A Case Study of the Desert Mountain Comprehensive Assessment, Research, and Evaluation (CARE) Process

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Abstract

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In 2002, President George W. Bush's Commission on Excellence in Special Education outlined issues within the nation's education system that hindered adequate service to students. The report identified three overarching problems: (1) an antiquated and burdensome system, (2) an ineffective identification process, and (3) poorly implemented services that negatively affected the general education process and impacted all struggling students, not only special education students. Because the inefficiencies affected the overall system, solutions needed to address both special and general education, seeing all students as part of the same overall process. In that context, the commission made three broad recommendations: (1) to focus on results, not process, (2) to embrace a prevention model, not a failure model, and (3) to consider children with disabilities as general-education children first. In response to the commission's findings, state education departments and local school districts implemented four models for programs: response-to-intervention (RtI), positive behavior intervention and support (PBIS), multi-tiered system of support (MTSS), and integrated MTSS systems that combined components of the RtI

and PBIS models. All these methods showed promise when used in an early-education setting with a robust, data-driven assessment process. The purpose of this study was twofold: First, to describe an early-education, multi-tiered, prevention and intervention process called SART (Screening, Assessment, Referral, and Treatment), with a focus on the third tier in the process, known as the CARE (Comprehensive Assessment, Research, and Evaluation) Clinic; second, to gather participating families' perceptions of the process and its outcomes through a social-validation study. Overall, families found the CARE process extremely valuable, identifying their own child's outcome as the most important reason for recommending it to others. In addition to positive student outcomes, the community also benefited from increased parent advocacy and the knowledge that families gained. Any issues with implementation were solvable or needed further study to identify solutions for future implementation. One parent's statement best summarized the value of the CARE process: "Yes most definitely, the process was worth it!"

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"Black families fight entrenched prejudices to get fair discipline for their children in schools" headlined a *Washington Post* op-ed essay (Powell, 2014, p. 1) authored by an African American mother whose 3-year-old son had been suspended five times from his preschool. She learned from other parents that her child's discipline was more severe than for offenses more egregious committed by other children. For example, her son received a suspension for throwing a chair that did not hit anyone, while when another parent's son threw a chair that sent a child to the hospital, that parent received only a phone call from the preschool.

Published research shows that schools routinely suspend and expel African American students as young as 5 years old for minor infractions such as talking back to teachers or writing on their desks (Losen, Martinez, & Gillespie, 2012). Unfortunately, the practice of overly identifying African American students as discipline problems, an acknowledged phenomenon within the K-12 system, now extends down to preschool. From 2001 through 2012, children enrolled in state-funded preschool programs grew from 14 percent of the nation's population of 3- and 4-year-olds to 28 percent (Barnett & Carolan, 2013). Many of these programs based eligibility on family income or risk factors. Subsequently, the percentage of children of color in these programs grew substantially (Barnett, Carolan, & Johns, 2013) as the number of state-funded preschool teacher-reported suspensions grew. A 2005 study found that over 10 percent of pre-kindergarten teachers in state-funded preschool classrooms had self-reported expelling at least one preschooler during the past year (Gilliam, 2005). Ten years later, the overall preschool expulsion rate was three times higher than the rate reported in K-12 public schools (Gilliam et al., 2016; U.S. Department of Education Office of Civil Rights, 2014). The federal departments of Health and Human Services and Education released a joint policy

statement summarizing the issue: “Recent data indicate that expulsions and suspensions occur at high rates in preschool settings, and stark racial and gender disparities exist in these practices, with young boys of color being suspended and expelled much more frequently than other children” (U.S. Departments of Health and Human Services & Education, 2014, p. 1).

The above incident of the 3-year-old boy throwing a chair clearly illustrates this trend. While throwing a chair did not demonstrate good decision-making, it was not totally outside the norm of developmental appropriateness for a young child. Yet the boy received severe punishment instead of support. The response from the school and teacher indicated their inability to provide an appropriate educational experience to mitigate the child’s behavioral concerns.

Moreover, this is typical. As Ahram, Fergus, and Noguera (2011) stated, “Apparent across most of the school districts are the inconsistent practices in the implementation of intervention systems for struggling learners” (p. 2251). The long-term impacts for students inappropriately disciplined include higher risk for special education placement, continued disciplinary actions, and academic failure (U.S. Departments of Health and Human Services & Education, 2014; Cheney, Flower, & Templeton, 2008).

