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**409**

STATE OF ALASKA

STEVE COWPER, GOVERNOR

DEPARTMENT OF EDUCATION

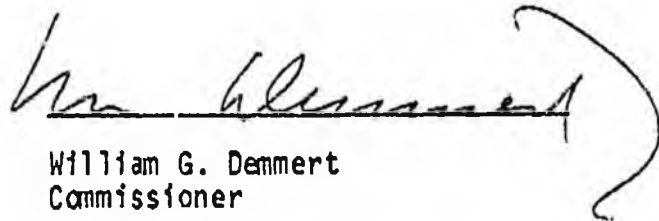
OFFICE OF THE COMMISSIONER

GOLDBELT PLACE  
801 WEST 10TH STREET  
P.O. BOX F  
JUNEAU, ALASKA 99811-0500

Position Paper on HB 203

Second Session  
16th Alaska Legislature

The State Board of Education supports HB 203 with amendments expanding the definition of teacher to include one who has primary responsibility to plan, instruct and evaluate student learning in the classroom or equivalent setting.

  
\_\_\_\_\_  
William G. Demmert  
Commissioner

2-21-90  
Date

# FISCAL NOTE

3-1-90

**REQUEST:**

Revision Date: \_\_\_\_\_  
Title: An Act relating to Training for Teachers and Certain School Officials  
Sponsor: Binkley  
Requestor: \_\_\_\_\_

Agency Affected: Health & Social Services  
BRU: \_\_\_\_\_  
Components: \_\_\_\_\_

**EXPENDITURES/REVENUES:** (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-

CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
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REVENUE	-0-	-0-	-0-	-0-	-0-	-0-
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**FUNDING:** (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

**POSITIONS:**

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

**ANALYSIS :** (Attach a separate page if necessary)

FY 90 fiscal impact is "0."

Prepared by: Sally Mead Phone: 561-4211  
Division: Office of Prevention Date: \_\_\_\_\_  
Approved by Commissioner: Myra M. Munson Date: 2/2/90  
Agency: Department of Health & Social Services

**Distribution (by preparer):**

Legislative Finance  
Legislative Sponsor  
Requestor  
Office of Management and Budget  
Impacted Agency(ies)

# Senator John Binkley

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Senate Finance Committee  
P.O. Box V • Juneau, Alaska 99811 • (907) 465-4985

Finance Committee  
Co-Chairman

## MEMORANDUM

February 21, 1990

TO: Senator Mike Szymanski, Chairman  
Senate Community & Regional Affairs Committee

FROM: Senator John Binkley

RE: Senate Bill 409 - Relating to training for teachers  
and certain school officials

---

### Sectional Analysis

Section 1. Amends AS 14.20 under Required Training in the Education Statutes to add a new section.

**AS 14.20.680 (a)** School districts and REAA's would be required to train teachers, administrators, counselors, and other school specialists on medical and psychological effects of alcohol-related disabilities and on the specific educational needs of these children.

**AS 14.20.680 (b)** Newly hired employees would be required to be trained within 45 days.

Section 2. Applicability.

Current employees, including those employed at the time of enactment, and those hired after enactment but before July 1, 1992, shall be trained before July 1, 1992.

**Fetal Alcohol Syndrome is a birth defect  
caused by the mother drinking alcohol  
during her pregnancy.**

---

**Children born with FAS experience:**

- growth retardation (prenatal or postnatal)
  - facial abnormalities
  - central nervous system impairment
- 

**FACT: FAS IS THE LEADING CAUSE OF MENTAL RETARDATION**

**FACT: THE BRAIN IS THE MOST AFFECTED ORGAN  
WHEN A MOTHER DRINKS ALCOHOL DURING HER PREGNANCY**

**FACT: ALCOHOL IS A NEUROBEHAVIORAL TERATOGEN**

Prenatal Exposure can cause Developmental Delays,  
Intellectual Defects, Academic Problems, and  
Behavioral Problems.

**FACT: THE RATE OF FAS IN ALASKA NATIVES IS CONSERVATIVELY  
ESTIMATED AT 4.2 PER 1,000 LIVE BIRTHS**

Given our high per capita drinking population (4th in the  
Nation), medical authorities believe FAS among non-  
Natives in Alaska would also be very high.  
Currently there are no statistics on non-Natives.

**FACT: PROFESSIONALS ESTIMATE THAT FOR EVERY CHILD BORN  
WITH FAS, 10 ARE BORN WITH FAE.**

Fetal Alcohol Effects are less severe birth defects  
caused by alcohol. FAE child experience many of the same  
problems as FAS children. Researchers are learning  
more about the learning and behavioral disabilities of FAS  
and FAE children every year.

**FACT: NO AMOUNT OF ALCOHOL CONSUMPTION DURING PREGNANCY  
IS SAFE**

Alcohol freely passes through the placenta to the baby.  
The baby's blood alcohol level is the same as the mother's,  
and it takes longer to remove the alcohol from the baby's system.

**FACT: THE COST TO CARE FOR ONE FAS CHILD FOR HIS/HER  
LIFETIME AVERAGES \$1.4 MILLION**

RECEIVED FEB 7 1990

STEVE COWPER, GOVERNOR

**DEPARTMENT OF EDUCATION**

OFFICE OF THE COMMISSIONER

GOLDBELT PLACE  
801 WEST 10TH STREET  
P.O. BOX F  
JUNEAU, ALASKA 99811-0500

January 30, 1990

The Honorable John Binkley  
Alaska State Senate  
P.O. Box V  
Juneau, Alaska 99811

Dear Senator Binkley:

Thank you for the opportunity to review and comment on your draft legislation relating to training teachers and certain school officials to deal with fetal alcohol-related disabilities in school children. I have reviewed your proposed legislation and have met with my staff on this matter.

General awareness training will be a positive beginning. Designing an effective training package will require consultation with fetal alcohol experts and experienced inservice trainers. Trainers will be responsible for conducting the inservice training for district staff.

We propose to develop a training model and to initiate the following timeline for inservice training of school personnel.

February - September 1990	Collect training materials and information on human resources for inservice training.
September 1990 - February 1991	Develop and acquire specific training materials, design delivery systems for training, and print the training materials.
February - April, 1991	Pilot training in designated school districts.
May 1991	Revise materials based on pilot evaluations.
June, 1991	Training of trainers during the "Alaska Staff Development Network Summer Academies".
August 1991 - June 1992	Conduct School District Inservices.

