were in emergency shelter care, seventeen children (19%) were in foster placement, eight children (9%) were with relatives and the remainder, seven children (8%) were with their biological mothers.
Scores on the initial REEL receptive language assessment (RLQ) ranged from 38 to 400, with a mean score of 122.5, s.d. = 54.3. The initial expressive language (ELQ) scores ranged from 0 to 200, with a mean score of 91.2, s.d. = 34.4. On the later assessment, the RLQ scores ranged from 33 to 150, with a mean score of 99.5, s.d. = 21.9. The later ELQ scores ranged from 57 to 150 with a mean score of 93.4, s.d. = 20.0. Paired t-tests on a subset of 41 children for which both pre- and post-test information was available indicates an improvement in receptive language scores only (t-test = -2.9, p = .007). Expressive language improved, but not a level considered to be statistically significant.

Initial language scores varied with the location of placement (See Graph 5.) Due to the limited sample size no conclusions can be drawn at this time from this observation. Continued exploration of the impact of placement on language development is needed.

**Graph 5. Initial Language Evaluation by Placement**

![Graph showing language evaluation by placement](image)

**Home Environment and Caregiver Needs**

**Caldwell Home Observation for Measurement of the Environment**
The Home Observation is an instrument developed in the 1970's to measure the areas in the home environment that support the development of the child. The six subscales measure different components of the environment. Subscale 1 focuses on assessing the parent (caregiver) emotional and verbal responsiveness to the child. Subscale 2 evaluates
discipline and the use of restriction or punishment by the parent. Subscale 3 measures the ability of the parent to organize the environment and to expose the child to outside stimuli. Subscale 4 evaluates the provision and availability of appropriate play materials in the home. Subscale 5 measures parental involvement with the child, while Subscale 6 assesses opportunities for daily stimulation and interaction with adults.

The total score on the HOME Observation indicates the degree to which the environment is supportive of the child’s growth and development. Scores can range from 0 to 45, with the higher the score, the more appropriate the environment is for development. Questions are formulated to give either a yes or no answer. All ‘yes’ answers are assigned a score of one and ‘no’ answers a score of zero.

**Home Environment Scores**

Eighty children were assessed on the HOME Observation. Average age of the child at the initial observation was 9 months. Fifty-five children were subsequently reassessed. Assessments occurred at three points in time throughout the in-home interventions. The majority of the children were assessed while in foster care (59%), both during the initial assessment and also at the time of reassessment (70%). Scores, on the fifty-five infants who received repeat assessments, demonstrated a consistent and steady increase in scores, reflecting an improvement in home environment.

**Graph 6. Home Environment (N=55)**

HOME Observation Scores, for the above subset of 55 infants, at the initial evaluation ranged from 14 to 44, with an average score of 31 (s.d. = 8.0). At the last analyses (time
#4) scores ranged from 18 to 45, with an average score of 38 (s.d. = 6.3). Paired t-test analysis was used only for the initial and the final evaluation. Time intervals between interim home evaluations varied too greatly for comparison. On the average, the final evaluation was conducted one year following the initial evaluation. This also indicates a subset of infants and families that continued in the program for at least one year. The analysis between time #1 and time #4 indicates a significant improvement in HOME Observation scores between the initial and final evaluation (t-test = -4.7, p = .001).

When the subscales on the HOME Observation were separately evaluated and compared by placement, maternal/paternal involvement with the child scored lowest for biological father and mother when compared to other placements. Provision of play materials appeared to be lowest for the biological father and highest for foster care and the biological mother. Caregiver interaction, emotional/verbal responsiveness, and daily stimulation were consistent among the four groups although the biological mother’s scores were slightly lower. Statistical comparisons were not made due to the limited number of cases in most categories. Based on descriptive data, the initial assessment of the home environment appears to indicate that the environment may vary qualitatively based on the subscale (or area) assessed and the placement of the child. Continued evaluation of the home environment based on category of placement may provide guidance for clinical interventions.

Graph 7. Subscales of Home Environment at Initial Evaluation by Placement (N=80)
Comparison of subscales between time #1 and time #4 for fifty-five infants, indicates significant improvement in five of the six areas evaluated. Areas that improved over time were:

**Subscale 1** - caregiver emotional and verbal responsiveness.
(t-test = -2.3, p = .025)

**Subscale 3** - caregiver ability to organize the environment and provide outside stimuli.
(t-test = -3.3, p = .002)

**Subscale 4** - provision and availability of appropriate play material.
(t-test = -5.6, p = .001)

**Subscale 5** - parental/caregiver involvement with the child.
(t-test = -2.1, p = .045)

**Subscale 6** - opportunities for daily stimulation and interaction.
(t-test = -2.9, p = .006)

Much time is spent encouraging parents and other caregivers to interact with their child and to provide appropriate support and activities that foster growth and development. The only subscale that did not show an improvement in scores was the use of restriction and punishment for discipline. As children grow older, parents and caregivers are more likely to resort to restriction and punishment as a method to control the behavior of the child. Although staff members focused on providing education and guidance in the area of discipline, it continues to be an area in need of emphasis.

**Parent Need Questionnaire**

The Parent Need Questionnaire was developed at Children's Institute International and has been used by a variety of their programs, including their drug treatment program. A summary of the responses to the Parent Need Questionnaire has been included to provide some insight into the home situations and the need for in-home services.

The Questionnaire is divided into three sections covering the parent and/or caregiver's need for more information on **basic child care activities**, the need for **support**, and the need for additional **community resources**. Questions are scored with high scores indicating a greater level of need, for example, 3 = *I need help*, 2 = *Not sure I need help*, and 1 = *No, I do not need help* in the specific area identified. The type of questions included in the instrument are:

- *I need more information about how to feed my child;*
- *I need help handling stress;*
- *I need help finding a place to live, suitable for myself and my child.*
A total number of 38 questions are contained in the instrument and are divided into subscales. No reliability and validity studies have been conducted on the instrument. Answers are based on the parent’s perception of need for help. Subsequent evaluation of parent need may indirectly measure whether previous needs have been met.

**Parent Need Scores**

Seventy-eight caregivers completed the Parent Need Questionnaire, including foster families (58.6%), relatives (13.3%), and biological parents (28.0%). The average age of the child at the time of the initial observation was 7.7 months. Thirty-five parents/caregivers completed the questionnaire at two other points in time. These parents/caregivers including foster parents (60.0%), relatives (14.3%) and biological parents (25.7%). Average age of the child at the time of last parent need assessment was 21.4 months.

Scores on the Parent Need Questionnaire ranged from 38 to 90, with low scores essentially indicating the parent or caregiver’s perception of little or no need for information, support, or resources. High scores indicate needs in almost all areas. The average score was 51.4 (s.d. = 15.5). The area of highest need was the subscale that measured the need for support. The *Need for Support* ranged from 16 to 42, with an average score of 21.8 (s.d. = 7.6). The *Need for Information* ranged from 11 to 29, with an average score of 16.3 (s.d. = 5.3). The *Need for Community Resources* ranged from 0 to 31, with an average score of 13.4 (s.d. = 4.6).

**Graph 8. Parent Need Questionnaire**
There were differences in the level of need reported by relatives/parents and caregivers of children in foster placement. Parents identified a much greater need for basic care giving information initially than foster families. They also identified a greater need for general support, as well. Both parents/relatives and caregivers identified a need for community resources to assist in the care of the child. There were individual family differences and variations in the degree and extent of the need identified. Some families (both foster care and relative/parent) had intense, multiple needs, while other families were more stable with fewer needs and lower parent need scores. It is difficult to determine if lower parent need scores are actually reflective of a lower level of need, or if some families perhaps lack insight into the severity of their need. In general, foster families appear to express less needs initially, but the level of need increases as the child gets older. Biological and relative caregivers have a high level of need initially, but over time their level of need drops to a level similar to foster parents.

During the initial assessment both mothers and caregivers consistently identified the following areas as areas of greatest need:

Table IV. Initial Parent Need Assessment

Information:

- the effects of prenatal drug exposure on the child (51%)
- growth and development of infant (32%)
- crying and fussiness (23%)
- teaching infant (24%)
- health and safety needs of infant (22%)
- playing and talking with infant (22%)
- infant jitteriness (21%)

Support:

- literature on parents with similar child (32%)
- help handling stress (28%)
- talk to other parents (22%)
- talk to counselor (22%)
- more time to talk to doctor (21%)
- more time for self (18%)
- help coping with Child Protective Services or court (18%)
The scores on the subsequent Parent Need Questionnaire ranged from 38 to 98. Although there were some high scores, the average score decreased to 47.8 (s.d. = 14.6). The areas of highest need continued to be:

- **Need for Support** scores ranged from 16 to 41, with an average score of 20.3 (s.d. = 6.8).
- **Need for Information** scores ranged from 11 to 26, with an average score of 13.7 (s.d. = 4.0).
- **Need for Community Resources** scores ranged from 11 to 31, with an average score of 13.9 (s.d. = 4.9).

Biological parents, relative caregivers, and foster parents continued to need assistance for information, support and resources.

Table V. **Parent Need Assessment – Follow-Up**

<table>
<thead>
<tr>
<th>Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>the effects of prenatal drug exposure on the child (27%)</td>
</tr>
<tr>
<td>growth and development of infant (17%)</td>
</tr>
<tr>
<td>teaching infant (17%)</td>
</tr>
</tbody>
</table>
Support:

- more time to talk to doctor (26%)
- literature on parents with similar child (23%)
- talk to other parents (20%)
- help handling stress (17%)
- more time for self (17%)

Resources:

- infant care (27%)
- started on WIC, SSI or AFDC (21%)
- a place to live for self and child (18%)
- finding special services for the child (18%)

For the thirty-five families where pre and post assessment information was available, subscales were assessed for changes in the level of need. The Need for Information was significantly decreased (t-test = 2.76, p = .009), particularly in the areas related to infant care giving. The Need for Support subscale also decreased, particularly the question that indicated a need for support coping with child protective services, but not at a level that was statistically significant. The Need for Resources subscale did not change. Families continued to request assistance accessing additional resources.

Relationship between Infant/Child and Parent/Caregiver

**The Neonatal Perception Inventory, Attachment Subscale**

The Neonatal Perception Inventory, Attachment Subscale is used to evaluate caregiver and child interaction. The instrument evaluates the caregiver response to the infant in a feeding or care taking situation and the child’s response to the caregiver. The instrument allows for both quantitative and qualitative analysis of the interaction.
The quantitative component consists of six questions. Questions are scored from 1 to 4 with four representing a more positive reaction. For example, "When the infant cried, did the mother (caregiver) attempt to soothe?" is scored as 1 = ignored infant; 2 = rarely soothed; 3 = sometimes soothed; and 4 = frequently or always soothed. Possible scores range from 6 (detached) to 24 (very involved). The higher the score the more attentive and "attached" the caregiver appears to be. Consistently low scores of two or less per item would be cause for concern. Questions pertain to:

1) caregiver attentiveness to child,
2) response to child distress,
3) involvement in feeding,
4) demonstration of interest and affection,
5) posture and position while holding child,
6) spontaneous positive interaction such as stroking and cuddling.

In addition to the scored items, observations were noted by the staff member and are descriptive of the interaction and the situation. These comments have been analyzed using qualitative data analysis software.

Attachment Subscale Scores
The Attachment Subscale was conducted on 77 infants initially and for 40 infants subsequently repeated. Median age of infants at the time of the initial observation was 8 months and 14 months at the second observation. Initial scores ranged from 8 to 24, with an average score of 19. Scores at the second observation ranged from 6 to 24, with an average score of 18. Overall scores at both the initial evaluation and subsequent evaluation were consistently high.

In analyzing the mean score for each question (see Table VI.), the scores were generally positive (except for question #3) with scores ranging between 3 and 4. Question #3 received a lower score overall. This question pertains to the observation of the parent (caregiver) in a feeding situation. In particular, it rates the position in which the caregiver holds the bottle and the child. Holding and positioning the bottle and child (as described in the instrument) would not be appropriate for a child over one year of age. Observers, therefore, tended to rate the answer to #3 as a one "did not observe the interaction" or avoided rating the question altogether.
Table VI. Average Attachment Scores

<table>
<thead>
<tr>
<th></th>
<th>Time #1</th>
<th></th>
<th>Time #2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N=77)</td>
<td>(N=40)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>Attentive</td>
<td>3.7</td>
<td>0.7</td>
<td>3.7</td>
<td>0.7</td>
</tr>
<tr>
<td>Response to crying</td>
<td>3.3</td>
<td>1.4</td>
<td>2.8</td>
<td>1.6</td>
</tr>
<tr>
<td>Feeding</td>
<td>2.2</td>
<td>1.9</td>
<td>1.6</td>
<td>1.8</td>
</tr>
<tr>
<td>Interest/affection</td>
<td>3.2</td>
<td>1.2</td>
<td>3.3</td>
<td>1.1</td>
</tr>
<tr>
<td>Holding/posture</td>
<td>3.5</td>
<td>1.0</td>
<td>3.2</td>
<td>1.3</td>
</tr>
<tr>
<td>Positive interaction</td>
<td>3.3</td>
<td>1.0</td>
<td>3.2</td>
<td>1.1</td>
</tr>
</tbody>
</table>

A second analysis was conducted of the Attachment Subscale with question #3 excluded from the comparison. Pre and post test results for forty infants, for whom both assessments were available, demonstrated similar average scores in all questions. The paired t-test indicating no significant difference between scores. Because of the small sample size, inferences are somewhat limited. In other studies the attachment subscale has been valuable in predicting mother-child relationships.