Statement of the Problem

Since 1990, the Individuals with Disabilities Education Act (IDEA) and Americans with Disabilities Act (ADA) have provided guidance to Local Education Agencies (LEAs) on how to find, identify, and classify students with disabilities. In intervening decades, the federal government expanded these laws to include students with behavior problems and medical issues such as attention-deficit hyperactivity disorder (ADHD) and post-traumatic stress disorder (PTSD). These modifications occurred as researchers looked more closely at who was receiving

special education, the underlying factors leading to that identification, and what services accompanied the diagnosis (Morgan, Farkas, Hillemeir, & Maczuga, 2012; Hibel, Farkas, & Morgan, 2010). Thus, research in special education has played a major role in designing interventions for general education classrooms aimed at enhancing outcomes for a range of learners, and developing intensive interventions for special educators to meet the individual learning and behavior needs of students with disabilities (Vaughn & Swanson, 2015). Special education has transitioned from serving only children diagnosed with a special need to aligning or partnering with general education to create processes that serve all struggling students.

In 2001, President George W. Bush issued Executive Orders 13227 and 13255, establishing the President's Commission on Excellence in Special Education and affirming federal recognition of the issues associated with serving struggling students. In his forwarding letter, Bush made two statements that created hope: "The education of all children, regardless of background or disability, must always be a national priority" and "One of the most important goals of my administration is to support states and local communities in creating and maintaining a system of public education where no child is left behind" (p. 1). Unfortunately, his words did not match the reality that "among those at greatest risk of being left behind are children with disabilities" (p. 1) and "children with needs that are left unattended" (p. 7).

After conducting multiple hearings and meetings throughout the nation with a diverse group of stakeholders, the commission released a report on July 9, 2002. The report listed nine systemic failures that fit within three overarching themes that prevented struggling children from achieving: (1) an antiquated and burdensome system, (2) an ineffective identification process, and (3) poorly implemented services (p. 7-8). Although extensive research has been done on overrepresentation (Donovan & Cross, 2002; Harry & Anderson, 1994) and more recently the

underrepresentation (Hibel, Farkas, & Morgan, 2010) of African American students in special education due to an overburdened, ineffective system, the commission acknowledged throughout the 2002 report that most students had not been adequately served. In some ways, African American students were the proverbial canary in the coal mine.

Antiquated and burdensome system.

The President's Commission on Excellence in Special Education's report stated, "The system is antiquated and waits for children to fail before providing services, placing little effort in prevention and intervention" (p. 7). Brown-Chidsey and Steege (2010) described the waiting-to-fail posture as, "If a child is lucky he may eventually qualify for some services, but services have traditionally been associated with Special Education and not seen as part of the educational process" (p. 1). This scenario highlighted one of the predominant reasons the system is broken (Wagner & Compton, 2011; Brown-Chidsey & Steege, 2010): The ongoing tension between appropriately identifying the students who need services versus those who qualify for special education based on existing regulations created two distinct systems of which the financial model "creates incentives for misidentification and academic isolation" (p. 7).

Unfortunately, those 2002 findings continued to be the issues identified in research that is more recent. Aron and Loprest (2012) found the same financial concerns exist in the system, and the problems have grown exponentially. This has resulted in rising costs along with a widening educational gap between children with disabilities and other students.

This broken system reduced or eliminated options for children and families (p. 8) and ultimately undermined families' trust in the system. Conflicts observed between parents and education staff during Individualized Education Program (IEP) meetings highlighted this lack of trust (Mueller & Buckley, 2014; Harry, Allen, & McLaughlin, 1995). These conflicts, which were potentially harmful to the child, can be traced to "poor communication, strained

relationships, and misunderstanding of the special education law" (p. 120), which was driven by a compliance-oriented system that did not utilize data to monitor results and ensure all students were academically successful (President's Commission on Excellence in Special Education, 2002). This compliance-driven system circumvented "the public schools' first mission: educating every child" (p. 8). The over-reliance on compliance and under-reliance on data diminished a system's ability to understand how well the system is serving its constituents, children and their families.

Ineffective identification process.

Much research has been done on the over-identification of some students in certain special needs categories, specifically African American children (Oswald, Coutinho, Best, & Singh, 1999; Zhang, Katsiyannis, Ju, & Roberts, 2014; U.S. Department of Education, 2017). In 1979, African Americans comprised 25% of all students identified as Educable Mentally Retarded (EMR) in the state of California, even though they constituted only 10% of the entire student population (Harry & Anderson, 1994). Approximately 25 years later, African American students in California still accounted for 17% of all students categorized as emotional disturbed even though they were only 5.8% of the state population and 3.5% of the special education population (California Department of Education, 2017b). This disproportionality was influenced by implicit bias; poorly implemented curricula and instruction; and no, limited, inappropriate, and/or too many services (Ahram, Fergus, & Noguera, 2011).

The inappropriate identification of African Americans and other race or ethnic groups has been a concern that has resulted in, "policy briefs, position statements, federal civil rights investigations, legal challenges, and legislative amendments" (Morgan et al., 2017, p. 181). In the last 10 years, a counter discussion emerged that African American students were not over-represented but under-represented in special education (Hibel, Farkas, & Morgan, 2010).