Costs for the above activities through the 1991 Summer Training Academy are estimated at \$50,000. It does not include personnel involved in administering the program or the costs for other school district inservices.

Senator Binkley

-2-

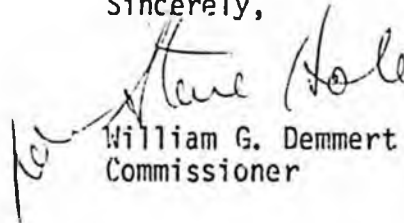
January 30, 1990

In the short term, the Department will continue to gather resources and information appropriate for use in the schools in their alcohol and drug abuse prevention efforts through the federal Drug Free Schools program. This information is available to school districts across the state for use by teachers and students.

In addition, I have enclosed other items discussed by our Department staff.

If I can provide additional information do not hesitate to contact me at your convenience.

Sincerely,

  
William G. Demmert  
Commissioner

cc: Toni Kahklen Jones  
Helen Mehrkens  
Chris Niemi

Enclosures

Department Staff Discussion Items  
Fetal Alcohol Syndrome/Fetal Alcohol Effect  
(FAS/FAE)

Program Services for Students

Identification - Proper identification of FAS/FAE students is needed. Over or under identification of these students may lead to inappropriate program for the student. FAS/FAE should neither negatively label the child nor provide an excuse for nonperformance.

Periodic screening of students previously identified for FAS/FAE.

Program Design - Even though low-achieving students in the regular classroom may not qualify for special education services or federal remedial programs, they may need additional educational aid. The process may be enumerated as follows:

1. Identify needs of FAS/FAE children at all stages of development.
2. Determine if needs can be met within the regular classroom setting.
  - a) If so, develop a suitable structure within which these children can best function.
  - b) If not, design programs and provide services.
  - c) Funding may be needed for additional services.
  - d) Identify and provide support services needed to ensure students learn and move forward.

Effects of Other Chemical Use - To date, alcohol use has been the predominant factor affecting children in Alaska. Health professionals now tell us that other drugs, e.g. cocaine, are also Alaska problems. We must determine whether abuse of these drugs requires a different response than alcohol abuse.

Student Self Concept - We must help educators, parents, community members reinforce a healthy self concept for FAS/FAE children, especially when they are old enough to recognize their differences from their peers. This includes fostering personal hopes for the futures and defining achievable career plans for each student.

The University of Alaska system needs to incorporate training into its teacher training pre-service programs while the Department and the school districts provide inservice training.

Parental Involvement and Support

Identifying cooperative programs to support the parents of FAS/FAE children. Involving parents in the child's schooling will be a critical and delicate effort.

### Prevention Education

Although the present concern is to address the needs of current FAS/FAE children, it is important to expand the effectiveness of programs to prevent FAS/FAE. Local comprehensive school health education is needed throughout the school years. Comprehensive health education programs promote healthy knowledge, attitudes and behaviors in all areas and support alcohol and drug prevention education.

Within the confines of the current federal Drug-Free Schools and Communities Act, the Department will identify and distribute materials to school districts on the effects of alcohol in unborn children. Districts will be encouraged to integrate this information into their drug and alcohol prevention and/or health education efforts.



A MANUAL ON  
ADOLESCENTS AND ADULTS  
WITH FETAL ALCOHOL SYNDROME  
WITH SPECIAL REFERENCE TO AMERICAN INDIANS

## EXECUTIVE SUMMARY AND RECOMMENDATIONS

The Fetal Alcohol Syndrome (FAS) Follow-Up Study evaluated 61 adolescents and adults who had previously been diagnosed FAS (70%) or had Fetal Alcohol Effects (FAE) (30%). They ranged in age from 12 to 40 years: 70% were 12 to 18 years old. Data were derived from individual assessment of patients; from interviews with caretakers, teachers, physicians, and social workers; and from review of medical and school records. Not all data were available on all patients. The following findings were important in making recommendations:

1. Average intellectual level of the 52 patients tested was considered mildly mentally retarded. The average IQ was 68; however, the range of IQ scores is very broad, from an IQ of 20 (severely retarded) to an IQ of 105 (normal range). This indicates that it is impossible to predict from the diagnosis alone how handicapped an individual patient with FAS/FAE will be as an adolescent or adult.
2. Patients with a diagnosis of the full FAS had an average IQ of 66, while those called FAE had an average IQ of 73. This indicates that the prognosis is less favorable for patients with the full syndrome, but that patients with only partial effects are also at risk for compromised intellectual functioning as adolescents and adults. No patient with FAS had an IQ over 90 on follow-up.
3. The average reading, spelling, and arithmetic level of these patients was 4th grade, 3rd grade, and 2nd grade, respectively. Average level of general adaptive functioning was 7 years, 5 months, although median age of those tested was 16 years, 5 months.
4. There was no indication of a general improvement in IQ, achievement, or adaptive living scores as patients got older.
5. Governmental services for handicapped persons are not routinely available for persons with IQ scores of 70 and above. This arbitrary cut-off could exclude 42% of these adolescents and adults with FAS/FAE from community and educational services for the handicapped.
6. The alcoholic women who were the biologic mothers of these patients had grave difficulties assuming maternal responsibility: 21% of the patients had never been cared for by their biologic mothers. For those who went home after birth with their biologic mothers, the average age at which they stopped living at home was 3 years, 10 months.
7. Risk of premature death is apparently a major problem in women whose children have FAS/FAE: 69% of the biologic mothers were known to be deceased.

8. Most of the patients (77%) did not live with either biologic parent on follow-up: 26% were in foster homes, 21% with relatives, 16% adopted, and 9% in group homes or institutions. Only 5% lived alone but none were fully self-sufficient.
9. Neglect and abuse appeared high but accurate statistics were difficult to obtain retrospectively.
10. Communication among community agencies regarding the needs of patients with FAS/FAE seemed poor both on reservations and in urban areas.

## RECOMMENDATIONS

Because Fetal Alcohol Syndrome (FAS) is such a grave and disabling condition with lifelong consequences to patient and community, because the prevalence is so high in many American Indian communities, and because the identification of children with FAS is a marker for families in distress, it is imperative that tribal councils and communities consider the health and social consequences of this disorder, establish policies for protecting the welfare of such children, and develop programs for prevention and intervention.