**Mother Child Relationship**

The Mother Child Relationship was developed by Robert M. Roth and has been used since 1961 to help understand the relationship of the mother or caregiver to the child. It includes a series of 48 statements reflecting attitudes towards children and parenting. Parents or caregivers rate each item for agreement/disagreement. Statements may include such items as ‘My child cannot get along without me’, ‘Children should be seen but not heard’, and ‘A child is an adult in a small form’. Each statement is rated from one to five with a rating of one indicating a statement that the parent strongly disagrees with and a rating of five indicative of strong agreement with the statement. Scoring varies depending on the wording of the statement. High scores are reflective of positive parenting behaviors. Scores on the instrument can range from 48 to 240.

In addition to the overall score, the Mother-Child Relationship instrument can generate a separate score in the areas of acceptance and non-acceptance. Non-acceptance is also divided into sections called ‘over-protection’, ‘over-indulgence’ and ‘rejection’. A score can be calculated for each of these subscales. There are 12 items in each of the four subscales with scores ranging from 12 to 60 for each section. For example, an accepting parent or caregiver would have a high score in acceptance and lower scores in over-
indulgence, over-protection, and rejection.

Mother-Child Relationship Scores

Forty-two Mother-Child Relationship Evaluations were completed by twenty-seven foster parents (64.3%), six relatives (14.3%) and nine biological parents (21.5%). Total scores on the evaluation ranged from 125 to 170, with a mean score of 145.7 (s.d. 11.1).

Table VII. Mother-Child Relationship Subscales

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Range</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>acceptance scores</td>
<td>26 to 52</td>
<td>41.2</td>
<td>6.8</td>
</tr>
<tr>
<td>over-indulgence</td>
<td>24 to 47</td>
<td>35.1</td>
<td>5.7</td>
</tr>
<tr>
<td>over-protection</td>
<td>26 to 52</td>
<td>37.5</td>
<td>6.0</td>
</tr>
<tr>
<td>rejection scores</td>
<td>22 to 44</td>
<td>32.0</td>
<td>5.2</td>
</tr>
</tbody>
</table>

When scores were analyzed utilizing One-way ANOVA, no significant differences between the parent, relative caregiver, or foster parent emerged in either the total score or subscales. Individual scores varied widely among the three groups and the group size for both the biological parents and relative caregivers was small. Very large differences between the groups would have to have been present, in order for statistical significance to emerge. Repeat analysis with a larger sample size may provide interesting and different results.

Observation of Interaction

The Observation of Interaction was developed in 1991 at the High Risk Infant, Child and Family Project at California State University, Los Angeles as part of a federal grant. The Observation of Interaction assesses three areas of the interaction process between parent (caregiver) and child. The first section observes the caregiver’s ability to deliberately engage the infant in interaction. A number of questions focus on the skills of the caregiver and his/her ability to read the infant/child cues. The second section evaluates the infant’s capability to engage in interaction with the caregiver in developing a mutual exchange of information and pleasure giving responses. The third section focuses on the infant’s distress and the appropriateness of the caregiver’s response to that distress.

Observing the presence or absence of a particular interaction or response is the method by which the staff assigns scores. All ‘yes’ answers (i.e. facilitating behaviors) are positively scored. Each section is evaluated separately and then summed for a total score.
of caregiver response/infant response. The higher the score the greater the competence of
the caregiver and child in interaction with each other. Total possible score for each
section, the caregiver observation and the child observation, ranges from zero to nine.
Eighty-three parent-child pairs were assessed initially. Fifty-two received a repeat
assessment. A comparison between pre and post assessments was made only for the
fifty-two infants for whom both assessment scores were available. The average age of the
child at the initial assessment was 10 months and, at the subsequent assessment, 21
months. The majority of the infants were in foster placement.

Caregiver scores did not change dramatically. The average score was high at 8.0 initially
for caregivers and remained high. The average scores for the child’s observation of
interaction improved over time between from an initial assessment score of 7.2 to a
subsequent assessment score of 8.2. Paired t-test analysis indicates that the improvement
was statistically significant (t-test = -2.5, p = .015) and demonstrated an improvement in
the infant’s interactive ability. It is difficult to assess the degree to which the program
influenced this change, or if it was a result of the child’s growing maturation. In previous
studies in which this instrument was utilized, competent caregiver’s interactions with a
child resulted in an increase in the frequency of responses of the infant and greater
attempts by the infant/child to engage the caregiver in interaction.

The section on infant/child distress also demonstrated a decrease in scores over time.
Average scores decreased from 2.9 to 2.0, indicating the use of more restriction and
punishment to control behavior. This was similar to the findings in the HOME
Observation. As a child becomes older, caregivers may be more likely to use restriction
and punishment as a method of intervening in distressing situations. This would certainly
be an area to explore in subsequent evaluations. The group used for the analysis is small,
only 34 infants, as not all infants exhibited distress at the time of assessment. Perhaps
infants observed in distress had a more difficult temperament or were more irritable?
Continued assessment with larger groups may yield additional information relevant for
clinical practice.

Caregiver and infant scores on the Observation of Interaction assessment were correlated
with each other and with the age of the child. Caregiver interaction scores correlated
moderately with infant interaction scores (r = .57, p = .001). Subsequent evaluation and
correlation of caregiver interaction scores with infant interaction scores demonstrated a
stronger correlation (r = .85, p = .001). Mutually pleasurable interactions tend to foster
continued responsiveness in the infant. This is not dependent on age. Both initial and
subsequent Caregiver Observation of Interaction scores did not correlate with the age of
the child. The strong association between caregiver competence in interaction and infant
competence indicates statistical support for the mutuality of response and the importance
of both evaluating and supporting both partners in the interaction process.
Qualitative Analysis of Interactions with Parents/Caregivers

A rich source of information on the interaction between the mother (caregiver) and the child came from the comments noted following the observation. Quotes from the comments on the Observation instruments are noted in italics. Staff observed not only mothers in interaction with their infant/child, but also fathers, grandmothers, aunts, and CII caregivers in the shelter. Qualitative analysis of the staff comments provided unique opportunities to identify specific behaviors that support positive interaction between child and mother, as well as highlight the importance of the father in the parenting role.

Behaviors noted during infant care activities focused on mutual pleasure in the interaction of feeding, bathing and holding. Behavior that fostered development was also noted, including play activities, alertness of the infant and ability of the infant to attend to the activity. Observations of staff are noted in italics and interpretations in bold.

Parents
Many positive observations were indicative of interest, concern and mutual pleasure in the interaction between parent and child.

Mother
Mother is very attentive with child. Speaks to him ... in teaching manner describing toys or items.

Mother is very nurturing and observant. Speaks to child in a loving and fun way.

Child and mother interact positively and appropriately. Both initiate interaction with each other.

Mother was bathing child during my observation. There was constant talking and praising.

Child is very playful and alert. Interacts well with both parents.

Father
Father was very attentive to child. I observed at feeding time.

Father was constantly talking to and showing affection for child.

Father responds quickly to infant's distress. Handles (child) gently and soothingly.

Natural father provided constant physical comfort and verbal soothing to infant during today's visit. Good eye contact from infant in response to father's voice and tone.
Observations also allowed in-home visitor to identify interactions which had not progressed to a comfortable stage or which might have been showing the effects of separation. Mothers were attentive and observant, but not as directly engaged with the child as the parents noted above.

*Mother watched child closely but did not engage in play with child.*

*Mother was observant but not involved.*

*Child played on the floor with sister. Parents just watched and did not get involved in the play.*

*Mother was attentive to child but not holding him. She answered questions while child played.*

*Mother sometimes seems distracted, like she is always thinking of something else.*

A few parents were not able to appropriately moderate their behavior in response to infant cues.

*Father does not allow child to exit interaction when he has had enough. Father is constantly trying to engage (child).*

*Mother is attentive and caring, but does not pickup on infant’s cues.*

*Mother does not understand...and continues activities until he (infant) is crying.*

Actual areas of concern were highlighted. These observations, in conjunction with low attachment scores, would identify areas of intervention directed to fostering positive interactions between parent and child.

*Mother never picked child up. I did not see any involvement.*

*Child was playing with brother. Did not pay attention to mother.*

*No interaction between mother and child.*

*Child was more interested in playing around the home than in paying attention to mother.*
**Grandmother**

Comments focused on observations that demonstrated pleasurable and enjoyable interactions, attentiveness of the grandmother, cuddling, rocking, and expressions of mutual pleasure.

- Child is very attached to grandmother. She always looks around and is touching and reaching for her.

- Child was crying a little because it was near bedtime, but grandmother soothed her by holding her and rocking her. She is very loving toward child.

- Child is really attached to grandmother. She cried every time grandmother was not close to her.

- Child smiles when grandmother talks to her, but also when biological mother does.

- Grandmother still interacted with child while cleaning and cooking.

The need for continued support, particularly with elderly grandparents, also became evident when observing interactions.

- Grandmother is deaf so a lot of her interaction with the child is nonverbal.

- Grandmother is elderly and uses cane to walk around, but does seem to handle child (well).

**Foster Parent**

Foster parents demonstrated many loving and attentive behaviors to the children in their care.

- Foster mom seemed to be very interested in child's educational growth and is fascinated by the playful activities kids engage in.

- Foster mom is very caring. She invests in equipment and learning tapes.

- Foster mom talked to her constantly. Always praising qualities.

- Foster mom lets her explore, does not crowd her, but always keeps a close eye on her.

- Child very attached to foster mom. Will not let others touch her.

- Foster mother observed play. She only interrupted play when child was being unfair to other children.
Although most of the foster parents were actively involved with the children in their care, responding affectionately and fostering development, some foster parents also required intervention and support.

Infant was not very alert and foster mom was....observant but not really interested.

Foster mother is not interacting with child.

Foster mother does not demonstrate affection. Does not seem very involved with children.

Foster mother does not initiate contact with child and he is more attached to the other foster children in the home than he is to the foster mother

Foster mother was not involved. She was simply FEEDING the baby.

**Infant’s Ability to Interact with Caregivers**

Qualities of the infant are also important in shaping the interaction process and reinforcement by the parent (caregiver) of the child’s interaction attempts are crucial in maintaining the process of communication.

Child initiates a lot of interaction and his vocalizations are positively reinforced by caregiver.

Child is starting to interact with me (observer). This visit she said a couple of words to me.

He is running and talking and overall very happy.

Child smiles a lot when foster mother talked to her.

Child initiates many of the interactions.

Child is very playful and alert.

Child laughs a lot and enjoys interacting with others around him.

Absence of the positive response in the child is more striking and may result in a general decrease in interaction between the parent/caregiver and the child.

Caregiver talks to infant often but child does not respond.

Infant was not very alert.
Infant did not seem alert or attentive. Very sleepy.

Infant still does not look at caregiver for too long.

Regardless of the infant/child's capabilities, the parent (caregiver) response was crucial in mediating the situation.

Child became distressed because she was tired and hungry. Foster mother held and fed her and talked to her in a soothing fashion.

Child likes to be comforted but she does not look at the caregiver. However, she wants to be held, especially in the presence of strangers.

Child is responding to caregiver in a better way since the last observation.

Child became distressed because she was hungry and it was close to her morning nap. The caregiver rocked her until she could prepare a bottle.

She was very good at calming her.

Parent/caregiver and child interaction is a major focus of the intervention efforts of Project Stable Home. Communication and the facilitation of positive interactions are emphasized during home visits and in clinical situations. Additional interventions are also directed toward education on a variety of topics such as activities that foster the child's development, growth, health, and nutrition.

Mother (has) been attentive and concerned. Asked nutritional and growth questions.

Aunt was very observant and asked lots of questions. Child was congested with a cold but was still alert and playful.

She asks questions when in doubt and always appreciates suggestions.

Very concerned foster mother. She plays (with child) and encourages floor play for muscle exercise.

I like the way she is always talking to the baby.

Father was very attentive to child. I observed feeding time and father was constantly talking .... No educational or developmental toys were seen.
Families discontinued services with Project Stable Home for a wide variety of reasons. At this time 206 families have discontinued services or have completed services. Forty-nine families continue active in the program as of October 1997. A brief summary of the still active cases indicates that the children range in age from 5 months to 40 months, with an average age of 20 months. Many have been in the program from birth and average approximately 14 months of services. Sixteen children are with their biological parents (32%) and eight children (16%) are with relatives. Two children continue in emergency shelter care and the remaining twenty-three children (47%) are in placement with foster families.

The following section will summarize basic information on the 206 infants/children who are no longer in the program. Age of the child at discharge from Project Stable Home varied from one month to 3 years of age. On the average, the age of the child at discharge was 18 months. Infants were enrolled in the program for services from one month to forty months with an average time in the program of nine months. Placements varied at the time of discharge. One hundred nineteen children (58%) have been placed with parents, family members, or in adoptive homes, while eighty-one children (39%) are in foster homes. Six children are in residential placement.

Table VIII. Placement of Child at Discharge

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother (only)</td>
<td>30</td>
<td>15%</td>
</tr>
<tr>
<td>Father (only)</td>
<td>12</td>
<td>6%</td>
</tr>
<tr>
<td>Both Parents</td>
<td>19</td>
<td>9%</td>
</tr>
<tr>
<td>Adoptive Parents</td>
<td>13</td>
<td>6%</td>
</tr>
<tr>
<td>Relative</td>
<td>45</td>
<td>22%</td>
</tr>
<tr>
<td>Foster Care Home</td>
<td>81</td>
<td>39%</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>206</td>
<td>100%</td>
</tr>
</tbody>
</table>
The most common reasons for discontinuing services early was lack of family availability and/or children no longer met service criteria. Parents moved frequently, often out of the service area, and were subsequently lost to follow-up. Foster families, who no longer perceived a need for services or felt that adequate services were being provided by other agencies, also tended to discontinue services. Occasionally children were referred to other programs for special services and/or special needs.