Researchers posing this theory used risk factors such as substance abuse (Galera et al., 2011), socioeconomic statistics (Claycomb, Ryan, Miller, & Schakenberg-Ott, 2004), and exposure to poverty due to historical oppression, discrimination, and segregation (Donovan & Cross, 2002) as potential confounders in determining special-education eligibility (Morgan et al., 2015).

The over- and under-representation of minorities, specifically African Americans, in special education highlights two key issues identified by the President's Commission on Excellence in Special Education. First, current methods of identifying students with special needs or disabilities lack validity, and as a result, "thousands of children are misidentified every year while others are not identified early enough or not at all" (p. 8). Second, the factors thought to influence or determine eligibility are in dispute or conflate the issue of students and families simply needing appropriate services. Hibel, Farkas, and Morgan (2010) stated, "Teachers (particularly those in high-minority schools) may have reduced their special education referral rates for members of racial/ethnic minority groups as they became more sensitive to the possibility of such racial inequality" (p. 327).

Poorly implemented services.

Special education is not the gateway to more effective instruction or strong interventions. In 1974 and 2004, Congress passed the Individuals with Disabilities Education Acts (IDEA) to ensure that all children, including those with disabilities, received the same free, public education (Lueker, 2016), along with guidance to meet the goals. To that end, the system's motivation was the regulatory requirements deemed necessary to demonstrate goal achievement, such as the actual IEP process. These processes did not ensure effective instruction (President's Commission on Excellence in Special Education, 2002) or that all special and general education students were provided the most qualified teachers (Voulgarides, Fergus, & Thorius, 2017). Then (and now), rigorous practices were lacking and adequate safeguards did not exist for

struggling students (Ahram, Fergus, & Noguera, 2011). Even if these students were appropriately assessed and services properly identified, it was not clear the system could adequately provide the services. Again, a plethora of research identified the lack of services available to struggling students (President's Commission on Excellence in Special Education, 2002; U.S. Surgeon General, 1999), specifically African American students (Fergus, 2017; Barnett, Carolan, & Johns, 2013).

Summary.

The president's commission clearly outlined the issues within the system working against identifying and appropriately serving students with special needs. The report went further by stating the problems identified affected the overall general-education process and negatively influenced all struggling students. The antiquated system influenced the assessment process and the quality of services, and thus any solution needed to include special and general education systems working together to create a process that meets the needs of all children.

Chapter 2: Literature Review

The Four Models Identified

The President's Commission on Excellence in Special Education made three overarching recommendations: (1) focus on results, not process; (2) embrace a prevention model, not a failure model; and (3) consider children with disabilities as general education children first (Eagle, Dowd-Eagle, Snyder, & Holtzman, 2015; President's Commission on Excellence in Special Education, 2002). The recommendations were further solidified afterwards by the Individuals with Disabilities Education Act (IDEA), the No Child Left Behind Act (NCLB), and subsequent statutes and regulations (Fletcher & Vaughn, 2009). In response to the findings, state departments and districts throughout the nation implemented systems using four distinct models – response to intervention (RtI), positive behavior intervention and support (PBIS), multi-tiered system of support (MTSS), or integrated MTSS combining components of RtI and PBIS (Preston, Wood, & Stecker, 2016; McIntosh & Goodman, 2016; Glover & DiPema, 2007). All of these methods showed promise when used in an early-education setting with a robust, data-driven assessment process (President's Commission on Excellence in Special Education, 2002, p. 23). The paragraphs below review literature about each of these models.

Response to intervention (RtI).

Fletcher and Vaughn (2009) stated that, "RtI models are multi-tiered service delivery systems in which schools provide layered interventions that begin in general education and increase in intensity (such as increased time for instruction to smaller groups of students) depending on the students' instructional response" (p. 31). Thus, the strategies observed in an RtI model were not new to the education system, as teachers working with struggling students had used methods such as small-group instruction for years (Gresham, 2005). It was "the cause-

effect relationship(s) between academic or behavioral invention and the student's response to the interventions" (Brown-Chidsey & Steege, 2010, p. 2) that determined if the intervention had its intended effect, as what the next level of intervention should be and whether the intervention was appropriate. The RtI model was distinguished by how the strategies were organized into a "system with data-based activities" (p. 4) to increase the likelihood of student impact (Glover & DiPerna, 2007). The data-based activity system tracked a child's response to the intervention and made necessary modifications throughout the intervention.

Typically, the RtI models studied addressed either – academic or behavioral needs. An RtI model signified academic orientation, while RtI2 meant both academic and behavior were part of the model. RtI aligned with the MTSS model in that services were delivered in a three-tier framework (Brown-Chidsey, & Steege, 2010; Sugai & Homer, 2006). Tier 1 strategies were universal (primary) for all students, regardless of whether they were general or special education. At-risk students received additional supports that were either Tier 2 (secondary prevention) or Tier 3 strategies, the most intensive of services (King, Lembke, & Reinke, 2016; Glover & DiPerna, 2007).