1. Each tribe or urban Indian community should systematically evaluate the prevalence of FAS and FAE among members of all ages and in all types of living and educational institutions. Tribal awareness of the local prevalence of FAS/FAE will permit proper planning for the needs of these developmentally disabled patients at the community level.
2. Each tribe should systematically review the policies that impinge on FAS patients of all ages and the services available to them. Planning for their needs at all ages is essential: infants and toddlers need environmental protection; preschool and school age children need proper education and training; disabled adults need sheltered living and a structured work environment.
3. Each tribe should set up an FAS Program to coordinate education, prevention, and intervention efforts across all community agencies. FAS awareness and in-service programs should be ongoing for all community agencies involved in work with patients with FAS/FAE or their families.
4. Community-wide screening programs should be developed to identify newborn infants with possible FAS/FAE. Identification of pregnant women with alcohol problems and families at risk for producing children with FAS will facilitate both prevention and intervention efforts in the community.
5. An FAS registry should be maintained by each tribe and used to monitor the needs and services provided to such children and their families over their lifetime. This system will not only assure better services to children and families, but will enable communities to plan more effectively for their needs.

6. A court or tribally appointed advocate should be actively involved with each patient diagnosed with FAS. Such a person is necessary because of the high rate of maternal death and disability, family disorganization, and special needs in families with FAS children.

7. Full psychosocial and medical examinations of each patient with FAS/FAE and multidisciplinary staff conferences at key ages should be carried out. Key ages include infancy, preschool, the end of elementary school, the end of middle school, and the end of high school. A full evaluation at these key transition ages will facilitate planning for the next stage, as well as provide proper documentation of areas of disability necessary for eventual benefits from State and Federal services.

8. Community policies and programs to meet the needs of FAS patients should be developed. These include policies regarding when to terminate maternal rights, when to encourage adoptions, and when to develop special programs. Types of programs include temporary care homes when natural parents are unable to care for their children; summer-work programs for the developmentally handicapped; and ongoing programs to develop job skills, feelings of self-worth, and appropriate personal management skills.

9. Community programs should also be developed to meet the needs of caretakers of FAS patients, including respite care for vacations and crises; support groups for caretakers, particularly caretakers of adolescents; informational programs for distribution of appropriate materials, including materials on sex education, driving, dating, finishing high school, and getting available subsidies for care.

10. Tribes are urged to realize and utilize the unique opportunities that exist on reservations for providing many types of traditional environments that may facilitate the adaptive functioning and good mental health of patients with FAS. For example, programs teaching traditional handicrafts and opportunities to learn traditional skills such as sheepherding, may ultimately be more useful and satisfying to adolescents with FAS than further efforts to teach higher math and reading skills that do little to enhance self-esteem or economic viability.

11. Finally, we urge a community commitment to the eradication of alcoholism and to abstinence from alcohol during pregnancy.

These recommendations are based on six underlying assumptions, developed after intensive study of these 61 adolescents and adults with FAS and FAE.

1. Fetal Alcohol Syndrome is a tragic symptom of community problems with alcoholism. It is a community problem.

2. Patients with FAS are at high risk for lifetime developmental disabilities. There is little indication that most of them will ever be able to be self-sufficient, financially or socially, or be responsible parents themselves. They will need care, protection, and age-appropriate special community resources throughout their lives.

3. Patients with FAS/FAE are often raised in alcoholic families during their early years. Families who are unable to maintain sobriety are often unable to protect their children from neglect, physical abuse, sexual abuse, sexual promiscuity, violence, maternal death, and abandonment. Despite good intentions, such mothers have difficulty providing the calm, nurturing, structured, consistent environment that appears to be most facilitating to the optimal development of children with FAS/FAE. The emotional problems and psychosocial residuals of early years in neglectful and abusive homes are particularly difficult for children with FAS/FAE to overcome because of their developmental handicaps.

4. The rights of the child to protection, nurturance, and a productive life are more important than the rights of neglectful or abusive parents to raise their own children. Tribal policies regarding termination of parental rights need to be evaluated in this regard as well as the strength of the tribal commitment to the eradication of alcoholism.

5. The level of adaptive functioning and the good mental health of children with FAS/FAE is ultimately of more value to their success and satisfaction in life than their level of academic achievement. Poor psychosocial functioning of developmentally disabled children places them at increased risk for sexual offenses, victimization, isolation, depression, and antisocial behavior within the community as adolescents and adults. The community planning for patients with FAS/FAE should focus on the needs of the whole child, not just on their academic education.

6. While proper care, programming, and training cannot eradicate the basic disability of patients with FAS, they can be the crucial factors in the level of self-sufficiency, personal adjustment, and adaptive, productive living that each patient achieves in his lifetime. The outcome observed in patients in the present study are those that occur without special programming. We do not yet know the levels achievable if proper planning and programming are available throughout the life of these patients.

American Indian communities must have healthy people for leadership and the survival of their culture. The high rate of FAS and FAE in many Indian communities precludes the accomplishment of this goal. Tribal and community agencies need to make a strong commitment not only to the eradication of alcoholism and the prevention of FAS, but also to the provision of services for the long-term needs of these patients and their families. It is our hope that, through this manual and through the work of dedicated people within Indian communities, a better way of life can be made, not just for those directly affected by FAS and FAE but for all Indian people.

STATE OF ALASKA  
1990 LEGISLATIVE SESSION

BILL VERSION: SB 409  
PUBLISH DATE: \_\_\_\_\_

### FISCAL NOTE

**REQUEST:**

Revision Date: \_\_\_\_\_  
Title: Training for Teachers and certain State Officials  
Sponsor: Binkley  
Requestor: Senate C&RA

Agency Affected: Education  
BRU: Educational Program Support  
Components: Office of the Director

**EXPENDITURES/REVENUES:** (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL	15.0	2.0	2.0	2.0	2.0	2.0
CONTRACTUAL	35.5	13.0	13.0	13.0	13.0	13.0
SUPPLIES	3.0					
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	30.0	30.0	30.0	30.0	30.0	30.0
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	<b>83.5</b>	<b>45.0</b>	<b>45.0</b>	<b>45.0</b>	<b>45.0</b>	<b>45.0</b>

CAPITAL						
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REVENUE						
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**FUNDING:** (Thousands of Dollars)

GENERAL FUND	83.5	45.0	45.0	45.0	45.0	45.0
FEDERAL FUNDS						
OTHER						
TOTAL						

**POSITIONS:**

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

See attached analysis.