Table IX.

<table>
<thead>
<tr>
<th>Reasons for discharge from Project Stable Home</th>
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<tbody>
<tr>
<td>Valid</td>
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</tr>
<tr>
<td>Not closed</td>
</tr>
<tr>
<td>3 years old</td>
</tr>
<tr>
<td>Services refused</td>
</tr>
<tr>
<td>Out of area/moved</td>
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<tr>
<td>Difficult/unable to locate</td>
</tr>
<tr>
<td>Deceased</td>
</tr>
<tr>
<td>Services from other program</td>
</tr>
<tr>
<td>No longer met criteria</td>
</tr>
<tr>
<td>Shelter services</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Placements

An area of both national and program concern is the impact of the number of changes in placement on the infant. The literature substantiates that frequent changes in placements are often detrimental to the child's growth, development and overall well being. Infants with multiple placements are considered to be at much greater risk for subsequent emotional and behavioral problems. The majority of infants referred to Project Stable Home were already in protective custody. Many had at least one previous shelter and/or foster care placement. Project Stable Home staff worked actively with DCFS caseworkers to identify appropriate homes for children in the shelter and to continue to evaluate the placement throughout the enrollment of the child in the program. Anecdotal stories support the level of effort staff members invested in identifying permanent placements for the infants/children and in maintaining these placements, whether in the home of the biological parents or in foster care. Based on the initial evaluation, these children were at high risk for abandonment. The small number of infants with multiple placements was reflective of the program's on-going efforts in this area. Although 49 infants are still in the program, they are included in the Table X, which describes the frequency of placement of children enrolled in Project Stable Home.
Table X. Number of Placements after Entry to Program (N=255)

<table>
<thead>
<tr>
<th>Placements</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>48</td>
<td>18.8%</td>
</tr>
<tr>
<td>One</td>
<td>150</td>
<td>58.8%</td>
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<td>Two</td>
<td>35</td>
<td>13.7%</td>
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<tr>
<td>Three</td>
<td>12</td>
<td>4.7%</td>
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<tr>
<td>Four</td>
<td>5</td>
<td>2.0%</td>
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<tr>
<td>Five</td>
<td>5</td>
<td>2.0%</td>
</tr>
<tr>
<td>Total</td>
<td>255</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Because of the small numbers, comparative analysis is not feasible, but subsequent tracking of children with three or more placements may provide interesting qualitative information and case studies. Several anecdotal stories have been included, both to highlight the complexity of the family situations and the severity of need in addition to illustrating the intensity of the intervention effort.

**Anecdotal Stories**

**Case #220**

Ms. D self-referred to Project Stable Home, while attending a CII parenting/recovery group. Her son had tested positive for cocaine at birth. The initial attraction for Ms. D. was the belief that the ongoing in-home support of the program could increase the likelihood of being granted probationary custody of her son, who was in foster care. The infant’s social worker recommended a sixty-day probationary, custodial period for Ms. D. and her son, after Ms. D enrolled in Project Stable Home. The initial goals were to assist her in establishing financial support and to provide her with a better understanding of her son’s needs, particularly her son’s developmental delays and special medical care needs. Staff members were successful in initiating contact between Ms. D. and the foster care agency responsible for providing care for her son. Ms. D. began receiving financial support shortly after the initial needs assessment indicated that this was a priority concern. A toddler bed was purchased with Project Stable Home emergency funds.
The in-home service worker continues to provide bimonthly in-home supportive services focusing on child development and parenting skills.

Case #188

Baby J. was enrolled in Project Stable Home when she was three weeks old. Both Baby J. and her mother are deaf. At the time of the baby’s birth, the mother tested positive for cocaine. The infant was detained by child protective services (DCFS) and brought to the shelter at CII for interim care. During placement in the emergency shelter, Project Stable Home’s case manager coordinated her care. The case manager monitored visits for the infant’s relatives, developed a working relationship with the infant’s child protective services case worker, and had the infant carefully evaluated and screened for developmental delays. The case manager also worked actively to engage the biological mother in drug treatment and in a support group for the hearing impaired.

After a brief stay at the emergency shelter, the infant was placed with her biological grandmother, who was also hearing-impaired. A great deal of time and effort was expended to ensure proper care for the infant. When it became clear that the placement was not in the best interest of the child (and her 3 year-old sibling) Project Stable Home staff played a crucial role in identifying suitable placement. The children are presently being cared for in a foster home where both parents are deaf and use American Sign Language. Their teenage daughter, who is not hearing impaired, also uses sign language. The collaboration between Project Stable Home and child protective services (DCFS) was essential in developing a successful transition and stable placement for the infant and sibling.

Case #251

Baby G. was a four day old female when referred to Project Stable Home. Toxicology screening at birth came back positive for cocaine. After five days in the shelter, the infant was discharged home in the care of her biological father. This is Mr. G.’s first child. Mr. G. is a recovering addict with at least four years sobriety. His primary need, as a beginning parent, was for information on normal child development. As this was his first endeavor at parenting, he was a little anxious at the prospect of rearing a little girl. In addition to providing him with a frame of reference for child development, the Project Stable Home in-home service worker assisted him in obtaining his daughter’s birth certificate and social security card. He was referred to a support group for single fathers, in which he is now an active participant. Mr. G.’s response to Project Stable Home’s services has been very positive, and he verbally expresses his appreciation. On occasion he will visit the agency with his daughter to update Project Stable Home on their progress.
Case #89

Baby S. was admitted to the shelter at CIU at the age of five days and referred to Project Stable Home. She and her mother tested positive for cocaine at her birth. Baby S.'s mother did not receive prenatal care and was homeless throughout her pregnancy. While pregnant, the mother smoked cigarettes, used methamphetamine and alcohol daily, as well as frequent use of cocaine. Mother was referred to a drug treatment program, when she exhibited hallucinatory and delusional behavior, during a monitored visit with her daughter.

Baby S. was placed in foster care while mother subsequently enrolled in a residential treatment facility. While in treatment, Baby S.'s mother enrolled in college and worked part-time. After about a year, mother and baby were reunited and resided together in residential treatment. Mother progressed to a sober living environment. At that time she requested that Project Stable Home discontinue services due to her busy schedule, i.e., work, school, and treatment. The in-home service worker made a closing visit with the needed referrals for childcare for Baby S.

Two months later mom called to re-open the case with Project Stable Home. She realized that she had lost a great support system and referral source. She missed the continuity of contact and wanted to schedule future visits. Baby S.'s mother is now doing well. She is still in school and working on a technical degree in Environmental Studies.

During the most recent visit, Baby S., who is now 2 1/2 years old, performed well on her developmental evaluation. No special problems were noted. Mom is anticipating obtaining custody of her nine year-old daughter, as well. She is experiencing some appropriate anxiety in raising a toddler and a nine year-old. She has enrolled herself in a parenting class to help cope with toddler tantrums. She is also working closely with Baby S.'s school to promote her growth and development.
Summary and Recommendations

Programs need time to establish themselves following funding. It usually takes time to refine the setting and intervention approach, select the instruments for evaluation, and establish a client base. Collaboration with other agencies also has a normal developmental cycle. In evaluating many collaborative efforts, it is clear that a cohesive and effective approach to services is not established until several years into the program's development. The process of program development and refinement is essential in the establishment of a clearly designated target population and in specifying (with significant detail) the objectives of the program and the service activities. Modification and adjustment can be seen as the hallmarks of a program that is sensitive to the needs of the community and flexible in adjusting the program design to meet the needs of the community it serves.

Strengths of the Program

There are strengths that assist a program in overcoming the many challenges and difficulties inherent in designing a comprehensive service delivery system with a particularly difficult client base. CII has a strong presence in the community and has multiple on-site programs complimentary to the services provided by Project Stable Home. The Project was able to access services for families within the agency and within the larger community. It was also able to establish a close working relationships with DCFS caseworkers, which contributed to the stability and the success of many placements. The case manager, an integral part of service delivery team, has been a consistent presence throughout the four years of implementation of the program and has lend both stability and continuity to the in-home service workers. Paraprofessional in-home service workers have established close and supportive relationships with families. The case examples highlight not only the complexity of the family situations and severity of need, but also to illustrate the intensity of the intervention effort. The evaluation results, although not conclusive give valuable insight into the potential benefits of some of the interventions and offer suggestions for future explorations.

Barriers to Implementation and Recommendations

During the four-year grant period many changes occurred, both in program design and implementation, which impacted services and the evaluation component. Program modifications occurred particularly in the areas of referral, assessment, staffing, chart documentation/organization, and in-home service delivery. Based on program modifications, the evaluation design was similarly adjusted and simplified.

The program's development was essentially shaped by its referral base, which was almost exclusively composed of infants and children placed by child protective services.
caseworkers in the residential shelter at CII. The choice of clients was appropriate to the grant criteria and consisted of some of the most difficult cases referred to the agency. The focus on shelter referrals reduced the need for Project Stable Home to develop community referrals. As staff became increasingly oriented towards the children in shelter care, aggressive external outreach into the community for referrals was not developed as a core component of the program until well into the third year.

Recommendation: External outreach into the community for clients would allow increased access to families who are on the edge of dissolution, rather than ones in which the dysfunction has escalated to crisis proportions. This would allow for an expansion and broader implementation of the in-home component of the program. However, the children and families that Project Stable Home described in the evaluation are an integral part of the intent of the Abandoned Infants Assistance Act and in need of the type of service program established at CII. Maintenance of current effort with infants in the shelter whose families are still connected sufficiently to benefit from the intervention services should also be maintained.

Staffing
Staff are essential in shaping the objectives and intervention activities of a program, as they are the key elements of a successful implementation effort. Orientation of staff to home visiting is crucial to the implementation of the home-visiting component. Paraprofessional staff members were comfortable in the community and perceived home visiting as an 'essential' aspect of their responsibilities. Many of the professional staff members were more oriented to center-based services. Implementation of the in-home intervention and assessments component was, therefore, heavily depended on paraprofessional staff.

Recommendation: The families would benefit by expanding the professional service delivery component into the community, not just for assessment purposes such as developmental evaluations, but as an active intervention service, such as in-home counseling and health care.

Clarity of vision and service model
Staff turnover and vacancy, particularly at the Program Director level, resulted in varying interpretation of the program’s vision and goals. Inability to consistently maintain a nurse as a member of the team altered the health component of the program. Modification of the staffing model continued throughout the four years of program implementation and resulted in revision of the service delivery model and the evaluation design. Program and staff changes impacted, at times, both service delivery and continuity of documentation and assessments.

Recommendation: Staff support is essential in the maintenance of a service delivery system that deals with such a difficult client base. Increased attention to staff needs and can reduce the emotional impact of caring for families. Also clear communication with staff around the goals and objectives of the program is another element important in
successfully implementation the program model in which there is staff turnover. This could expand to including a more formally structured orientation program for new staff.

Variability of interventions
It was difficult to systematically quantify the intensity of the intervention effort. Individualized service plans increased the amount of variation in the type of services received by families, as well as the intensity and frequency of services delivered. Varied participation in program activities, as well as the small number of biological parents who completed the full program, influenced attempts to identify effective interventions. In addition, evaluation tends to be staff and resource intensive, requiring staff time for planning, instrument development, data collection and program modification. It can be viewed by many as time-consuming and intrusive, not as a positive attempt to document the effectiveness of the program's intervention strategies. Evaluation efforts may not perceived as being essential to the program implementation and are only reluctantly allocated time and effort by busy staff members.

Recommendation: The initial evaluation design may have been too ambitious. Over the years the number of data elements collected were greatly reduced and only a few assessments relevant to clinical management of the cases were used for the evaluation. Increased funding and commitment of program staff to the evaluation effort would enhance, over time, their ability to identify program activities that are effective. Variability in service delivery is always a difficulty in program evaluation, but continued effort by staff to quantify their efforts could improve the measurement of their efforts.

Access to client information
Access to data is essential for evaluation of the program. Data offer an accurate picture of the client and allow for the establishment of baseline information against which future assessments can be compared. This is particularly important if there is limited access to formal records and information, and reliance on the client to accurately self-report the essential information. Project Stable Home was hampered in collecting descriptive and baseline data by the fact that they did not have access to medical records or family members, particularly biological parents, for over 50% of the children referred to the program. The type of information collected by AIA on biological parents was frequently not available to the program, particularly at referral.