To determine the level of intensity, a major component of an RtI system is the data-based assessment process. Wagner and Compton (2011) referred to this system as a dynamic-assessment system based on assumptions that "conventional assessments do not work for children who have diverse educational and cultural experiences, and the system must measure the direct implications for selecting and modifying the interventions" (p. 1). Though there were some differences between this dynamic and RtI theory (Grigorenko, 2009, p. 111), the concepts were complementary in that dynamic assessment recognize that conventional assessments did not address learning potential and the best educational strategies for students. RtI highlighted the

inadequacy of conventional instruction when a child did respond to it. Therefore, the assessment process must clearly highlight the best strategies based on data collected, a process affirmed if the interventions work.

Lastly, the integrity of the strategy was necessary, as measured by a student's response to the intervention. Did the intervention work? If not, was there a potential modification to make the intervention successful? Did the modification work? If not, what was the next step? Other researchers identified additional components, but the ones listed above were evoked most consistently.

Positive behavioral interventions and supports (PBIS or PBS).

RtI provided a structure for implementing a multi-tiered system of support (MTSS), while the positive behavioral interventions and supports (PBIS or PBS) model identified a specific set of strategies to address behaviors. Kincaid et al. (2016) defined PBS as,

> an approach to behavior support that includes an ongoing process of research-based assessment, intervention, and data-based decision-making focused on building social and other functional competencies, creating supportive contexts, and preventing the occurrence of problem behaviors. PBS relies on strategies that are respectful of a person's dignity and overall well-being and that are drawn primarily from behavioral, educational, and social sciences, although other evidence-based procedures may be incorporated. PBS may be applied within a multi-tiered framework at the level of the individual and at the level of larger systems (such as families, classrooms, schools, social service programs, and facilities).

PBIS strategies focused on establishing behavioral systems and decreasing challenging behaviors in classroom settings (Green, Robbins, & Bucholz, 2017; Chitiyo, May, & Chitiyo, 2012; George, George, Kern, & Fogt, 2013). An example of a Tier-1 strategy was the "Teaching

Pyramid" (Fox et al., 2003), in which students learned explicit social skills through discussion and repetitive role-playing (Jolstead et al. 2017). Examples of Tier 2 and Tier 3 strategies include picture-exchange communication systems (PECS) or a self-regulation process taught in small-group or one-on-one sessions (McDaniel, Bruhn, & Mitchell, 2015). Like the MTSS and RtI models, PBIS depended heavily on data analysis to determine what strategies were appropriate in each situation (Brown-Chidsey, 2016; Brown-Chidsey & Steege, 2010). The use of schoolwide, positive-behavior supports increased in early-childhood settings (Hemmeter, Fox, Jack, & Broyles, 2007).

Multi-tiered system of support (MTSS).

Sugai and Horner (2009) defined a multi-tiered system of support (MTSS) as a framework for decision-making that systematically determined the intensity of scientifically based intervention required to move learners toward their behavioral or academic goals. The framework combined academic, behavioral, and social-emotional structures and procedures into one system to help every student to be successful (Brown-Chidsey, 2016). The system was fundamentally preventative, and used "evidence-based [strategies] that employ data-based problem-solving techniques" (Gamm et al., 2012, p. 4) that identified struggling students early, and provided appropriate levels of intervention that reversed or remediated behavioral problems. Historically, an MTSS model was used to identify students with learning disabilities, but in recent years it transitioned to a service-delivery system (Murawski & Hughes, 2009; Fuchs, Mock, Morgan, & Young, 2003) similar to public-health prevention models in which Tier 1 strategies were provided for all, such as mandated immunization schedules. If students did not respond to the intervention, they received a more intense Tier 2 intervention followed by a continuation of progress monitoring (Anderson & Borgmeier, 2010). If Tier 2 interventions were not effective, non-responders were elevated to Tier 3 interventions that are the most intense

services and individualized supports (Ardoin, 2006; Christ & Poncy, 2005; Gresham, 2004).

MTSS systems therefore focused on identifying students at-risk for school failure versus waiting for the problem to manifest or receive a diagnosis. For example, giving a preschool student a special-education diagnosis such as emotional disturbed versus identifying a student demonstrating behavioral risk factors such as throwing a chair. While many multi-tiered intervention processes are still available, this study highlighted an integrated MTSS system grounded in RtI and PBIS within an early-education setting.

Multi-tiered system of support (MTSS) combining components of RtI and PBIS.