Prepared by: Toni Kablen-Jones Phone: 465-2830  
Division: Educational Program Support Date: 2/21/90

Approved by Commissioner: William G. Demmert Date: 2/21/90  
Agency: Education

Distribution (by preparer):  
Legislative Finance  
Legislative Sponsor  
Requestor  
Office of Management and Budget



## Narrative Outline - Fiscal Note for SB 409

FY'91Personal  
Services

-0-

Travel

15,000

Task Force: Nine (9) members at three (3) meetings to determine content of the inservice training module for serving FAS/FAE students.

Contractual

35,500

Phone/audio conference, phone contact with other states, task force members, and in-state school districts, other agencies, and task force members development of training program. (2,500)

Development of Training materials; trainer for pilot training and summer academies - identify experts and materials to provide training (15,000).

Print and duplicate materials for all the school districts (15,000).

Postage for sending materials to school districts (3,000).

Commodities

3,000

Supplies, and purchasing copyright of training materials.

Grant

30,000

June '91 Summer Academies (Fairbanks, Anchorage, Juneau) Training of Trainers/Scholarships to school districts.

Total83,500FY'92-'98

(each year)

Travel

2,000

Subsequent years inservice training related travel, technical assistance to school districts, and revisions to the training module and materials.

Contractual

13,000

Phone/audio conference (2,500)  
Print materials, updating/revision of materials for school district use. (7,500)  
Postage (2,000)  
Purchase of copyright (1,000)

Grant

30,000

Scholarships for school districts to participate in Summer Academy Training or for accessing trainers through the Talent Bank to provide staff in-service training in their district.

Total\$45,000

**TODAY'S CHALLENGE:**  
**TEACHING STRATEGIES FOR WORKING WITH YOUNG CHILDREN**  
**PRE-NATALLY EXPOSED TO DRUGS/ALCOHOL**  
**JULY, 1989**

LOS ANGELES UNIFIED SCHOOL DISTRICT  
Division of Special Education  
Pre-Natally Exposed to Drugs (PED) Program

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## FOREWORD

The purpose of this booklet, Today's Challenge: "Teaching Strategies for Working with Children Pre-Natally Exposed to Drugs/Alcohol" is to provide guidelines for the adaptation of preschool programs to serve these children at risk.

The strategies are organized in the areas of learning, play, social/emotional, communication and motor development and home/school partnership. The strategies in each area follow a description of normal development and behaviors that place children at risk.

The strategies have been adapted with permission from the Child Development Subcommittee Report, California Foster Care Network, and Children's Research Institute of California.

This booklet is based on a review of the literature as well as the observations and experiences of the contributors most of whom have worked with the PED Program for three years. Because the educational treatment of children exposed to drugs and/or alcohol is a relatively new field, the booklet cannot reflect research or data comparisons in this area.

Following in-services, it is hoped that staff will use their knowledge and experience and adapt the teaching strategies as needed to meet the individual needs of children.

PHILLIP T. CALLISON  
Assistant Superintendent  
Division of Special Education

ACKNOWLEDGEMENTS

Appreciation is extended to the following individuals for their development of this booklet:

Carol K. Cole, PED Program Teacher  
Vicky Ferrara, PED Program Teacher  
Deborah J. Johnson, Psychiatric Social Worker, School Mental Health  
Mary W. Jones, PED Program Teacher  
Marci Blankett Schoenbaum, PED Program Teacher  
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Valerie R. Wallace, Special Education School Psychologist  
Marie Kanne Poulsen, Ph.D., University Affiliated Program, Children's Hospital,  
Los Angeles

Appreciation is also extended to Nancy Lawrence, Specialist, Instructional Services.

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Assistant Superintendent  
Division of Special Education

CONTENTS

FOREWORD . . . . .	ii
ACKNOWLEDGEMENTS . . . . .	iii
I. OVERVIEW . . . . .	1
II. PHILOSOPHY OF PROGRAM . . . . .	2
III. TEACHING STRATEGIES . . . . .	7
A. LEARNING . . . . .	7
B. PLAY . . . . .	10
C. SOCIAL/EMOTIONAL . . . . .	12
D. COMMUNICATION . . . . .	15
E. MOTOR . . . . .	18
F. HOME/SCHOOL PARTNERSHIP . . . . .	19

## I. OVERVIEW

### A. Statement of Problem

There is mounting concern at the rising incidence in the population of children who are born prenatally exposed to drugs/alcohol. The National Institute for Drug Abuse reports one out of ten pregnant mothers uses or has used cocaine during pregnancy. With 500,000 children born in California each year, the total impact of prenatal drug exposure on society's ability to provide medical, social and educational services has not yet been felt; the child who has been prenatally exposed to drugs/alcohol is at risk for developmental, behavioral, psychosocial and learning problems. Schools must continue to prepare to meet the educational needs of these children.

### B. Characteristics of Children Prenatally Exposed to Drugs/Alcohol

There is no "typical profile" of a drug exposed child, and as such each child must be educated as an individual with particular strengths and vulnerabilities. Because the effects of prenatal drugs/alcohol use on children are varied, the continuum of impairment can range from minimal symptomology to severe impairment in all areas of the child's development. Characteristic behaviors include a heightened response to internal and external stimuli, irritability, agitation, tremors, hyperactivity, speech and language delays, poor task organization and processing difficulties, problems related to attachment and separation, poor social and play skills and motor development delays.

While organic deficits caused by prenatal exposure to drugs cannot always be remediated, and while immunity against adverse child rearing conditions cannot always be created, high quality child/family intervention services can significantly improve a child's self esteem, self-control, and ability to solve problems in the real world.

### C. Description of the Prenatally Exposed to Drugs/Alcohol Program

The Los Angeles Unified School District, Division of Special Education, in cooperation with District Psychological, Health and School Mental Health Services, has created a pilot program at the Salvin Special Education Center. At present there are four classes including a transition Kindergarten class located on a regular elementary school campus.

Children, ages 3-6, and their families are currently being served in the pilot program. Transportation is provided for the children and they receive support from a district speech and language specialist, adaptive physical education teacher, school social worker, school psychologist, school physician and school nurse.