Recommendation: This continues to be a challenging area. As referrals focus on children where the biological family is still available, improvement may be made in gathering baseline information. This will continue to be a challenge for staff.
APPENDIX A

LOGIC MODEL – PROJECT STABLE HOME
# LOGIC MODEL - PROJECT STABLE HOME
(Modified from the Original Goals)

<table>
<thead>
<tr>
<th>GOALS</th>
<th>INTERVENTION (ACTIVITIES)</th>
<th>PROCESS OUTCOMES</th>
<th>ULTIMATE OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prevent the abandonment of infants, ages 0 to 3, who have been prenatally exposed to drugs and/or HIV/AIDS virus by providing early identification and case management services:</td>
<td>Early identification of infants Family need assessment Case planning Case management Case reviews Referrals for services Drug treatment Counseling Monitoring child/family progress Monitoring safety and stability of home</td>
<td># of families contacted through outreach # of children/families identified # of children/families referred to program # of children/families assessed # of children/families enrolled for services Documentation of case plan and reviews Documentation of referrals Case notes on family progress Caldwell Home Inventory to assess home environment, safety and stability DCFS risk assessment</td>
<td>Placements of infants/children Level of reduction in risk status Safety of child</td>
</tr>
<tr>
<td>1.1 residential shelter care 1.2 foster care 1.3 placement with relatives 1.4 care of biological parents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Prevent the subsequent abandonment of infants and young children, ages 0 to 3, who are at risk for disruption or dissolution due to substance abuse and/or AIDS through in-home intervention for children in:</td>
<td>In-home interventions/visits Case management and reviews Child developmental assessment Referrals for services such as child care, financial assistance, etc. Coordination with child protective services Parenting support Parent education Drug treatment/AA Assessment of parent-child interaction Counseling/Therapy Monitoring child/family progress Monitoring home environment Home making activities</td>
<td>Type and intensity of in-home intervention Documentation of counseling sessions Documentation of case management Documentation of case reviews Documentation of referrals Documentation of parent education Attendance at parent support groups/AA Degree of participation in drug treatment services Case notes on family progress Results of development, health, and psycho-social assessments Results of home and parent need assess. Modification of case plan to reflect assessments and progress</td>
<td>Maintenance of child with biological parents/ Degree of improvement in parenting behavior/interaction Parents clean and sober Degree of improvement and/or safety of the home environment Level of reduction of risk and/or maintenance of low risk status Decrease in parent/caregiver needs Child assessments within appropriate range for age</td>
</tr>
<tr>
<td>2.1 placement with relatives 2.2 care of biological parents</td>
<td></td>
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<td></td>
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</tbody>
</table>
| 3. Prevent abandonment and/or multiple placements of children, ages 0 to 3, who cannot be placed with biological parents or relative caregivers through: | In-home visits  
Case management  
Assessments/monitoring of placements  
Case reviews  
Referrals for community services  
Respite care  
Parenting education  
Support for caregivers  
Education on child development  
Counseling for caregivers  
DCFS collaboration/planning  
Assessment of caregiver needs  
Monitoring of home environment  
Assessment of child development, health, psycho-social skills | Documentation of in-home visits  
Documentation of case management services  
Monitoring of child placements  
Documentation of case reviews  
Documentation of frequency and type of referrals  
Documentation of intensity and type of parenting, education and support for caregivers  
Documentation of child development education  
Documentation of counseling sessions (if needed) for caregivers  
Case notes on family progress  
Results of child assessments  
Results of evaluation of home environment  
Frequency of contacts with DCFS  
Documentation of collaboration with DCFS | # of placements per child  
# of children in permanency planning  
Length of time in placement  
Reduction of caregiver needs  
Level of satisfaction with program services  
Child assessments within appropriate range for age |
|---|---|---|---|
| 3.1 permanency planning in conjunction with the DCFS  
3.2 development of comprehensive services for foster/adoptive parent | Agency collaboration/coordination  
Professional networking  
Community networking  
Program resource and service development planning  
Planning for fiscal maintenance  
Community need assessment  
Establishment of Community Advisory Committee  
Education of community agencies and development of linkages | Documentation of members of collaborative network  
Documentation of meetings  
Documentation of networking with professional groups  
Documentation of networking with community groups  
Summary of needs assessment  
Identification of collaborative goals  
Plan for resource and service development | Identification of community and service needs  
Degree to which collaborative has addressed community and service needs |
| 5. Improve medical and developmental outcomes for targeted children | In-Home visits  
Nutrition counseling  
Monitoring growth parameters  
Referrals for well child care  
Monitor immunizations and well child care  
Referrals for assessment and specialized interventions  
Assessment of development  
Developmental education  
Language promotion activities  
Increase infant/child competence in interaction through: interactive parenting  
Mommy and Me classes  
Therapeutic Daycare | Identification of nutritional needs  
Maintenance of growth parameters  
Documentation of immunizations  
Documentation of doctor's visits for well baby care and illness  
Documentation of developmental assessments  
# and type of referrals for special assessment and developmental services  
Attendance of class activities | Progression of child along a stable growth curve  
Progression of development along a stable development curve  
Current immunization status  
Availability of health care  
Improvement in nutrition  
Reduction in incidence of failure to thrive and/or health problems  
Improved language scores  
Improvement interaction scores |
## Schedule of Follow-Up

### Assessments & Forms

<table>
<thead>
<tr>
<th>Intake</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<th>10</th>
<th>11</th>
<th>12</th>
<th>15</th>
<th>18</th>
<th>21</th>
<th>24</th>
<th>27</th>
<th>30</th>
<th>33</th>
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<tr>
<td>Risk Assessment</td>
<td>Hosp/Staff</td>
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<td>Consents/Intake</td>
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<td>(AIA Entry Form)</td>
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<tr>
<td>Home Visit Form</td>
<td>Professional staff will document regular in-home visits and on-going interventions with the infant/child on Home Visit Forms.</td>
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<tr>
<td>Parent Activity Form</td>
<td>Staff will utilize Parent Activity Form to provide information to parent/caregiver about infant/child status, referrals to other services, agencies, etc.</td>
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<td>Progress Notes</td>
<td>Staff will document all contacts with family and other professionals, including additional home visits, phone calls, etc., not documented elsewhere.</td>
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<td>Immunization Sched.</td>
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<td>Bayley or Mich. Sch.</td>
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Key: **RN** = Home visitor (Paraprofessional)  **RN** = Mother  **RN** = Case Manager/Social Worker  **RN** = Psychologist/Social Worker

Adapted from Schedule of Intervention - 1994 Ajin Tsunekers LeSh CSULA/High Risk Infant, Child and Family Project

Schedule 7/94
<table>
<thead>
<tr>
<th>Assessments/Forms</th>
<th>Initial</th>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
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<td>Initial developmental assessment at intake. Remaining Assessments completed according to age of child, e.g. 6 mo., 12 mo., 18 mo., etc.</td>
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All forms (except development and language) are to be completed from date of enrollment in Project.

Adapted from: Tubbeners-Leash, Ph.D. High Risk Infant, Child and Family Project, California State University, Los Angeles

H:\QPDATA\SCHEDULE.WB1 11/11/96
PROJECT STABLE HOME

Initial Screening

DATE: ______________________________________

SCREENER: __________________________________

NAME OF PATIENT: ____________________________

SEX: _____ AGE: _____ DATE OF BIRTH: ____________

ETHNICITY: ___________ PLACE OF BIRTH: ______________

DATE OF ADMISSION: ____________________________

VOLUNTARY OR INVOLUNTARY PLACEMENT? ________________

REASON FOR ADMISSION: __________________________________

____________________________________________________________________

____________________________________________________________________

REFERRED BY: ________________________________________________

CONTACT PERSON: __________________________ PHONE #: ____________

RELATIONSHIP TO PATIENT: ________________________________
TOXICOLOGY SCREEN: (CIRCLE ONE)

- POSITIVE
- NEGATIVE
- PENDING
- NOT APPLICABLE

IF POSITIVE, TYPE OF SUBSTANCE: ________________________________

MOTHER’S NAME: _____________________________________________

AGE: _____ DATE OF BIRTH: _________________________________

ETHNICITY: ____ CURRENT LOCATION OF MOTHER: ______________

MATERNAL RESIDENCE: _______________________________________

PATERNAL INVOLVEMENT: _____________________________________


EXTENDED FAMILY INVOLVEMENT: ______________________________

OTHER INTERESTED PARTIES: _________________________________

SIBLINGS: SEX AGE COMMENTS

________________________________________________________________

________________________________________________________________

________________________________________________________________

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VISITATION HISTORY: ____________________________________________
______________________________________________________________
______________________________________________________________

VISITATION RESTRICTIONS/COURT MANDATES: ________________________
______________________________________________________________
______________________________________________________________

SPECIAL NEEDS:
MOTHER: _______________________________________________________
______________________________________________________________

CHILD: _________________________________________________________
______________________________________________________________

PRIOR DCS HISTORY: ____________________________________________
______________________________________________________________
______________________________________________________________

CURRENT CSW: ______________________ PHONE NUMBER: ____________
PROJECT SUMMARY: (CHECK APPLICABLE CRITERIA)

___ AGE: BIRTH TO 3 YEARS
___ PRENATAL DRUG EXPOSURE
___ CURRENT DRUG USE BY MOTHER
___ PAST DRUG USE BY MOTHER
___ HIGH-RISK: ____________________________

MEETS PROJECT CRITERIA: (CIRCLE ONE)  YES  NO

IF NOT, WHY? _____________________________

________________________________________________________________________

REFERRED INTO PSH (DATE): __________________________

BY: __________________________

CASE # __________  DIRECTOR'S SIGNATURE: ____________________________
### Project Stable Home Entry Data Form

**Target Infant/child date of birth:**
- Month: ___  
- Day: ___  
- Year: ___

**Referral to Project Stable Home:**
- Month: ___  
- Day: ___  
- Year: ___

**Entry to Project Stable Home:**
- Month: ___  
- Day: ___  
- Year: ___

**Age of target infant/child in weeks at entry into Project Stable Home**: [VI.M]

**Sex:**
- 1 = Male  
- 2 = Female

**Source of Referral:**
- 1 = DCFS  
- 2 = Intra-agency  
- 3 = Court order  
- 4 = Drug treatment (outside agency)
- 5 = Hospital/Clinic  
- 6 = Other medical referral  
- 7 = Other social service agency  
- 8 = Other

**Services requested by the referral source:** (Check all that apply)
- In-home
- Emergency care
- Foster care
- Other

**Primary caregiver of target infant/child at time of entry:**[I.A.]
- 1 = Biological mother  
- 2 = Biological father  
- 3 = Foster care - relative  
- 4 = Foster care - non relative
- 5 = Shelter care  
- 6 = Adoptive parents  
- 7 = Unknown

**Open DCFS case on target infant/child at time of entry to PSH?** [VI.G.]
- 1 = No  
- 2 = Yes  
- 9 = Unknown

**Type of DCFS referral on target infant/child:**
- 1 = No DCFS referral  
- 2 = Positive toxicology screen  
- 3 = Abuse of sibling  
- 4 = Neglect of sibling  
- 5 = Abandonment  
- 6 = Other

**Open DCFS case on sibling of this child:**
- 1 = No  
- 2 = Yes  
- 9 = Unknown

**Target infant/child placement at time of entry to PSH:** [VI.J.]
- 00 = Hospitalized  
- 05 = Foster care (Other:)
- 01 = Home with biological parent  
- 06 = Group home/residential care (CII agency)  
- 02 = Pre-adoptive/adoptive home  
- 07 = Group home/residential care (Other:)
- 03 = Home with relative  
- 08 = Residential treatment with biological parent  
- 04 = Foster care (CII agency home)  
- 09 = Other:

**Hospital Protective Hold on target infant/child?** [VI.I.]
- 1 = No protective hold  
- 2 = Protective hold - parent unavailable  
- 3 = Protective hold - parent unable/unwilling to care for child  
- 4 = Protective hold - other:

**Source of DCFS referral:**
- 1 = No DCFS referral  
- 2 = Hospital  
- 3 = Family member
- 4 = Other

---

*Project Stable Home/CII*
Parent Demographics: Biological Mother

Source of information: _Mother_ _Father_ _DCS_ _Family member_ _Other_ ____________

Date of birth:
Month _ _ Day _ _ Year _ _ (99= UNK)

Age [II.E.] (99= UNKNOWN)

Marital Status 9= Unknown  
1= Single - never married - no partner  
2= Single - never married - currently has partner  
3= Married/remarried - lives with spouse  
4= Separated/divorced - no current partner  
5= Separated/divorced - new partner  
6= Other __________________________

Current partner is biological parent of target infant/child  
0= No current partner  
1= No 2= Yes  
9= Unknown

Ethnicity [II.A.] 9= Unknown  
1= African American/Black  
2= Asian/Pacific Islander  
3= Hispanic/Latina  
4= White - not of Hispanic origin  
5= Native American  
6= Bi-racial __________________________  
7= Other __________________________

Primary Language 9= Unknown  
1= English  
2= Spanish  
3= Chinese  
4= Other Asian  
5= Other __________________________

Highest level of education completed [II.C.] 9= Unknown  
1= 8th grade or less [II.D.]  
2= Less than high school graduation  
3= High school or GED  
4= Trade school  
5= Some college  
6= 2 or 4 year college or more

Sources of income: [II.D.] (Indicate all sources.)  
1= NO; 2= YES; 9= UNKNOWN  
- Employment earnings  
- Unemployment benefits  
- AFDC  
- Social Security Disability Insurance  
- Supplemental Security Income (SSI)  
- Foster care payments  
- Medi-Cal  
- Housing subsidy/public housing  
(Include Section 8 housing, vouchers or grants for housing assistance, not temporary housing such as homeless shelters or residential treatment.)  
- WIC  
- Food Stamps  
- Other: __________________________

Household income -- monthly cash income [II.E.] (Do not include Food Stamps, MediCal, etc.)  