The last model identified by State departments and school districts was a combination of MTSS, RtI, and PBIS. The three previous models had complimentary processes and shared similar characteristics, such as evidenced-based, holistic, systemic approaches to learning, social-emotional-behavioral functioning, and implementing services using tiers or levels of intervention (Sink, 2016). Combining the three models leverages the strengths of each while mitigating possible weaknesses. For example, the PBIS or PBS and RtI frameworks focus on social-emotional-behavioral aspects of a child. By combining the two, the attention paid to results adds an assessment and accountability aspect to the frameworks. Because MTSS processes are comprehensive and school- and district-wide in design (Sink, 2016; Sugai & Horner, 2009), folding the RtI and PBIS models into a MTSS process strengthens the overall process (Freeman, Miller, & Newcomer, 2015).

Summary.

The President's Commission on Excellence in Special Education recommended solutions that included general education as well as special education and required system-wide processes for identifying and serving struggling students. The recommendations included creating a multi-tiered system that included leveled strategies – Level 1 for all students and specific and

targeted assistance for students who did not respond to Tier 1 strategies. To determine what strategies were appropriate, the assessment system looked at students through multiple lenses, such as content areas, learning styles, and, when appropriate, cultural influences. Lastly, the services had to align with the assessment processes, preserving the integrity of the approach.

California's Multi-Tiered System of Support

In 2014, the State of California directed all school districts to create a multi-tiered system of support for their student bodies. In a letter to California school districts, charter schools, and education agencies, State Superintendent of Instruction (Tom Torlakson) described California's Multi-Tiered System of Support (MTSS) as follows:

> As our districts and local education agencies re-envision how they are supporting all students to be academically and socially successful . . . California's Multi-Tiered System of Support (MTSS) framework supports . . . a system-wide approach that promotes deeper knowledge of differentiated instruction. It is aligned with Response to Instruction and Intervention approach and problem-solving teams. It allows educators to evolve their thinking on how to create and maintain the structural support they need to address the needs of all California students. Explicitly acknowledging that our diverse California student population requires a comprehensive, flexible, evidence-based process such as MTSS moves educators, students, and parents forward in our journey (Torlakson, 2014, p. 1).

California's MTSS explicitly deals with diversity by requiring school districts to create system-wide strategies that target vulnerable populations who historically struggle in the educational system or are disproportionality represented in district disciplinary data. These populations may include English Language Learners, Foster Youth, Free- and Reduced-Price

Lunch recipients, or African American students, among others (California Department of Education, 2017).

To assist districts with addressing struggling students, disproportionality, and other issues that affect special education services, California formed a Statewide Special Education Task Force in 2015. The task force examined the current system to identify successfully implemented, evidence-based practices that utilized a MTSS process. It recommended high-quality, early-childhood education as a setting in which many potential disabilities, previously unidentified disabilities, and mental health issues could be prevented, corrected, or resolved before more intensive services or lifelong interventions and supports were required. The task force identified the 10-week Diagnostic Clinical CARE Model of the Desert Mountain Special Education Local Plan Area (SELPA) as "a good working example" (California Department of Education, 2015, p. 16).

CAHELP and the Desert Mountain diagnostic clinical CARE model.

As described on the California Department of Education website in 1977, the State of California mandated all school districts and county offices of education "to form consortiums in geographical regions of sufficient size and scope to provide for all special education service needs of children residing with the region boundaries" (California Department of Education, 2017), called Special Education Local Plan Areas (SELPAs). California has 133 SELPAs of varying sizes, serving 1,000 to 10,000-plus students identified with special needs. SELPAs may be composed of one single school district or countywide office or a combination of multiple school districts and county offices. However, once a SELPA is configured, each must "develop a local plan describing how it provides special education services" (California Department of Education, 2017) that at a minimum ensure communities meet federal regulations identified in the Individuals with Disabilities Education Act (IDEA), such as:

- Child Find, how the SELPA would identify students with a disability.
- Individualized Education Planning (IEP), how the SELPA would ensure the appropriate program and set of services to meet the individual needs of students with disabilities.
- Free Appropriate Public Education (FAPE), how the SELPA would ensure a student receives the appropriate services at no expense to the parents.
- Least Restrictive Environment (LRE), how the SELPA would ensure each student has a right to education with non-disabled peers "to the maximum extent appropriate" (California Department of Education, 2017, p. 1).
- Due Process, how the SELPA would maintain the right of parent participation in all parts of the process.

Ensuring that children are properly identified and receive individualized services that are free to their families in the best educational environment while engaging parents throughout the process is not an easy task. While the mandates listed above are the minimum requirements for all SELPAs, doing the minimum does not ensure that the needs of all struggling students are being addressed. The President's Commission on Excellence in Special Education's final report noted, "IDEA provided for legal safeguards, [thus] the current system often places process above results and bureaucratic compliance above student achievement, excellence, and outcomes" (p. 7). While every SELPA is responsible for setting the agenda for its local area, some follow only the minimum requirements, while others exceed the commission's recommendations on prevention and intervention. One local plan area that clearly adopted a preventative position was the California Association of Health & Education Linking Professions (CAHELP), whose vision on the website stated "the relentless pursuit of whatever works in the life of a child" and

whose staff must often travel substantial distances in diverse settings to serve struggling students and their families.