#### D. Goals of the PED Program

1. To develop a preschool program that incorporates a family focus, systematic interdisciplinary assessments, individualized programming, consistent teaching, support staff and program evaluation.
2. To develop effective strategies and provide structured learning experiences to promote the cognitive, communicative, psychosocial and motor development of children prenatally exposed to drugs/alcohol.
3. To identify preschool children who are at risk for behavioral and developmental learning problems due to prenatal drug/alcohol exposure.
4. To facilitate the successful transition of PED children to a regular education setting or to their least restrictive special education program placement.
5. To promote a better understanding of young children who have been prenatally exposed to drugs/alcohol and who are at risk for school failure.

## II. PHILOSOPHY OF PROGRAM

The behaviors seen in the preschooler prenatally exposed to drugs/alcohol are the result of a constellation of risk factors resulting from possible organic damage, early insecure attachment patterns, and often ongoing environmental instability. The child is particularly vulnerable to many stresses that impact on daily living. The extremes observed in a child's behavior, be it passivity or hyperactivity, apathy to aggression, indiscriminate trust to extreme fear and suspicion, must be understood in the context of the child's experience.

Research has shown that the progress of children prenatally exposed to drugs is more favorable when the child is placed in a predictable, secure and stable environment; therefore, intervention programs for these children must include the development of protective environments with defined structure, expectations and boundaries, as well

as the provision of on-going nurturing and support. Early positive, responsive care is crucial for children's emotional and cognitive well being. Establishing a strong attachment with each child through understanding and acceptance is a teacher's major priority. Only in the context of a good attachment will a child's true potential be realized.

Intervention strategies, to be effective, must attempt to counteract prenatal risk factors and stressful life events. To accomplish this the teacher must build in protective factors within the classroom environment and provide facilitative ways for young children to cope appropriately with stress. Self-esteem, self-control and problem solving mastery is best achieved when protective factors are coupled with a facilitative approach in the acquisition of better coping skills. These protective and facilitative factors are similar to those built into any good preschool program, but because children prenatally exposed to drugs/alcohol are more vulnerable, these program components are essential.

The following are protective factors to be built into a classroom for at risk children:

**A. Respect**

Children at risk need a setting composed of nurturing adults who are respectful of children's work and play space and who do not make unrealistic demands nor unpredictably appear and disappear.

**B. Routines & Rituals**

Children at risk need a setting which is predictable. Providing continuity and reliability through routines and rituals and scheduling activities to occur in a predictable order over time strengthens a child's self-control and sense of mastery over the environment.

In staffing programs for children at risk, not all professionals (speech and language therapist, psychologist, social worker, etc.) come into the classroom weekly to interact with the children. These adults should develop a routine for reintroducing themselves and predicting for the children when they will appear again. Consistent personnel who help children understand the visiting adult's schedule enhance a child's sense of security.

### **C. Observation & Assessments**

While monitoring skill acquisition in the areas of language, social emotional, cognitive and motor development is necessary, it does not constitute an adequate assessment of the child's progress. The manner in which the child uses these skills during play, at transition time and while engaged in self-help activities is equally important. Close observation of a child's behavior at these times allows for the understanding of how the child experiences stress, relieves tension, copes with obstacles and reacts to change. It provides valuable information on how the child uses peers and adults to meet needs and solve problems.

### **D. Flexible Room Environment**

Children at risk need a setting in which classroom materials and equipment can be removed, to reduce stimuli, or added, to enrich the activity.

### **E. Transition Time Plans**

Children at risk need a setting in which transition time is seen as an activity in and of itself and as such has a beginning, middle and end. Special preparation is given to transition time, recognizing that it is one of the best times of the day to teach the child how to prepare for and cope with change and ambivalence.

### **F. Adult:Child Ratio**

Children at risk need a setting in which the adult-child ratio is high enough to promote attachment, predictability, nurturing and on-going assistance in learning appropriate coping styles.

The following are facilitative factors to be built into a classroom for children prenatally exposed to drugs.

### **A. Attachment**

Children at risk need a teacher who accepts the child with history of both positive and negative experiences. It is assumed that as a high risk child there may be a history of poor attachments and lack of trust. The degree to which a child comes to trust the world depends, to a great extent upon the quality of care received. When care is inconsistent, inadequate or rejecting it fosters mistrust,

fear, suspicion, apathy or anger towards the world and people in particular. These feelings will carry through to later stages of development.

#### **B. Feelings**

Children at risk need a teacher who accepts that children have negative and positive feelings. Feelings are real, important and legitimate. Children behave and misbehave for a reason, even if it cannot be figured out. In responding to a child's misbehavior, the first priority should be to acknowledge what the child seems to want before dealing with the misbehavior. Doing so allows the child to recognize that his/her feelings are real and valid. Being understood facilitates self esteem and promotes a willingness to function within prescribed limits.

Different children respond to stress (internal or external) in different ways. Individual children show different responses to the same stressful events on different days. Teachers need to develop a sensitivity to the particular meaning different stressors have for the individual child and not have a predetermined set of expectations for or responses to child behavior.

#### **C. Mutual Discussion**

Children at risk need a teacher who acknowledges that children's behavior, feelings and experiences are open to mutual discussion. Talking about behavior and feelings, (done with empathy rather than judgment) validates the child's experiences and sets up an accepting atmosphere. Permission to have these feelings leads to the increased ability to distinguish between wishes and fantasies on the one hand, and reality on the other. Verbal expression allows the child to integrate past and present events into a total experience. This integrating process leads to the child's increased ability to modulate behavior, gain self-control and express feelings.

#### **D. Classroom Rules**

Children at risk need a setting in which the number of explicitly stated rules are limited. By limiting classroom rules, children are encouraged to explore and actively engage in their social and physical environment. While it is possible to teach specific objectives by relying on rules to control the child, it may be at the expense of the child's intrinsic motivation, problem solving capacity and self-mastery.

#### **E. Role Model**

Children at risk need a teacher who understands that by establishing an individual, trusting relationship, the teacher becomes an important person, and behavior the teacher models is more likely to be imitated.

#### **F. Peer Sensitivity**

Children at risk need a teacher who realizes that a child becomes sensitive and aware of the needs and feelings of others only by repeatedly having their own needs met.

#### **G. Decision Making**

Children at risk need a teacher who recognizes that it is important that they be allowed to make decisions for themselves. Freedom to choose and to assume the responsibility for those choices gradually expands the in view of the child's physical, social, emotional and intellectual growth, promotes self-esteem, problem solving mastery and moral values.