# of other children in household [I.B.]  
# of other adults in household [I.A.]  
Total # of individuals in household [I.A./B.]
MOTHER'S DRUG/ALCOHOL HISTORY

Reported drug use at intake/first assessment:

[III.H.] 1 = No; 2 = Yes; 9 = Unknown
- Alcohol
- Amphetamines
- Barbiturates
- Cocaine
- Crack
- Marijuana
- Methadone
- Opiates/Heroin
- PCP
- Tobacco
- Other

Reported polydrug use [III.I] 9 = Unknown
1 = No reported use of above substances
2 = Used one of the above substances
3 = Used two or more of the above substances (excluding alcohol and tobacco)

Substance abuse treatment/recovery status at time of intake. [V.] 9 = Unknown
0 = Not a substance abuser.
1 = 1 month or less in treatment/recovery
2 = 1 to 6 months in treatment/recovery
3 = 7 to 12 months in treatment/recovery
4 = 13 to 18 months in treatment/recovery
5 = 19 months/more in treatment/recovery
6 = Substance abuser but not in treatment

Drug/alcohol history of maternal family
(Reported history or treatment at time of entry/initial assessment.) Indicate family member and drug/alcohol used if known.
1 = No; 2 = Yes; 9 = Unknown
- Mother's sibling: __________
- Mother's parent: __________
- Mother's grandparent: __________
- Other relative: __________

MENTAL HEALTH/ABUSE HISTORY

Psychiatric history of mother's family:

[III.E.] (Known history/ diagnosis/ hospitalization for a psychiatric problem excluding drug/alcohol treatment. Indicate family member and diagnosis)
1 = No; 2 = Yes; 9 = Unknown
- Mother's sibling: __________
- Mother's parent: __________
- Mother's grandparent: __________
- Other relative: __________

Physical abuse of mother: current

[III.F.] 9 = Unknown
1 = Mother is not currently in a physically abusive relationship.
2 = Mother is currently in a physically abusive relationship.

Physical abuse of mother: past history
1 = No physical history of being physically abused.
2 = Mother has a history of being physically abused.
9 = Unknown

Maternal history of sexual victimization:

[III.G.] (Reported history of sexual abuse/assault as a child/adult, or raped.)
1 = No reported history of sexual abuse/assault.
2 = Reported history of sexual abuse/assault:
9 = Unknown.

Maternal history of being removed from her home due to abuse/neglect:
1 = No reported history of being removed from home as a child.
2 = Reported history of being removed from home as a child.
9 = Unknown.

Mother has history of child abuse or neglect of previous children: [III.B.]
0 = Not applicable; target infant is first child.
1 = No prior history of abuse/neglect of previous child/ren.
2 = Prior history of abuse/neglect of previous children; child/ren were not removed from home.
3 = Prior history of child/ren being removed from home due to abuse/neglect.
9 = Unknown

Source of information:  __ Mother     __ Father
                     __ DCS      __ Family member  __ Other
**PREGNANCY INFORMATION**

**Biological Mother:**

- Total # of pregnancies (Gravida)
- # of live births (Para)
- # of miscarriages/abortions (SAB/TAB)
- # of premature births
- # of infant deaths
- # of living children

**Prenatal care this pregnancy:** [III.A.]
1 = No prenatal care
2 = Began prenatal care in 1st trimester
3 = Began prenatal care in 2nd trimester
4 = Some care, trimester unknown
9 = Unknown

**Alcohol/Drug use during pregnancy with this child:** [III.C.]
1 = Evidence supporting no use.
2 = Evidence supporting use.
9 = Unknown

**Mother's HIV status:** [III.D.]
0 = Not tested
1 = Known to be HIV negative
2 = Known to be HIV positive
9 = Unknown

**Mother's VDRL status**
0 = Not tested
1 = Known to be HIV negative
2 = Known to be HIV positive

---

**Drug screen at delivery?**
1 = NO; 2 = YES; 9 = Unknown

**Drug Screen Results:** Indicate for each substance.
0 = Not tested; 1 = Tested - negative;
2 = Tested - positive; 9 = Unknown

- Alcohol
- Amphetamines
- Barbituates
- Cocaine
- Marijuana
- Opiates
- PCP
- Other

**Tested at delivery but specific substance unknown**
1 = No; 2 = Yes; 9 = Unknown

**Source of information:**  
Mother  
Father  
DCS  
Family member  
Other
Parent Demographics: Biological Father

<table>
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<tr>
<th>Source of information:</th>
<th>Mother</th>
<th>Father</th>
<th>DCS</th>
<th>Family member</th>
<th>Other</th>
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Date of birth:
Month __ Day __ Year __ (99= UNK)

Age (99= UNKNOWN)

Marital Status
1 = Single - never married - no partner
2 = Single - never married - currently has partner
3 = Married/remarried - lives with spouse
4 = Separated/divorced - no current partner
5 = Separated/divorced - new partner
6 = Other ______________________
9 = Unknown

Current partner is biological parent of target infant/child
0 = No current partner
1 = No 2 = Yes
9 = Unknown

Ethnicity
1 = African American/Black
2 = Asian/Pacific Islander
3 = Hispanic/Latina
4 = White - not of Hispanic origin
5 = Native American
6 = Bi-racial __________________
7 = Other _____________________
9 = Unknown

Primary Language
1 = English 3 = Chinese
2 = Spanish 4 = Other Asian
5 = Other ____________________

Highest level of education completed
1 = 8th grade or less
2 = Less than high school graduation
3 = High school or GED
4 = Trade school
5 = Some college
6 = 2 or 4 year college or more
9 = Unknown

Sources of income: (Indicate all sources.)
1 = No; 2 = Yes; 9 = Unknown

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<tr>
<th>Employment earnings</th>
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<tr>
<td>Unemployment benefits</td>
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<td>Social Security Disability Insurance</td>
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<td>Foster care payments</td>
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<td>Medi-Cal</td>
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<td>Housing subsidy/public housing</td>
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(Sources of income: (Indicate all sources.))

Household income -- monthly

cash payments (do not include Food Stamps, Medi-Cal, etc.)

- # of children
- # of children living with the father
- # of infant/child deaths
- # of children in placement

Father's HIV status 9 = Unknown
0 = Not tested
1 = Known to be HIV negative
2 = Known to be HIV positive
**FATHER'S DRUG/ALCOHOL HISTORY**

Source of information:  
- Mother  
- Father  
- DCS  
- Family member  
- Other  

Reported drug use at intake/first assessment:  
1 = NO; 2 = YES; 9 = UNKNOWN  
- Alcohol  
- Amphetamines  
- Barbiturates  
- Cocaine  
- Crack  
- Marijuana  
- Methadone  
- Opiates/Heroin  
- PCP  
- Tobacco  
- Other  

Reported polydrug use 9 = Unk.  
1 = No reported use of above substances  
2 = Used one of the above substances  
3 = Used two or more of the above substances (excluding alcohol and tobacco)  

Substance abuse treatment/recovery status at time of intake:  
0 = Not a substance abuser  
1 = 1 month or less in treatment/recovery  
2 = 1 to 6 months in treatment/recovery  
3 = 7 to 12 months in treatment/recovery  
4 = 13 to 18 months in treatment/recovery  
5 = 19 months or more in treatment/recovery  
6 = Substance abuser but not in treatment  
9 = Unknown  

Drug/alcohol history of paternal family (Reported history or treatment at time of entry/initial assessment.) Indicate family member and drug/alcohol used if known.  
1 = NO; 2 = YES; 9 = UNKNOWN  
- Father's sibling:  
- Father's parent:  
- Father's grandparent:  
- Other relative:  

**MENTAL HEALTH/ABUSE HISTORY**

Psychiatric history of father's family:  
(Known history/diagnosis/hospitalization for a psychiatric problem excluding drug/alcohol treatment. Indicate family member and diagnosis.)  
1 = No; 2 = Yes; 9 = Unk  
- Father's sibling:  
- Father's parent:  
- Father's grandparent:  
- Other relative:  

Physical abuse of father: current  
1 = Father is not currently in a physically abusive relationship.  
2 = Father is currently in a physically abusive relationship.  
9 = Unknown  

Physical abuse of father: past history  
1 = Father has no history of being physically abused.  
2 = Father has a history of being physically abused.  
9 = Unknown  

Paternal history of sexual victimization:  
(Reported history of sexual abuse/assault as a child/adult, or raped.)  
1 = No reported history of sexual abuse/assault.  
2 = Reported history of sexual abuse/assault:  
9 = Unknown.  

Paternal history of being removed from his home due to abuse/neglect:  
1 = No reported history of having been removed from home as a child.  
2 = Reported history of having been removed from home as a child.  

Father has history of child abuse or neglect of previous children:  
0 = Not applicable; target infant is first child.  
1 = No prior history of abuse/neglect of previous child(ren).  
2 = Prior history of abuse/neglect of previous children; child(ren) were not removed from home.  
3 = Prior history of child(ren) being removed from home due to abuse/neglect.
FOSTER CAREGIVER DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Age</th>
<th>(99 = UNKNOWN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>African American/Black</td>
</tr>
<tr>
<td>2</td>
<td>Asian/Pacific Islander</td>
</tr>
<tr>
<td>3</td>
<td>Hispanic/Latina</td>
</tr>
<tr>
<td>4</td>
<td>White – not of Hispanic origin</td>
</tr>
<tr>
<td>5</td>
<td>Native American</td>
</tr>
<tr>
<td>6</td>
<td>Bi-racial</td>
</tr>
<tr>
<td>7</td>
<td>Other</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
</tr>
<tr>
<td>Primary Language</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>English</td>
</tr>
<tr>
<td>2</td>
<td>Spanish</td>
</tr>
<tr>
<td>3</td>
<td>Chinese</td>
</tr>
<tr>
<td>4</td>
<td>Other Asian</td>
</tr>
<tr>
<td>5</td>
<td>Other</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
</tr>
<tr>
<td>Highest level of education completed</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>8th grade or less</td>
</tr>
<tr>
<td>2</td>
<td>Less than high school graduation</td>
</tr>
<tr>
<td>3</td>
<td>High school or GED</td>
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<tr>
<td>4</td>
<td>Trade school</td>
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<tr>
<td>5</td>
<td>Some college</td>
</tr>
<tr>
<td>6</td>
<td>2 or 4 year college or more</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
</tr>
<tr>
<td>Living situation at time of infant/child’s entry to PSH</td>
<td></td>
</tr>
<tr>
<td>01</td>
<td>Lives with no other adult</td>
</tr>
<tr>
<td>02</td>
<td>Lives with child’s mother/other sexual partner</td>
</tr>
<tr>
<td>03</td>
<td>Lives with own parents/other relatives</td>
</tr>
<tr>
<td>04</td>
<td>Lives with non-relatives</td>
</tr>
<tr>
<td>05</td>
<td>Residing in residential treatment</td>
</tr>
<tr>
<td>06</td>
<td>Homeless/street/transient</td>
</tr>
<tr>
<td>07</td>
<td>Residing in homeless shelter</td>
</tr>
<tr>
<td>08</td>
<td>Residing in domestic violence shelter</td>
</tr>
<tr>
<td>09</td>
<td>Residing in Single Room Occupancy hotel (SRO)</td>
</tr>
<tr>
<td>10</td>
<td>Residing in supported living situation (eg: group home for HIV, sober living, etc.)</td>
</tr>
<tr>
<td>11</td>
<td>Incarcerated</td>
</tr>
<tr>
<td>12</td>
<td>Other</td>
</tr>
<tr>
<td>99</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

Infant/Child Name: _______________________

Sources of income: [II.D.] (Indicate all sources.)
1 = No; 2 = Yes; 9 = Unknown

- Employment earnings
- Unemployment benefits
- AFDC
- Social Security Disability Insurance
- Supplemental Security Income (SSI)
- Foster care payments
- Medi-Cal
- Housing subsidy/public housing
  (Include Section 8 housing, vouchers or grants for housing assistance, not temporary housing such as homeless shelters or residential treatment.)
- WIC
- Food Stamps
- Other: _______________________

Household income -- monthly cash income [II.E.] (do not include Food Stamps, MediCal, etc.)

- # of children in home [I.B.]
- # of other adults in home [I.A.]

Case #: ____________________________
### INFANT/CHILD CHARACTERISTICS

**Target infant/child ethnicity:**
- 1 = African American/Black
- 2 = Asian/Pacific Islander
- 3 = Hispanic/Latino
- 4 = White – not Hispanic
- 5 = Native American
- 6 = Bi-racial
- 7 = Other
- 8 = Hispanic/Latino
- 9 = Unknown

| Gestational age at delivery in weeks [VI.B.] | 99 = Unknown |
| Birth weight in grams [VI.C.] | 9999 = Unknown | (Lbs/Oz: ) |
| Length at delivery in centimeters (99.9 = Unknown) | (Inches: ) |
| Head circumference in centimeters (99.9 = Unknown) |
| Apgar score at 1 minute (99 = Unknown) |
| Apgar score at 5 minutes (99 = Unknown) |
| Weight at discharge (grams) (9999 = Unknown) |

**HIV status at delivery [VI.D.]**
- 1 = Not tested
- 2 = Not HIV positive
- 3 = HIV positive
- 9 = Unknown

**VDRL status at delivery**
- 1 = Not tested
- 2 = Not VDRL positive
- 3 = VDRL positive
- 9 = Unknown

**Drug screen results:**
- 1 = Not tested
- 2 = Negative
- 3 = Positive
- 9 = Unknown

- Cocaine
- Amphetamines
- Opiates
- Alcohol
- Barbiturates
- PCP
- Marijuana
- Other

**Neonatal Problems in the Hospital:**
- 0 = None
- 1 = Yes
- 9 = Unknown

- Medical problems in the hospital after delivery

- On medications: Type/reason

- On special equipment: Type/reason

- Needs specialists care: Type/reason

- Physical malformations/defects

- Neurological problems

- Feeding problems

- Special Formula

- Other
Case #:

Infant/Child Name:

General Health Status at Entry: (0 = None; 1 = Yes; 9 = Unknown)

Medical problems

On medications: Type/reason

On special equipment: Type/reason

Needs specialists care: Type/reason

Physical malformations/defects

Neurological problems

Feeding problems

Special Formula

Other

Form completed by ________________________________ Date: ________________

Updated: Date ___________ Initials _______ Date ___________ Initials _______

Date ___________ Initials _______ Date ___________ Initials _______
PROJECT STABLE HOME -- SIX MONTH REPORTING FORM

Age of child in months at time of this report: Use lead "0" if necessary.