California Association of Health & Education Linking Professions (CAHELP).

The California Association of Health & Education Linking Professions (CAHELP), Joint Powers Authority (JPA), is a consortium of over 30 school districts, charter schools, and the County Office of Education in San Bernardino County, California. CAHELP serves more than 44% of all districts and charters in a county that is the fifth most populous in California and 12th most populous in the United States (U.S. Census Bureau, 2017). Demographically, the county is 51% Hispanic, 31% White, and 8% African American, with the remaining 10% either two races or more, Filipino, Asian, American Indian, Pacific Islander, or did not report. The student population CAHELP serves aligns with the county demographics except for families identifying as African American, in which the student population is greater at 12% (California Department of Education, 2017). Besides being one of the most populous counties in both California and the United States, San Bernardino is the largest county by area in the United States at more than 20,000 square miles (see Figure 1). CAHELP's local plan area covers districts that are more than 200 miles apart and are located in urban, suburban, rural, and isolated areas in mountains, desert, and national parks. This complex terrain, known as Desert Mountain (DM), is where the San Bernardino, San Gabriel, and San Jacinto mountains meet Morongo Valley and the Mojave Desert.

Figure 1 San Bernardino County

To provide services to such a diverse community, CAHELP divided itself into three distinct branches – DM Special Education Local Planning Area (SELPA); DM Charter SELPA; and DM Children's Center. First, the two SELPAs were organized to specifically supply services meeting the regulations outlined in state and federal mandates under the IDEA. But it is in the third branch, DM Children's Center, that the organization has done its most visionary work. The DM Children's Center provides behavioral health consultation, special education supports, and professional development services and programs to its charter member students and families (California Association of Health & Education Linking Professions, n.d.). For example, the DM Children's Center offers three programs that serve students from birth through 6 years old: Early Identification & Intervention Services (EIIS), Screening, Assessment, Referral, and Treatment (SART), and the Comprehensive Assessment, Research, and Evaluation (CARE) Clinic. This organization is illustrated in Figure 2.

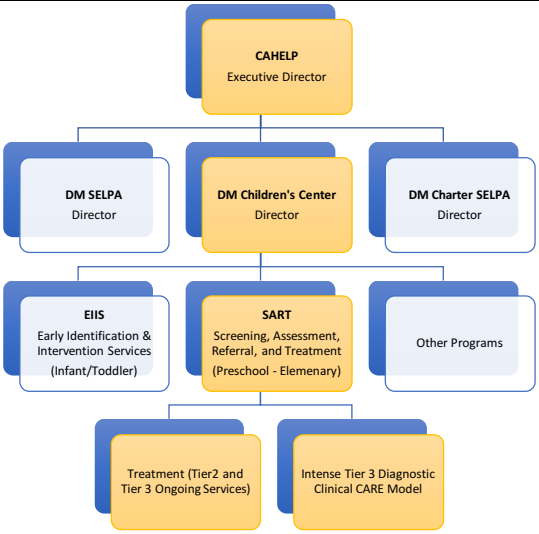

Figure 2 CAHELP Organization Chart

The Screening, Assessment, Referral, and Treatment (SART) process.

While this study focused on the CARE Clinic, an understanding of the Screening, Assessment, Referral, and Treatment (SART) process is first necessary. The DM SART brochure describes it as a "comprehensive screening, assessment, and referral process for students experiencing behavioral problems and difficulties maintaining appropriate behaviors in preschool settings and the child's home" (Desert Mountain Children's Center, 2015, p. 1). SART is a dynamic assessment process (see Table 1) that utilizes 32 screeners, diagnostic methods and parent surveys to identify students' strengths and modifiable issues in two areas, mental health and social emotional, to determine behavioral risks and potential solutions. The Desert Mountain assessment matrix uses diagnostic, formative, benchmarking, and summative assessments. This variety of tools provided the staff with a clearer understanding of the child's needs, response to intervention, and a more thorough summative report generated for the family.