#### **H. Home**

The home is recognized as an essential part of the curriculum. Facilitating parental/caregiver goals helps to establish a close working relationship between home and school. Intervention strategies that strengthen the positive interaction between child and family increase parental confidence and competency.

#### **I. Program**

Program intervention is best achieved when all professionals concerned with the child and family are coordinated. To accomplish this successfully, time must be allotted for teachers to meet and plan with assistants and for support services of social workers, psychologists, speech and language and adaptive physical education to come together in a transdisciplinary model.

### III. TEACHING STRATEGIES

#### A. Learning

Learning occurs in a developmental framework. Development is an internal process in which the child is consistently organizing and reorganizing experiences within a continuum of stages. Movement through the stages is not an automatic passive activity. From birth, a child who has not been exposed to drugs/alcohol has the potential to attend and respond to selected stimuli and take the initiative to explore and control the environment.

Competency to perceive and explore the environment can be damaged in the child pre-natally exposed to drugs/alcohol. Concrete experiences, decision-making and problem solving within a nurturing environment as well as a positive interactive communication help to build the foundation for development. This foundation promotes self-esteem, competence and motivation for new learning.

#### NORMAL LEARNING DEVELOPMENT

The child:

- .learns to focus on tasks in play situations.
- .uses numerous problem solving strategies.
- .shows sustained attention in individual and small group activity.
- .develops a sense of task completion.
- .steadily progresses in the acquisition of skills.
- .learns to delay immediate needs and to conform to the social expectations of the classroom.
- .is able to end a preferred activity and start a teacher directed activity.
- .demonstrates sporadic/

#### LEARNING BEHAVIOR OF AT RISK CHILDREN

The child:

- .may easily be distracted by sounds, people and movement.
- .may have poor visual scanning.
- .may show decreased trial and error.
- .may show decreased problem solving strategies.
- .may have decreased attention and concentration.
- .may show perseverative behavior in problem solving.
- .may show decreased task completion.
- .may need longer time to complete task.

#### TEACHING STRATEGIES

Teaching staff:

- .provide support and emotional reassurance.
- .reduce classroom interruptions as much as possible.
- .limit number of objects in room.
- .establishes classroom routines with minimum number of transitions.
- .model alternative strategies.
- .direct child to watch another child who is using a successful strategy.
- .consider developmental level of child.
- .recognize preschoolers may need to sit in

intermittent mastery of  
of skills in new learning  
situations.

.acquires pre-academic  
concepts through  
incidental learning.

- .may give up easily when  
confronted by problem  
solving situations.
- .may be easily frustrated  
and becomes irritable in  
problem solving  
situations.
- .may be unable to do task  
previously mastered.
- .may be unable to take  
turns.
- .may not remain seated in  
circle or at the table  
with the other children.
- .may withdraw from a lack  
of social and envi-  
ronmental stimulation and  
may learn to become non-  
responsive.
- .may not have regular  
play/rest cycles or  
patterns
- .may become upset with  
changes in routine
- .may have difficulty with  
changes/transitions.
- .may be unable to end or  
let go of preferred  
object or activity.
- .may demonstrate sporadic/  
intermittent mastery of  
skills over prolonged  
period of time.
- .may not learn  
incidentally.

adult's lap.

- .recognize preschoolers  
may need to sit next to  
an adult.
- .use physical, concrete  
and verbal cues to direct  
or redirect child in task  
or activity.
- .recognize and  
consistently praise  
child's attempts and  
accomplishments.
- .ask child to verbalize  
steps of a task.
- .provide verbal cues (talk  
the child through task)  
if child is unable to  
verbally give steps of  
task.
- .provide the child with an  
opportunity to take turns  
with peers and adults.
- .model taking turns.
- .provide attention and  
time to children who are  
behaving appropriately.
- .protect child from the  
over-stimulation of  
intrusive persons or  
noisy environments and  
from the under-  
stimulation of a bland  
social and environmental  
experience.
- .provide the child a  
schedule of play and rest  
activities to help  
develop regular patterns.
- .alert the children  
routinely 1-2 minutes

ahead of time that the  
activity will soon be  
over.

- .talk about the next  
activity before entering  
into the activity.
- .allow adequate time for  
the transition activity.
- .guides the child through  
the transition and into  
the next activity.

## B. PLAY

Play is the area where a child integrates learning communication, social/emotional and motor skills. Through play, a child can learn to understand him/herself and the relation to others and the world around him/her. As a child grows and matures his/her play involves increased communication skills, attention, concentration and concept development. Strategies for play are important because a child prenatally exposed to drugs/alcohol is at risk for poor play skills.

### NORMAL DEVELOPMENT PLAY

The child:

- .learns to organize his/her own play.
- .can independently select materials and focus on them in an appropriate manner.
- .progresses from parallel to interactive play.
- .joins in play with other children.
- .initiates interactive play.
- .takes part in and initiates dramatic play.

### PLAY BEHAVIORS OF AT RISK CHILDREN

The child:

- .may show decreased spontaneous play with increased aimless wandering.
- .may not organize own play, appear perplexed and confused and cannot select materials and focus adaptively.
- .may be easily over-stimulated by too many things and people and by too much noise, movement and excitement.
- .may show delay, discontinuity and disorder in representation play.
- .may have difficulty joining others in play.
- .may not initiate appropriate interactive play.
- .may not initiate dramatic play.

### TEACHING STRATEGIES

Teaching staff:

- .give child toys and/or areas in the classroom that are child's alone, and do not have to be shared.
- .recognize that the child may not have had consistent play objects in child's environment.
- .find out what is available for the child in child's home.
- .decrease/regulate amount of toys for child.
- .will respond to and follow the child's lead in play.
- .will model toy choices for child with correct verbal cues.
- .verbally and physically models play with toys.
- .provide opportunities for the child to play interactively in a safe environment with the adult available for

- assistance and  
reassurance.
- .provide child with  
opportunities to take  
turns with peers and  
adults.
- .provide time to model  
interactive play.
- .provide child with  
support and encouragement  
during play.
- .initiate and models  
dramatic play with child.
- .respond to child when  
child initiates dramatic  
play by verbal responses  
or by playing with the  
child.