Target infant/child placement at this time [VI.K.1]
0 = Hospitalized
1 = Home with biological parent
2 = Pre-adoptive/adoptive home
3 = Home with relative
4 = Legal guardianship
5 = Foster care home
6 = Treatment/specialized foster care home
7 = Group home or residential care
8 = Residential treatment with biological parent
9 = Unknown

Target infant/child placement involving Child Protective Services supervision: [VI.K.2.]
0 = No DCS supervision
1 = Open DCS case
2 = Closed DCS case
9 = Unknown

CDA involved with target infant/child. 1 = No; 2 = Yes; 9 = Unknown

Number of placements in past six month period.

Number of days in each placement in past 6 months: (Use lead "0" where necessary: eg: 24 days = 0 2 4; 999 = Unk

Target infant/child HIV status at 15 months (i.e., after sero-conversion may occur) [VI.E.]
1 = Not HIV-infected
2 = HIV-infected
9 = Unknown

Target Infant/child's protective services referral -- at time of termination: [VI.H.]
0 = Target infant/child continues in Project.
1 = No protective services referral made at any time while in Project.
2 = Protective services referral made while in Project.
9 = Unknown

If case has been closed, give reason: [VII.A.] 9 = Unknown
1 = Services completed
2 = Caregiver chose to terminate services
3 = Client moved out of the service area
4 = Whereabouts unknown/unable to contact
5 = Client referred to another agency
6 = Client transferred to another agency
7 = Client deceased
8 = Other

Total number of months in Project Stable Home. [VII.B.] (Use lead 0's: 007 = seven months in Project.)

Substance abuse treatment/recovery status of biological mother (at most recent assessment or at termination) [V.]
0 = Not a substance abuser
1 = 1 month or less in treatment/recovery
2 = 1 to 6 months in treatment/recovery
3 = 7 to 12 months in treatment/recovery
4 = 13-18 months in treatment/recovery
5 = 19 months or more in treatment/recovery
6 = Substance abuser but not in treatment
9 = Unknown
In the past 6 month period, while in shelter care, the following services were provided: [IV.A.0.]
(1 = In-home; 2 = Clinic/Hospital; 3 = Neighborhood/community; 4 = Center/Agency; 9 = Unk.)

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<thead>
<tr>
<th>Services</th>
<th>Received</th>
<th>Referred</th>
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</thead>
<tbody>
<tr>
<td><strong>Health Related Services</strong></td>
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<td>Prenatal care</td>
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<tr>
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<td>Pediatric health care</td>
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<td>HIV screening/assessment</td>
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<td><strong>Drug and Counseling Related Services</strong></td>
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<tr>
<td>Out-patient drug treatment</td>
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<tr>
<td>Recovery support (e.g. 12-Step group)</td>
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<tr>
<td>Mental health counseling</td>
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<tr>
<td>Peer counseling (i.e. services not provided by a professional)</td>
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<tr>
<td><strong>Housing, Advocacy and Skills</strong></td>
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<tr>
<td>Vocational/educational assistance</td>
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<tr>
<td>Housing assistance - Homefinding for families</td>
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<tr>
<td>Residential facility for women and children (not drug treatment)</td>
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<td>** Foster Care Related Services**</td>
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<tr>
<td>Foster parent recruitment</td>
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<td>Homefinding services for infants</td>
<td></td>
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<tr>
<td><strong>Other</strong></td>
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</tbody>
</table>
In the past 6 month period, the Biological Family received or was referred to the following services: [IV.A.1].

(1 = In-home; 2 = Clinic/Hospital; 3 = Neighborhood/community; 4 = Center/Agency; 9 = Unk.)

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<thead>
<tr>
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<tr>
<td><strong>Other</strong></td>
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</tbody>
</table>
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(1 = in-home; 2 = Clinic/Hospital; 3 = Neighborhood/community; 4 = Center/Agency; 9 = Unk.)

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<td><strong>Other</strong></td>
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<tr>
<td>Child's Name: ____________________________</td>
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<tr>
<td>DOB: ____________________________ Current Age: ____________________________ DOA: ____________________________</td>
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<tr>
<td>Case Manager: ____________________________</td>
<td></td>
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<tr>
<td>Primary Caregivers: (AM) ____________________________ (PM) ____________________________ (Relief) ____________________________ (Night) ____________________________</td>
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<tr>
<td>Present at Rounds: ____________________________</td>
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<tr>
<td>Nutrition: No. formula feedings/day: ____________________________ Total intake per feeding: ____________________________ oz.</td>
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</tr>
<tr>
<td>Juice intake/day: ____________________________ oz. ____________________________ Water intake/day: ____________________________ oz.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent changes in feeding routine: ____________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any foods given/type/amount: ____________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child's response to feedings: ____________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns re: feeding habits or routines: ____________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep Patterns and Schedule: ____________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental Concerns and/or Achievements: ____________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Concerns or Follow-up: ____________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
External Contacts (during past week):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Child's Behavioral Response to External Contact:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Additional Concerns or Information:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Recommendations and Suggested Plan of Care:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Known Disposition or Placement Planning:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature

________________________________________________________________________

Title

________________________________________________________________________
**PROJECT STABLE HOME**  
**MONITORED PARENT-CHILD EVALUATION**  

**CHILD'S NAME**  

**DATE OF VISIT**  

**VISITOR'S NAME**  

**MONITOR**  

**RELATIONSHIP TO CHILD**  

**LENGTH OF CONTACT**  

1. **ATTENDANCE/PUNCTUALITY**  
   0 - Did not show for schedule appointment.  
   1 - Arrived 15 or more minutes late.  
   2 - Arrived within 15 minutes of scheduled appointment time.  

2. **DISPLAY OF AFFECTION/POSITIVE ATTACHMENT**  
   0 - Minimal hugging, kissing or verbal stroking. Seemed apathetic or negative toward child.  
   1 - Some display of affection but also evidence of ambivalence, preoccupation or disinterest.  
   2 - Attentive, affectionate throughout visit.  

3. **DISPLAY OF NEGATIVE AFFECT**  
   0 - More than one negative statement or reprimand directed toward child or any instance of slapping, hitting, pinching, etc.  
   1 - At least one negative statement of reprimand directed toward child.  
   2 - No negative statements or reprimands directed toward child.  

4. **RECOGNITION OF CHILD'S NEEDS/DEVELOPMENT STAGE**  
   0 - Two or more examples during the visit of failing to recognize child's needs as separate from her own or having overly high or overly low expectations of child.  
   1 - One such example.  
   2 - No evidence of failure to recognize child's needs or developmental capacities.  

5. **COMFORT/SKILL AT CHILD CARE**  
   0 - Appears awkward or tense in handling, feeding, diapering, or burping child. Needs much guidance.  
   1 - Some discomfort or uncertainty noted in caring for child but generally seems on target. Needs some guidance.  
   2 - Appears relaxed and confident in caring for child.  

6. **RECEPTIVITY TO GUIDANCE**  
   0 - Very defensive/hypersensitive to criticism. Does not follow-through on suggestions.  
   1 - Somewhat defensive - may be initially resistant to suggestions but, with encouragement, can listen and try out new behaviors with child.  
   2 - Open to suggestions - will readily try out new behaviors with child.
7. **VERBAL EXPRESSION**
   0 - Parent talked very little to child throughout visit. Either sat quietly or talked primarily to monitor.
   1 - Some appropriate talking to child but parent occasionally ignored child or lapsed into silence.
   2 - Appropriate frequency of talking to child.

8. **INTRUSIVENESS/CONTROLLING**
   0 - Parent was excessively controlling and/or intrusive throughout visit. Was unable to follow child's lead.
   1 - Some evidence of overly controlling/intrusive behavior, but parent was also able at times to follow child's lead.
   2 - Parent followed child's lead throughout visit.

9. **SEPARATION BEHAVIOR**
   0 - Parent handled separation poorly - either a) provoked clinging behavior by child, or b) left abruptly without an appropriate goodbye.
   1 - Parent handled separation with difficulty.
   2 - Parent handled separation with sensitivity to child's feelings and needs.

10. **GENERAL EMOTIONAL FUNCTIONING**
    0 - Parent presents as either angry, labile and agitated or as significantly depressed, with little effective coping in evidence.
    1 - Evidence of significant emotional turmoil but parent appears to be making constructive efforts to cope.
    2 - Parent appears emotionally stable - is generally coping well.

11. **JUDGMENT/INSIGHT**
    0 - Parent evidences little or no understanding of his/her role in bringing about current difficulties. Generally externalizes responsibility.
    1 - Parent evidences inconsistent understanding of his/her role in bringing about current difficulties. Accepts some responsibility but also attempts to externalize.
    2 - Parent appropriately accepts responsibility for current difficulties.

12. **OTHER COMMENTS**
Children's Institute International  
Project Stable Home  

Parent Need Questionnaire  

<table>
<thead>
<tr>
<th>I Need Help</th>
<th>Not Sure</th>
<th>Definitely Need Help</th>
</tr>
</thead>
</table>

A. Need for Information  

1. I need more information about how to feed my infant.  
2. I need more information to provide for the health and safety needs of my infant.  
3. I need more information about how drug exposure may have affected my infant's behavior and development.  
4. I need more information about how to handle my infant's crying and fussiness.  
5. I need more information about how to handle my infant's jitteriness.  
6. I need more information about how to bathe my infant.  
7. I need more information about how to change and dress my infant.  
8. I need more information about how to develop a close relationship with my infant.  
9. I need more information about how to teach my infant.  
10. I need more information about how to play with and talk to my infant.  
11. I need more information about how ifant grow and develop.
### Parent Need Questionnaire

<table>
<thead>
<tr>
<th></th>
<th>I Need Help</th>
<th>Not Sure</th>
<th>Definitely Need Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Need for Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. I need help handling stress.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I need help handling my anger and frustration.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I need to have someone in my family that I can talk to more about problems.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I need to have more friends that I can talk to.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I need to have more opportunities to meet and talk with other parents.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I need to have more time just to talk with my child’s doctor.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I would like to meet more regularly with a counselor (psychologist, social worker, psychiatrist) to talk about problems.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I need to talk more to a minister who could help me deal with problems.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I need reading material about other parents who have a child similar to mine.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I need to have more time for myself.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. I need help dealing with my drug or alcohol problem.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. I need help making better choices in my intimate relationships.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Need Questionnaire</td>
<td>I Need Help</td>
<td>Not Sure</td>
<td>Definitely Need Help</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------</td>
<td>----------</td>
<td>----------------------</td>
</tr>
<tr>
<td>13. I need help making better choices in friends.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. I need help overcoming the guilt about having a drug exposed infant.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. I need help coping with the Department of Children's Services and the Court System.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. I need help coping with my family.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Parent Need Questionnaire

<table>
<thead>
<tr>
<th>C. Community Resources</th>
<th>I Need Help</th>
<th>Not Sure</th>
<th>Definitely Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I need help finding a place to live suitable for myself and my child.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I need help finding a job.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I need help finding infant care.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I need help finding a drug program.</td>
<td></td>
<td></td>
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<tr>
<td>5. I need help finding individual counseling.</td>
<td></td>
<td></td>
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<tr>
<td>6. I need help finding marital counseling.</td>
<td></td>
<td></td>
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<tr>
<td>7. I need help finding a church program.</td>
<td></td>
<td></td>
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<tr>
<td>8. I need help finding a women's group.</td>
<td></td>
<td></td>
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<tr>
<td>9. I need help finding a parent group.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10. I need help finding special services to help with my child's problems.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>11. I need help getting started on AFDC, WIC and/or SSI.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# HOME VISIT REPORT

**Infant/Child**

**A.K.A.**

**Mother/Caregiver**

**Adj. Age**

**Date**

---

**PURPOSE OF VISIT**

---

**MOTHER'S CONCERNS**

---

**PHONE CALLS/ATTEMPTED VISITS**

**Date**

(since previous visit)

---

**INFORMATION CHANGES OR ADDITIONS**

(address, phone #, physician, social worker, etc.)

---

**HEALTH/ILLNESS**

Well Baby Checks (# of visits) __________ Illness (# of visits) __________

<table>
<thead>
<tr>
<th>Dates</th>
<th>Doctor/Clinic/Hospital</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PHYSICAL/MEDICAL**

---

**MEDICATIONS/VITAMINS**

<table>
<thead>
<tr>
<th>Dosage/Frequency</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**NUTRITION/GROWTH**

**Weight**

**Length**

**Head Cir.**

**Ant. Font.**

**Foods**

**Breast Feeding**

**Formula/Milk**

**Amt/Freq**

**24-Hr. Total**

**Feeding Skills/Concerns**

**Dental Hygiene/Dentition**

**Nutritional/Growth Concerns**

---

**Signature**

**Title**

---

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Newborn Follow-Up Project/Family Recovery Program - California State University, Los Angeles

rev:10/91: Forma/homevisi.3
**HIGH RISK INFANT FOLLOW-UP SPECIAL CARE CENTER**

**ELIGIBILITY CRITERIA**

Referral form must be submitted to the HRIF SCC and to the County CCS program as soon as the infant is medically eligible.