Table 1

SART Assessments

Parent Orientation and Assessment Packet	SART Assessment	SART Tier 3: CARE Clinic Pre- & Post-Assessments
1. Behavior Rating Inventory of Executive Functioning Brief 2. Child Behavior Checklist (CBCL) 3. Sensory-processing measure 4. Eyberg Child Behavior Inventory ECBI 5. Therapy Attitude Inventory 6. Vineland-II Adaptive Behavior 7. Parent Stress Index-4 (PSI-4)	1. CHI Mental Health Intake Packet 2. Children's Global Assessment Scale 3. Adult-Adolescent Parenting Inventory (AAPI-2) 4. Ages & Stages Questionnaire Social-Emotional 5. Child and Adolescent Needs and Strengths (CANS) 6. Mullen Scales of Early Learning 7. Developmental Profile-3 (DP-3), if needed 8. Peabody Developmental Motor Scale-2 9. Sensory Processing Measure – Preschool 10. Rosetti Infant-Toddler Language Scale, if needed 11. DAYC-2 - Adaptive Behavior Domain - Communication Domain - Physical Development Domain - Social Emotional Domain	1. Behavior Rating Inventory of Executive Functioning Brief 2. Child Behavior Checklist (CBCL) 3. Sensory-processing measure 4. Eyberg Child Behavior Inventory ECBI 5. Therapy Attitude Inventory 6. Vineland-II Adaptive Behavior 7. Parent Stress Index-4 (PSI-4) 8. Bracken Basic Concepts – Expressive 9. Bracken Basic Concepts – Receptive 10. Preschool Language Scale 11. Receptive One Word Picture Vocabulary Test-4 12. Sensory Processing Measure Preschool 13. Peabody Developmental Motor Scales 14. Psychoeducational Profile-3

During the 2015-2016 school year, SART received approximately 15,000 referrals for mental health assessments, 10% of them for children 3 to 5 years old. The preschool students came from both general and special education classrooms. Children with special needs were referred to SART when their home schools were unable to stabilize behaviors and because they needed additional assessment to determine how to serve them best. After that assessment, the

students' families received recommendations and referrals to appropriate providers when they needed mental health services.

Through the SART program, the DM Children's Center may have also been the provider of these services. Treatment may have include (but was not limited to) Theraplay®, sensory processing, speech-language instruction, individual or family psychological therapy, or parent-child interaction therapy (PCIT). Of students referred to SART for mental health assessments, the agency reported that 90 to 95% received services through either the DM Children's Center or other community agencies. The remaining 5 to 10% did not need services because either the problem was resolved when the family or school received the initial SART recommendations (Desert Mountain Children's Center, 2015), or no services were needed.

SART - Tier 3 Behavioral and Social Emotional Assessment Strategy: The Comprehensive Assessment, Research, and Evaluation (CARE) Clinic.

CAHELP's Comprehensive Assessment, Research, and Evaluation (CARE) Clinic is a 10-week intensive assessment program with two additional weeks of pre- and post-transitional activities for a total of 12 weeks of off- and on-site services. The program conducts four sessions a year (winter, spring, summer, and fall), with up to 10 students enrolled in each session for 40 total participants a year.

The CARE Clinic is not a treatment center. A deeper level of assessments occurs for students between 3.5 and 6 years old in a process. The clinic's trained transdisciplinary team conducts ongoing assessments to identify strategies that successfully mitigate or eliminate behavioral problems. The team includes a pediatrician, a pediatric neuropsychologist, a clinical psychologist, a school psychologist, a speech-language pathologist, an occupational therapist, a public health nurse, a licensed clinical social worker, a marriage and family therapist, and employees trained in applied behavioral analysis (ABA) techniques (Desert Mountain Children's

Center, 2015). The team works with the families to ensure that strategies developed to address behavioral concerns experienced in the school and at home are developmentally and culturally appropriate. During the 10 weeks of sessions, every student must attend the clinic for four hours a day and participate in two to three sessions a week of sensory processing, speech and language instruction, and occupational therapy. Families must participate in PCIT as well. At the end of the 10 weeks, the transdisciplinary team, in partnership with the families, completes a transition plan that includes an extensive report that the CARE Clinic shares with each student's home school.

The transition plan is more than a written document, however. It is also a series of activities, starting with a summary of the student's pre- and post-program assessments, a list of strategies that mitigated behaviors, and in some cases educational tools (for example, picture cards), visits to classrooms where clinic employees model strategies, and meetings with home school personnel.

Purpose of Study and Research Questions

Even though the DM Children's Center provides Tier 1 through Tier 3 preventative and intervention services, the focus for this study was the Tier 3 CARE Clinic model. This model has integrated three major recommendations from the 2002 President's Commission on Excellence in Special Education in a single program that looks at children struggling with behavior or social emotional issues in their earlier years to mitigate future problems, and does so using a complex assessment system that integrates parents throughout the process. Figure 3 demonstrates the logic behind the model. The bolded blue outline indicate the areas that this study investigated. The logic model included inputs, process, who/what is being impacted (such as system or student), and outcomes. The inputs reflect the resources used to create the SART

model. The process reflects how the resources are deployed and the strategies that make up the SART model. The third component of the model identifies the intended recipient, and the fourth covers the outcome(s) of the model.