### C. SOCIAL/EMOTIONAL

When interactions between the drug/alcohol exposed infant and caregivers result in lack of attachment, rejecting or inconsistent care, this child is at greater risk for developing mistrust, suspicion and fear. These attitudes may carry through to later stages of development and manifest themselves behaviorally. Exaggerated behavior patterns are often the way a child copes with a situation that is overwhelming. Each child must be made to feel emotionally safe to attempt new learning. It is important to establish a responsive, nurturing environment conducive to active learning in which the child may build a positive self-concept.

NORMAL SOCIAL/EMOTIONAL DEVELOPMENT	SOCIAL/EMOTIONAL BEHAVIOR OF AT RISK CHILDREN	TEACHING STRATEGIES
<p>The child:</p> <ul style="list-style-type: none"> <li>.develops and maintains healthy attachments.</li> <li>.separates from parent when trust has been established.</li> <li>.learns to look for and respond to adult approval.</li> <li>.learns to respond to gestural/verbal praise and setting of limits by teacher.</li> <li>.forms attachment to teacher.</li> <li>.learns to socially signal desires and needs.</li> <li>.learns to interpret and respond to social cues of adults.</li> <li>.learns to read and respond to social cues of peers.</li> <li>.shows broad range of emotions, including pleasure, anger, fear, curiosity and assertiveness.</li> </ul>	<p>The child:</p> <ul style="list-style-type: none"> <li>.may not use adults for comfort, play, approval or object attainment.</li> <li>.may go from one to another showing no preference for a particular adult.</li> <li>.may not look to adult for recognition of a job well done.</li> <li>.may not respond in any way to verbal praise from adult.</li> <li>.may ignore verbal/gestural limit setting.</li> <li>.may show decreased compliance with routine simple commands.</li> <li>.may show indiscriminate attachment to all adults.</li> <li>.may not signal desires by giving eye contact, gesturing or vocalizing.</li> <li>.may not read teacher's cue/look.</li> <li>.may show a restricted</li> </ul>	<p>Teaching staff:</p> <ul style="list-style-type: none"> <li>.provide opportunities for contact, mutual touch and smiling throughout the day.</li> <li>.respond to specific needs of child with predictability and regularity.</li> <li>.need to address child by name, elicit eye contact and/or touch child before giving verbal command.</li> <li>.talk child through to consequence of child's action.</li> <li>.provide the child with explicitly consistent limits of behavior.</li> <li>.take every opportunity to develop teacher child relations.</li> <li>.use close proximity and gestures.</li> <li>.respond to muted signals and gives child a verbal</li> </ul>

- .shows a balance in emotions.
- .learns to regulate own inner-state.
- .responds to emotions of others.
- .learns to develop an independent sense of self and responsible behavior resulting in self-esteem.
- .develops a strong self-interest.

- range of emotion.
- overreacts to "no" by total withdrawal.
- rarely smiles, laughs or show joy.
- lethargy, listlessness, lack of affect.
- clingy behavior with adult.
- .may not express fear, grief, worry.
- .may withdraw, seem to daydream or not be there.
- .may have poor inner controls (giggles turn into screams).
- .may remain clingy and dependent on teacher for decisions and daily living activities for extended periods of time.
- .may over-react to separations from primary caregiver.
- .may show some lack of self-awareness as an individual.
- .may not show concern for hurt peers.

- explanation of child's behavior.
- .move close to the child, look at the child and help the child to read teacher's cues by explaining to the child what the teacher's look, body language, or gesture means.
- .label expression of emotions so child learns to identify those emotions.
- .use books, pictures, doll play and conversation to explore and help child express a range of feelings.
- .allow, identify and react to child's expression of emotions:
  - pleasure            -curiosity
  - protest            -dependency
  - excitement       -love
  - anger              -fear
  - self-assertion
- .model full range of emotions for child.
- .communicate with caregiver and finds out if there has been an upset in the home or any change of routine in the home, any family emergency or if the child's sleeping pattern has changed.

- .assist child in gaining control by:
  - getting eye contact
  - sitting next to the child
  - verbal reassurance
  - physical comfort, i.e., teacher rubs child's back.
- .use stories, puppets and role play to develop empathy for others.
- .provide daily opportunity for the child to practice independent feeding, dressing, bathing, toileting and play skills with tolerance for messiness and dawdling.
- .provide child with a daily opportunity to make small decisions and limited choices in play and/or self-help activities.
- .have activities centered around the child as an individual.
- .provide spaces and objects in the classroom that are for each child (cubbies with names, personal toys from home and individual picture books).

## D. Communication

The child's capacity to communicate evolves from early mother-child interaction. The development of a child's language depends on the child's ability to receive, understand, integrate and express meaningful experiences. The child learns to use gestures/words to express feelings, communicate wants and describe experiences. A child learns language best through social interaction with significant individuals and through active exploration of his/her environment.

### NORMAL COMMUNICATION DEVELOPMENT

The child:  
.is able to follow directions appropriate for his developmental level (simple commands, multiple commands).  
.learns to communicate simple wants and needs, name objects, expresses feelings at appropriate developmental levels and describes experiences and events.  
.is able to use pragmatic language.  
.learns to initiate appropriate interactions with peers.

### COMMUNICATION BEHAVIORS OF AT RISK CHILDREN

The child:  
.may have delayed receptive and expressive language.  
.may be unable to follow directions that are appropriate for the child's developmental level.  
.may have prolonged infantile articulation at the preschool level.  
.may not use attained language to communicate feelings, wants and needs.  
.may be unable to verbalize his/her needs, wants and fears and expresses them through behavior such as banging, stomping, shouting.  
.may show listlessness, passivity, and/or lack of social awareness.  
.may observe rather than verbally engage with peers in play.

### TEACHING STRATEGIES

Teaching staff:  
.creates a stable environment where child feels safe to express feelings, wants and needs.  
.use "hands-on" activities to reinforce the child's language.  
.use eye contact, gives simple one step directions, and gradually increases the number of steps in a direction.  
.map language in the context of the activity.  
.provide names of people, pets, food items, body parts, objects, feelings and events in the process of conversation.  
.immediately responds to beginning attempts at verbal communication.  
.investigate child's behavior by asking child questions to discover what child needs, wants, or fears.