<table>
<thead>
<tr>
<th>Field</th>
<th>Required Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Hospital NICU: (or referring agency)</td>
<td></td>
</tr>
<tr>
<td>Contact Person:</td>
<td>Phone: ( )</td>
</tr>
<tr>
<td>Date Eligibility Criteria Met:</td>
<td>Date referred to CCS in county of infant’s residence:</td>
</tr>
<tr>
<td>Name of HRIF SCC:</td>
<td>Date of referral to HRIF SCC:</td>
</tr>
<tr>
<td>Facility of birth:</td>
<td>(if different from referring hospital)</td>
</tr>
<tr>
<td>Name of Infant:</td>
<td>DOB</td>
</tr>
<tr>
<td>Mother:</td>
<td>Address: Phone:</td>
</tr>
<tr>
<td>Father:</td>
<td>Address: Phone:</td>
</tr>
<tr>
<td>Primary Caregiver:</td>
<td>Address: Phone:</td>
</tr>
<tr>
<td>Birth Weight:</td>
<td>Gestational Age at Birth: APGARS:</td>
</tr>
</tbody>
</table>

**ELIGIBILITY CRITERIA**

For each medical condition checked, documentation from the medical record must accompany this referral.

**DAY OF LIFE ONE**

- BW ≤ 1500 grams
- APGAR ≤ 3 at 5 minutes
- Hypotonia persisting to 2 hours of age
- GA ≤ 32 weeks
- No spontaneous respirations by 10 minutes
- Intrauterine Growth Retardation ≤ 3rd percentile

**FIRST MONTH OF LIFE**

- Assisted ventilation > 48 hrs. in first 28 days of life
- Symptomatic or prolonged hypoglycemia or acidaemia
- Hyperbilirubinemia at a level that would require an exchange transfusion
- Prolonged perinatal hypoxemia
- Infant placed on ECMO
- Seizure activity in the first 28 days
- Signs and symptoms of PDE

**AFTER FIRST MONTH OF LIFE OR CONDITION AT TIME OF NICU DISCHARGE**

- Hospitalized > 28 days from birth
- Documented CNS infection or sepsis
- Discharge with tracheostomy tube
- Discharge with continuous oxygen therapy
- Discharge on gastrostomy or jejunostomy tube feedings
- Discharge with feeding problems leading to slow weight gain
- Discharge on apnea monitor and/or pulse oximeter due to condition placing infant at risk for hypoxia: specify
- Repetitive Apnea
- Discharge on TPN
- Discharge on ventilator
- Discharge on other technology: specify:
- Documented central or peripheral nervous system pathology other than Grade I, IVH: specify pathology:
- Metabolic condition which is associated with physical disability: specify

**AFTER DISCHARGE FROM THE NEWBORN HOSPITALIZATION**

- Failure to thrive
- Hospitalization in the first year of life either > 1 month or for a medical problem that puts infant at risk for a subsequent developmental disability: specify
- Agency or physician: Date:
### OBSERVATION OF INTERACTION

**Infant/Child**

**AKA**

**Mother/Caregiver**

**Adj.Age**

**Date**

**Situation:**
- Play
- Caregiving
- Feeding
- Other

**Length of Observation**

**Observer/IDS**

<table>
<thead>
<tr>
<th>Caregiver's Response to Infant/Child</th>
<th>Observed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Uses positive touching (rocking, stroking, kissing, hugging, etc.).</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2. Displays signs of pleasure while interacting with infant/child.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3. Positions infant/child or self to establish or maintain eye contact.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4. Initiates interactions with infant/child (directs attention to environment, plays games, sings, etc.).</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5. Responds positively to infant/child’s attempts to communicate.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6. Encourages communication (turn taking, asking questions, waiting for responses, using repetition, imitating).</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7. Modifies interaction in response to infant/child cues (changes tone, position, verbalizations, touch, etc.).</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8. Varies voice in interaction with infant/child (changes pitch, tone, pace)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>9. Elaborates on infant/child’s vocalizations (naming, explaining, adding descriptive words, etc.).</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**TOTAL**

<table>
<thead>
<tr>
<th>Infant/Child's Response to Caregiver</th>
<th>Observed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Is alert and attentive during interaction.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>11. Looks at caregiver’s face or eyes.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>12. Laughs, smiles, or vocalizes during interaction with caregiver.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>13. Moves hands/feet, turns head, physical response to caregiver’s vocalizations.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>14. Touches, explores, or seeks contact with caregiver.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>15. Responds with pleasure to caregiver’s attempts to communicate.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>16. Matches caregiver’s response (mimics or repeats).</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>17. Initiates interaction with caregiver.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>18. Cooperates with caregiver during interaction (responds, takes turns).</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**TOTAL**

<table>
<thead>
<tr>
<th>Infant/child becomes distressed/upset during interaction.</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Caregiver's Response to Child's Distress</strong></td>
<td>Observed</td>
<td></td>
</tr>
<tr>
<td>19. Lowers voice, slows pace or makes soothing sounds.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>20. Alters activity by offering new activity, toy, changing position.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>21. Pats, rocks, or changes position of child.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>22. Raises voice, makes negative comments, yells.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>23. Maintains or increases original activity.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>24. Shakes, slaps, handles child roughly.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>25. Ignores, or does not attend to signs of distress or negative cues.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>26. Other:</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**TOTAL**

Comments:

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Newborn Follow-Up Project/Family Recovery Program - California State University, Los Angeles

10/91 Cortino/OCD
## INFANT NUTRITION SCREENING (Birth-12 Months)

### FOODS MONTHS

<table>
<thead>
<tr>
<th>Acceptable</th>
<th>Not Acceptable</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplement Vitamins/iron Brand</td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Plain with iron supplement Brand</td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Sugar, honey, Karo</td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>In bottle Adult cereal</td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Strained food in bottle</td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Finger foods, toast, cracker Sugared cereals, cookies</td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Infant or adult, diluted w/water Kool-aid, soda, &gt;8 oz/day</td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Cooked yolk Egg white Whole egg</td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Pudding, fruit, plain yogurt Candy, chips, sweats</td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Whole milk Nonfat milk</td>
<td></td>
<td>Yes No</td>
</tr>
</tbody>
</table>

**FOODS**

<table>
<thead>
<tr>
<th>FOODS</th>
<th>MONTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant formula</td>
<td><em>1Y.m</em> In no</td>
</tr>
<tr>
<td>Adult formula</td>
<td><em>1Y.m</em> In no</td>
</tr>
<tr>
<td>Powder</td>
<td><em>1Y.m</em> In no</td>
</tr>
<tr>
<td>Mixed correctly?</td>
<td><em>1Y.m</em> In no</td>
</tr>
</tbody>
</table>

**REQUIREMENTS**

- Foods should not be introduced

### SKILLS

#### Age/Weight | Formula/Food | Assessment | Interventions |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4 lbs.</td>
<td>11-12 oz. formula</td>
<td>Completes bottle in 20-30 minutes?</td>
<td>Yes No</td>
</tr>
<tr>
<td>7 lbs.</td>
<td>17-18 oz. formula</td>
<td>Holds baby while feeding?</td>
<td>Yes No</td>
</tr>
<tr>
<td>9 lbs.</td>
<td>23-24 oz. formula</td>
<td>Holds baby while feeding?</td>
<td>Yes No</td>
</tr>
<tr>
<td>11 lbs.</td>
<td>28-30 oz. formula</td>
<td>Completes bottle in 20-30 minutes?</td>
<td>Yes No</td>
</tr>
<tr>
<td>13 lbs.</td>
<td>28-32 oz. formula</td>
<td>Holds baby while feeding?</td>
<td>Yes No</td>
</tr>
<tr>
<td>4-6 months</td>
<td>30-32 oz. formula + strained foods</td>
<td>Hold head upright?</td>
<td>Yes No</td>
</tr>
<tr>
<td>7-9 months</td>
<td>28-30 oz. formula + junior foods</td>
<td>Picks up small objects?</td>
<td>Yes No</td>
</tr>
<tr>
<td>10-12 months</td>
<td>22-28 oz. + junior + table foods</td>
<td>Drinks from cup?</td>
<td>Yes No</td>
</tr>
</tbody>
</table>

#### Falling off the growth curve?

- Falling off the growth curve? No Yes

#### Problems with diarrhea or constipation?

- Problems with diarrhea or constipation? No Yes

#### Excessive weight gain?

- Excessive weight gain? No Yes

#### Bottle taken to bed?

- Bottle taken to bed? No Yes

#### Problems identified:

- Problems identified:  

  Interventions:  

  signature | title  

  Adapted from  
  Pat Morris, R.D., M.P.H. Memorial Hospital Medical Center of Long Beach - 1983  
  Newborn Follow-Up Project/Family Recovery Program - California State University, Los Angeles  
  10/91:formlnutrit.frm
THE BZOCII-LEAGUE
RECEPTIVE-EXPRESSIVE EMERGENT LANGUAGE SCALE
FOR THE MEASUREMENT OF LANGUAGE SKILLS IN INFANCY

NAME

Date

Address

Born

Age

Sex

Telephone

I.D. #

Father

Occupation

Mother

Occupation

Sisters

name age

name age

name age

name age

Brothers

name age

name age

name age

name age

Informant: mother____father____both____other (specify relationship)

Receptive Language Age

Expressive Language Age

Combined Language Age

To obtain quotients, divide each of the above language ages (RLA, ELA, and CLA) by the child’s chronological age and multiply by 100, or see Table 2 in the REEL manual.

RECEPTIVE

EXPRESSIVE

LANGUAGE

QUOTIENT

QUOTIENT

QUOTIENT
four to five months

--- R13. Regularly localizes source of voice with accuracy.
--- E13. Uses vowel-like sounds similar to "O" and "U."
--- E14. Expresses anger or displeasure by vocal patterns other than crying.
--- E15. Usually stops babbling in response to vocal stimulation, but may occasionally continue babbling for a short time.

--- R14. Recognizes and responds to his (her) own name.
--- R15. Usually stops crying when someone talks to him (her).

five to six months

--- R16. Appears by facial and bodily gestures to be able to distinguish general meanings of (1) warning, (2) anger, and/or (3) friendly voice patterns.
--- E16. Takes the initiative in vocalizing and babbling directly at others.
--- E17. Occasionally vocalizes with 4 or more different syllables at one time.
--- E18. Plays at making sounds and noises while alone or with others.

--- R17. Appears to recognize words like "daddy," "bye-bye," "mama," etc.
--- R18. Stops or withdraws in response to "no" at least half of the time.

six to seven months

--- R19. Appears to recognize names of family members in connected speech, even when the person named is not in sight.
--- E19. Begins some 2-syllable babbling (repeats combinations of 2 or more different sounds).
--- E20. At least half of the time responds with vocalizations when called by name.
--- E21. Uses some word-like vocal expressions (appears to be naming some things in his own "language").

--- R20. Responds with appropriate gestures to such words as "come," "up," "high," "bye-bye," etc.
--- R21. Gives some attention to music or singing.

--- R22. Frequently appears to listen to whole conversations between others.
--- E22. Occasionally vocalizes in sentence-like utterances without using true words.

seven to eight months

--- R23. Regularly stops activity when his (her) name is called.
--- E23. Plays speech-gestures games like "pat-a-cake" or "peek-a-boo."
--- E24. Occasionally "sings along" with some familiar song or music without using true words.

--- R24. Appears to recognize the names of some common objects when their names are spoken.
twelve to fourteen months

R37. Appears to understand some new words each week.
R38. Seems to understand the psychological feeling and shades of meaning of most speakers.
R39. Will sustain interest for 2 or more minutes in looking at pictures if they are named.
E37. Uses 5 or more true words with some consistency.
E38. Attempts to obtain desired objects by using voice in conjunction with pointing and gesturing.
E39. Some true words now occur in jargon utterances.

fourteen to sixteen months

R40. Demonstrates understanding by carrying out verbal request to select and bring some familiar object from another room.
R41. Recognizes and identifies many objects or pictures of objects when they are named.
R42. Clearly recognizes names of various parts of the body (such as hair, mouth, ears, hands, etc.).
E40. Consistently uses 7 or more true words.
E42. Most communication is now accomplished by using some true words along with gestures.

sixteen to eighteen months

R43. Comprehends simple questions and carries out two consecutive directions with a ball or other object.
R44. Remembers and associates new words by categories (such as foods, clothing, animals, etc.).
R45. From a single request identifies 2 or more familiar objects from a group of 4 or more familiar objects.
E43. Begins using words rather than gestures to express wants and needs.
E44. Begins repeating words overheard in conversation.
E45. Evidences a continual but gradual increase in speaking vocabulary.

eighteen to twenty months

R46. Upon verbal request points to several parts of the body and various items of clothing shown in large pictures.
R47. Demonstrates understanding by appropriate responses to such action words (verb forms) as "sit down," "come here," "stop that," etc.
R48. Demonstrates understanding of distinctions in personal pronouns (such as "give it to her," "give it to me," etc.).
E46. Imitates some 2-word and 3-word sentences.
E47. Imitates environmental sounds (such as motors, animals, etc.) during play.
E48. Has a speaking vocabulary of at least 10 to 20 words.
### thirty to thirty-three months

| R61. Demonstrates an understanding of all common verbs. | E61. Tells gender when asked, “Are you a boy or a girl?” |
| R62. Understands very long and complex sentences. | E62. Names and talks about what he (she) has scribbled or drawn when asked. |
| R63. Demonstrates an understanding of most common adjectives. | E63. Gives both first and last name when asked. |

### thirty-three to thirty-six months

| R64. Shows interest in explanations of “why” things are and “how” things function. | E64. Regularly relates experiences from the recent past (what happened while he (she) was “out” or separated from parent). |
| R65. Carries out three simple verbal commands given in one long utterance. | E65. Uses several verb forms correctly in relating what is going on in action pictures. |
| R66. Demonstrates an understanding of prepositions (such as on, under, front, behind, etc.). | E66. Uses some plural forms correctly in speech. |

NOTES (language disorders, clinical history, research notes, etc.)

Administered by ___________________________
# STABLE HOME ATTACHMENT OBSERVATION

<table>
<thead>
<tr>
<th>Infant/Child</th>
<th>AKA</th>
<th>Mother/Caregiver</th>
<th>Date</th>
</tr>
</thead>
</table>

If not observed, rate from previous observation.

## MATERNAL BEHAVIOR DURING HOME VISIT/FEEDING

<table>
<thead>
<tr>
<th>Was mother attentive during exam?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removed and detached = 1</td>
</tr>
<tr>
<td>Distracted, intermittent = 2</td>
</tr>
<tr>
<td>Observant, but not involved = 3</td>
</tr>
<tr>
<td>Attentive, close and watching, involved = 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When infant cried, did the mother attempt to soothe?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ignored infant = 1</td>
</tr>
<tr>
<td>Rarely soothed = 2</td>
</tr>
<tr>
<td>Sometimes soothed = 3</td>
</tr>
<tr>
<td>Frequently/always soothed = 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Position of bottle or breast during feeding.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk not filling nipple/infant not attached to breast, mother not looking = 1</td>
</tr>
<tr>
<td>Milk not consistently filling nipple/infant intermittently attached, mother not attentive = 2</td>
</tr>
<tr>
<td>Milk fills nipple/infant attached and sucking, mother sometimes looking = 3</td>
</tr>
<tr>
<td>Milk fills nipple/infant attached, regular rhythmic sucking, mother frequently/constantly looking = 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interest and affection demonstrated by mother.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No talking to infant or no en face = 1</td>
</tr>
<tr>
<td>Minimal talking or minimal en face = 2</td>
</tr>
<tr>
<td>Some talking and occasional en face = 3</td>
</tr>
<tr>
<td>Frequent/constant talking and en face = 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother’s holding posture when seated.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s body never touches infant’s trunk = 1</td>
</tr>
<tr>
<td>Mother’s body rarely touches infant’s trunk = 2</td>
</tr>
<tr>
<td>Mother’s body sometimes touches infant’s trunk = 3</td>
</tr>
<tr>
<td>Mother frequently/always holds infant close = 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternal fondling (spontaneous interaction initiated by mother not associated with feeding, such as stroking, cuddling, kissing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No fondling - detached = 1</td>
</tr>
<tr>
<td>Rare fondling - detached = 2</td>
</tr>
<tr>
<td>Sometimes fondling - not detached = 3</td>
</tr>
<tr>
<td>Frequent/constant fondling = 4</td>
</tr>
</tbody>
</table>

**TOTAL**

---

**GENERAL OBSERVATION OF INTERACTION:**

---

**Signature**

**Title**

---

*Adapted from the Neonatal Perception Inventory*

*Talkman-Leah*

*CSULA High Risk Index, Child Family Project*

*Revised 4/94 Forms/attach.htm*
# The Mother-Child Relationship Evaluation

By Robert M. Roth, Ph.D.

Published By

![Western Psychological Services](https://www.westernps.com)

A DIVISION OF MANSON WESTERN CORPORATION

---

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Years Married</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of Children</td>
<td>Names and Ages of Children</td>
<td>Telephone No.</td>
<td></td>
</tr>
<tr>
<td>Child Presented</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DIRECTIONS:**

To better understand you and your child, and your relationship with your child, please express your opinions or your feelings about the statements which follow, when you turn this page. There are no "right" or "wrong" answers, only your opinions or feelings. Let your personal experiences decide your answers. Keep in mind the child for whom you are seeking help.

Do not spend too much time on any one statement. If you are in doubt, circle the opinion or feeling closest to expressing your feelings at this time. BE SURE TO ANSWER ALL STATEMENTS.

Read each statement carefully, then draw a circle around the opinion or feeling to the right of the statement which comes closest to your opinion or feeling.

If you STRONGLY AGREE with the statement or feeling, circle the letters SA; if you AGREE, circle the letter A; if you are UNDECIDED, circle the letters UN; if you DISAGREE, circle the letter D; and if you STRONGLY DISAGREE, circle the letters SD.

You will have time to answer all the statements. When you finish, please turn in your booklet. NOW TURN THE PAGE AND BEGIN.
<table>
<thead>
<tr>
<th>OP</th>
<th>If possible, a mother should give her child all those things the mother never had.</th>
<th>STRONGLY AGREE</th>
<th>AGREE</th>
<th>UNDECIDED</th>
<th>DISAGREE</th>
<th>STRONGLY DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-R</td>
<td>Children are like small animals and can be trained the same as puppies.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>3-OP</td>
<td>Children cannot choose the proper foods for themselves.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>4-R</td>
<td>It is good for a child to be separated from its mother from time to time.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>5-OP</td>
<td>&quot;Having fun&quot; usually is a waste of time for a child.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>6-OP</td>
<td>A mother should defend her child from criticism.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>7-OP</td>
<td>A child is not at fault when it does something wrong.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>8-R</td>
<td>When a mother disapproves an activity of her child, she should over-emphasize its danger.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>9-OP</td>
<td>My child cannot get along without me.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>10-R</td>
<td>My child does not get along with other children as well as it should.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>11-A</td>
<td>A mother should be resigned to the fate of her child.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>12-OP</td>
<td>A mother should see that her child's homework is done correctly.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>13-R</td>
<td>To raise a child suitably, the mother should know fairly well what she would like her child to be.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>14-OP</td>
<td>A mother should &quot;show off&quot; her child at every opportunity.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>15-OP</td>
<td>It takes much energy to discipline a child properly.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>16-OP</td>
<td>A mother should never leave her child by itself.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>17-R</td>
<td>With the right training, a child can be made to do almost anything.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>18-OP</td>
<td>It is good for a mother to cut her child's hair if it dislikes going to the barber.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>19-OP</td>
<td>I often threaten to punish my child but never do it.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>20-R</td>
<td>When a child disobeys in school, the teacher should punish it.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>21-R</td>
<td>My child annoys me.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>22-OP</td>
<td>It is the mother's responsibility to see that her child never is unhappy.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>23-R</td>
<td>A child is an adult in small form.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>24-OP</td>
<td>A mother cannot spend too much time reading to her child.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>25-OP</td>
<td>A child needs more than two medical examinations each year.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td>26-OP</td>
<td>Children cannot be trusted to do things by themselves.</td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
</tr>
<tr>
<td></td>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNDECIDED</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------</td>
<td>-------</td>
<td>-----------</td>
<td>----------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>1-R</td>
<td>Breast feeding should be stopped by the mother as soon as possible.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>28-OP</td>
<td>Children should always be kept calm.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>29-OI</td>
<td>A child should not have a fixed allowance.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>30-R</td>
<td>I often play practical jokes on my child.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>31-OI</td>
<td>The mother should lie down with her child if it cannot sleep.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>32-R</td>
<td>Often children act sick when they are not sick.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>33-OP</td>
<td>Children can never bathe themselves as they should.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>34-OI</td>
<td>A child should not be scolded for grabbing things from an adult.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>35-A</td>
<td>When a mother has problems with her child with which she cannot deal, she should seek the proper help.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>36-OP</td>
<td>When a child cries, it should have the mother's attention at once.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>37-OI</td>
<td>Somehow, I cannot refuse any request my child makes.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>38-A</td>
<td>Children have rights of their own.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>39-OI</td>
<td>A mother should always see that her child's demands are met.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>40-A</td>
<td>A child should not get angry at its mother.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>41-A</td>
<td>Young children, like toys, are for their parents' amusement.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>42-A</td>
<td>Child-bearing is a responsibility of marriage.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>43-A</td>
<td>There are certain right ways of raising a child, no matter how the parents feel.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>44-A</td>
<td>Children should be seen but not heard.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>45-A</td>
<td>A mother should control her child's emotions.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>46-A</td>
<td>Since thumbsucking is an unhealthy habit, it should be stopped by all means.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>47-A</td>
<td>It is not too helpful for a mother to talk over her plans with her child.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>48-A</td>
<td>A child should please its parents.</td>
<td>SA</td>
<td>A</td>
<td>UN</td>
<td>D</td>
<td>SD</td>
</tr>
</tbody>
</table>

END

Please see that you have answered all statements, then turn in your booklet.
## THE MOTHER-CHILD RELATIONSHIP PROFILE

<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCEPTANCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NON-ACCEPTANCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CONFUSION-DOMINANCE</strong></td>
<td>Confusion</td>
<td>Dominance</td>
</tr>
<tr>
<td>(Number of scale scores in the highest quartile)</td>
<td>4 3 2 1</td>
<td>C+ C− D− D+</td>
</tr>
</tbody>
</table>

**Interpretation-Evaluation**
**HOME OBSERVATION FOR MEASUREMENT OF THE ENVIRONMENT (CALDWELL)**

**Infant/Child: [Name] **  
**AKA: [Name] **  
**Mother/Caregiver: [Name] **  
**Adj. Age: [Age] **  
**Date: [Date] **

### I. Emotional and Verbal Responsivity of Mother

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mother spontaneously vocalizes to child at least twice during visit (excluding scolding).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Mother responds to child's vocalizations with verbal response.</td>
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<tr>
<td>3. Mother tells child the name of some object during visit or says name of person or object in a “teaching style.”</td>
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<tr>
<td>4. Mother’s speech is distinct, clear and audible.</td>
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<tr>
<td>5. Mother initiates verbal interchanges with observer—asks questions, makes spontaneous comments.</td>
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<tr>
<td>6. Mother expresses ideas freely and easily and uses statements of appropriate length for conversations (e.g., gives more than brief answers).</td>
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<tr>
<td>7. Mother permits child occasionally to engage in “messy” types of play.</td>
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</tr>
<tr>
<td>8. Mother spontaneously praises the child's qualities or behavior twice during visit.</td>
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<tr>
<td>9. When speaking of or to child, mother’s voice conveys positive feeling.</td>
<td></td>
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<tr>
<td>10. Mother caresses or kisses child at least once during visit.</td>
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<tr>
<td>11. Mother shows some positive emotional responses to praise of child offered by visitor.</td>
<td></td>
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</tbody>
</table>

**Subscale Total (No. of yes answers):**

### II. Avoidance of Restriction and Punishment

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Mother does not shout at child during visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Mother does not express overt annoyance with or hostility toward child.</td>
<td></td>
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<tr>
<td>14. Mother does not slap nor spank child during visit.</td>
<td></td>
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<tr>
<td>15. Mother reports that no more than one instance of physical punishment occurred during the past week.</td>
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<tr>
<td>16. Mother does not scold or derogate child during visit.</td>
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<tr>
<td>17. Mother does not interfere with child’s actions or restrict child’s movements more than 3 times during visit.</td>
<td></td>
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<tr>
<td>18. At least ten books are present and visible.</td>
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<tr>
<td>19. Family has a pet.</td>
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</tbody>
</table>

**Subscale Total (No. of yes answers):**

### III. Organization of Environment

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. When mother is away, care is provided by one of three regular substitutes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Someone takes child into grocery store at least once a week.</td>
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<tr>
<td>22. Child gets out of house at least four times a week.</td>
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<tr>
<td>23. Child is taken regularly to doctor’s office or clinic.</td>
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<tr>
<td>24. Child has a special place in which to keep toys and “treasures.”</td>
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</tbody>
</table>

**Subscale Total (No. of yes answers):**

### IV. Provision of Appropriate Play Material

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Child's play environment appears safe and free of hazards.</td>
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<tr>
<td>26. Child has some muscle activity toys or equipment.</td>
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<tr>
<td>27. Child has push or pull toy.</td>
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<tr>
<td>28. Child has stroller or walker, kiddie car, scooter, or tricycle.</td>
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<tr>
<td>29. Mother provides toys or interesting activities for child during interview.</td>
<td></td>
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<tr>
<td>30. Provides learning equipment appropriate to age—cuddly toy or role-playing toys.</td>
<td></td>
<td></td>
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<tr>
<td>31. Provides learning equipment appropriate to age—mobile, table and chairs, high chair, play pen.</td>
<td></td>
<td></td>
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<tr>
<td>32. Provides hand-eye coordination toys—items to go in and out of receptacle, fit-together toys, beads.</td>
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<tr>
<td>33. Provides hand-eye coordination toys that permit combinations—stacking or nesting toys, blocks or building toys.</td>
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<tr>
<td>34. Provides toys for literature and music.</td>
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</tbody>
</table>

**Subscale Total (No. of yes answers):**

### V. Maternal Involvement with Child

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>35. Mother tends to keep child within visual range and to look at him or her often.</td>
<td></td>
<td></td>
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<tr>
<td>36. Mother “talks” to child while doing her work.</td>
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<tr>
<td>37. Mother consciously encourages developmental advance.</td>
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<td></td>
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<tr>
<td>38. Mother invests “maturing toys” with value via her attention.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. Mother structures child’s play periods.</td>
<td></td>
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<tr>
<td>40. Mother provides toys that challenge child to develop new skills.</td>
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</tr>
</tbody>
</table>

**Subscale Total (No. of yes answers):**

### VI. Opportunities for Variety in Daily Stimulation

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>41. Father provides some caretaking every day.</td>
<td></td>
<td></td>
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<tr>
<td>42. Mother reads stories at least three times weekly.</td>
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<td></td>
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<tr>
<td>43. Child eats at least one meal per day with mother and father.</td>
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<tr>
<td>44. Family visits or receives visits from relatives (approximately once a month).</td>
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<tr>
<td>45. Child has three or more books of his or her own.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Subscale Total (No. of yes answers):**

**TOTAL SCORE (No. of yes answers):**

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*Items which may require direct questions*

*Format adapted from original version by Dr. Bettye Caldwell. Copyright © 1978*
APPENDIX C

REFERENCES
REFERENCES