.may inappropriately  
initiate interaction with  
peers by:  
-hitting  
-pushing  
-biting  
-swearing  
-negative verbal remarks

.acknowledge the needs or  
wants or fears of the  
child.  
.provide strategies to the  
child of how to  
appropriately express  
child needs, wants, or  
fears.  
.acknowledge attempts by  
child to cooperate and  
interact with other  
children.  
.recognize negative  
behavior may be a signal  
of child's unmet needs.  
.reflects child's  
feelings.  
.verbally directs child's  
behavior.  
.verbally cues child's  
attempts toward adaptive  
behavior.  
.praise child's attempts  
toward adaptive behavior.  
.ignore inconsequential  
verbal behavior.  
.verbalize expected  
behaviors.  
.redirect behavior.  
.removes child and helps  
child calm self.  
.provide child verbal  
language to use with each  
other.  
.will intercede with extra  
support for child who has  
used best developmental  
skills to resolve  
conflict without success.

.set consistent limits on  
inappropriate behavior,  
but allows for expression  
of feelings.  
.provide time to talk with  
child about emotions.

## E. MOTOR

Motor and spatial development stems from the interplay of a number of factors beginning prenatally and continuing through early childhood. Any major interferences along this continuum can result in motor/spatial impairment. As a result of prenatal exposure to drugs/alcohol, the child may exhibit varying degrees of fine, gross motor and spatial relationship delays.

NORMAL MOTOR/SPATIAL DEVELOPMENT	MOTOR/SPATIAL BEHAVIOR OF AT RISK CHILDREN	TEACHING STRATEGIES
<p>The child:</p> <ul style="list-style-type: none"><li>.has awareness of child's body placement in relationship to his/her environment.</li><li>.has age appropriate gross motor skills.</li><li>.has awareness of space relationships among objects in relationship to self.</li><li>.has awareness of space relationship among objects in relationship to each other.</li><li>.is able to manipulate objects age appropriately.</li></ul>	<p>The child:</p> <ul style="list-style-type: none"><li>.may trip or stumble without apparent cause.</li><li>.may have difficulty with gross motor skills (e.g., swinging, climbing, throwing, catching, jumping, running and balancing).</li><li>.may walk into stationary or moving objects.</li><li>.may move too close or too far away from another object.</li><li>.may show splaying of fingers, immature grasping skills.</li><li>.may have difficulty manipulating objects (stacking, stringing, cutting drawing).</li><li>.may exhibit tremors when stacking, stringing or drawing.</li></ul>	<p>Teaching staff:</p> <ul style="list-style-type: none"><li>.verbally reminds child of obstacles.</li><li>.guide child through motor activities that emphasize the skills of rhythm, balance, and coordination.</li><li>.model and guide child in learning to control child's body through songs, games, and play.</li><li>.provide child with opportunities to experience spatial relationship through motor mazes, outdoor play and indoor play.</li><li>.provide a variety of tactile and small motor activities (water &amp; sand play, pegboards, puzzles, blocks, legos, etc.).</li><li>.observe child and notes tremor occurrences and duration and how child compensates for tremors.</li></ul>

## F. HOME-SCHOOL PARTNERSHIP

The home is recognized as an essential part of the curriculum. Research has indicated that early intervention programs are essential in producing long term positive results only when parents/caregivers are part of the program design. Interactions between teachers and parents/caregivers must be professional, sensitive and flexible. This relationship must be based on the expression of mutual concern and goals. Parents of children at risk may themselves have past and/or present experiences which can compromise their ability to effectively parent their child. Factors, which may include poverty, depression, a history of child abuse/neglect, family instability and violence, history of psychiatric problems, drug abuse, etc., are taken into consideration when staff is addressing the child's needs with the parent.

Children who reside in foster homes or are placed with extended family members are particularly vulnerable to the consequences of separation, loss and poor attachments. These children require on-going support and coordinated case management plans with the goal of maximizing the child's success within the home and in the school. The emphasis on strengthening the positive interaction between caregiver and child increases the caregiver's awareness and understanding of the child's individual needs and assists in promoting feelings of confidence and competency within the caregiver. This empowerment of the caregiver will benefit the child far beyond his/her formal school program.

Having the knowledge of school/community resources and a genuine interest in the parent's well-being are essential to bridging the home-school partnership.

### HEALTHY HOME ENVIRONMENT

The child:

- .will have a mother who receives proper prenatal care.
- .is provided consistent, responsive primary caregiver from birth.
- .is provided predictable, safe, stable environment.
- .has regular eating and sleeping patterns.

### AT RISK ENVIRONMENT

The child:

- .with prenatal exposure to drugs/alcohol may:
  - be premature
  - be small for gestational age
  - go through withdrawal
  - suffer damage to gastrointestinal endocrin, respiratory genitourinary, cardiovascular and/or central nervous

### TEACHING STRATEGIES

Teaching staff:

- .will identify family constellation and primary caregiver.
- .will develop relationship with caregiver and lines of communication.
- .will schedule ongoing visits to:
  - develop a child's history (number of placements, medical

- .will have a mother/primary caregiver who sees herself as child's first teacher.
- .is provided with established family rituals around daily living activities and special events.
- .is provided appropriate developmental activities.
- .is encouraged to express feelings.
- .is encouraged to be self-sufficient and independent.

- systems.
- .may have multiple home placements.
- .may have multiple caregivers.
- .may live with other young children who are at risk.
- .may be abused and neglected.
- .may receive inconsistent and intermittent nurturing.
- .may have caregiver who is emotionally unavailable.
- .may have caregiver who is overwhelmed or untrained in dealing with the child's emotional needs.
- .may be exposed to chaotic, unpredictable and unstable environments.

- history, family history, other agency involvement).
- explore what they are doing about child's behavior.
- discuss observations of child's behavior and progress.
- observe and discuss caregiver/child relationship.
- identify parental concerns and assess family needs.
- develop individual family service plan.
- facilitate referral to other agencies as services are needed.
- encourage participation in parent education classes.
- .will discuss and model the importance of predictability and organization:
  - by developing a transition plan with caregiver for entering school (books, toys, expected parent attendance).
  - by establishing regular patterns of communications with home (phone calls, classroom newsletter, informal notes, notebook back and forth.

-by anticipating,  
discussing and  
integrating events at  
home and school (daily  
routine, special  
events).

-discuss implications of  
prenatal exposure to  
drugs/alcohol (short  
term and long term  
effects).

-promote an understanding  
of psychosocial risk  
factors (abuse, neglect,  
multiple placements).