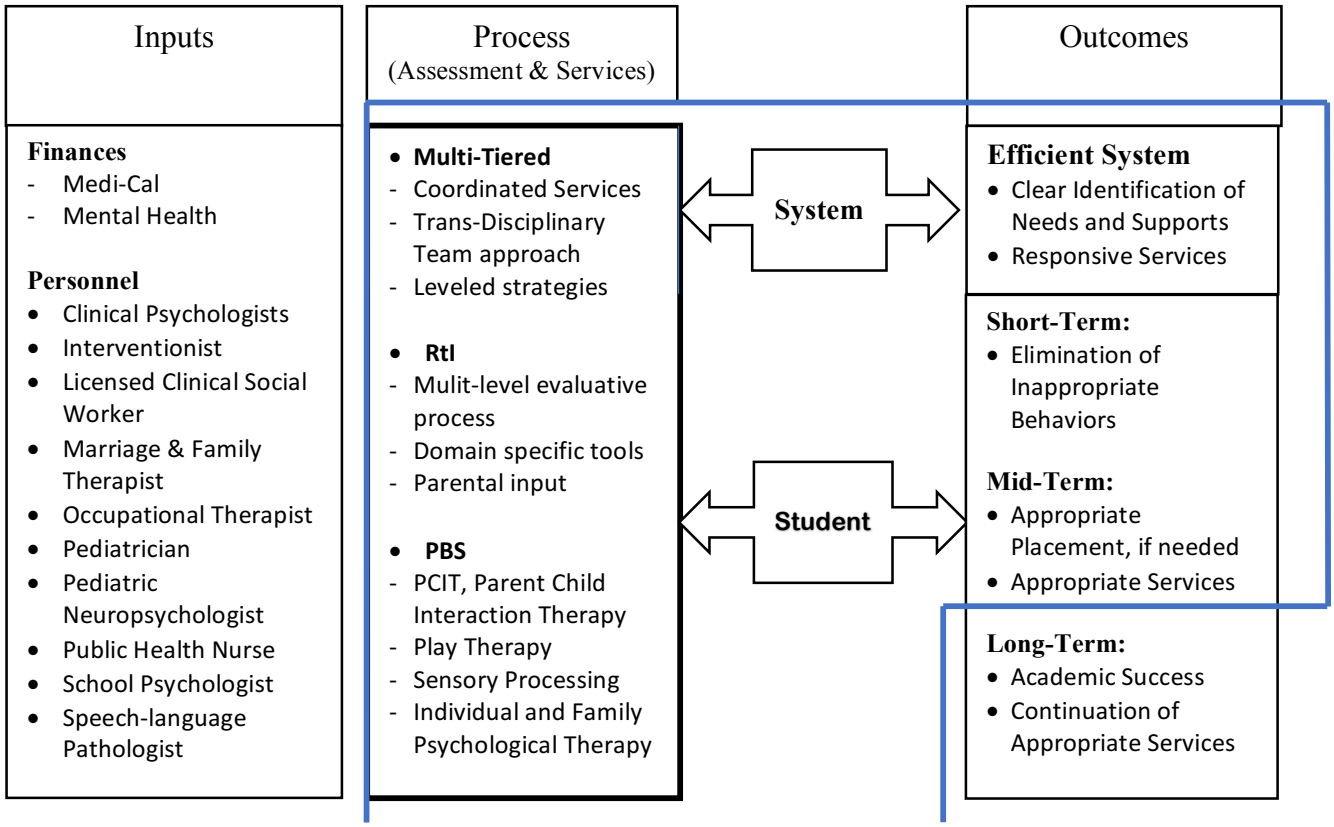

Figure 3 Logic Model

The purpose of this study was twofold. The first was to describe an early-education, multi-tiered, prevention and intervention process called SART, with a focus on the third tier called the CARE Clinic. The second was to examine families' perceptions of the process and its outcomes through the lens of a social-validation study.

The SART model and CARE Clinic process are complex systems. To fully understand the parents' perspectives and potential outcomes, a description of both the SART Model and CARE process was captured.

Data were collected from multiple sources at varying levels to answer the research questions. The questions asked participants to describe their experiences with the SART Tier-3 Clinical CARE process and to subsequently move to a more probative process in which more detail could be gathered and cross-referenced through observations and document analysis. The questions dealt with What is SART?, What are the outcomes of SART for the participating families?, and How are these outcomes valued by families? Survey questions and follow-ups are listed below.

Q1: What is the DM Children's Center early-education, multi-tiered or SART model?

- What is the assessment process and how does this process ensure appropriate services are provided for children and their families?
- What is the service-delivery system and how do the services align with family values?
- What role does the family play in determining what services are appropriate for their child?

Q2: What is the impact of the SART process for families?

- What is success, as described or expected by the family? Was success achieved?

Q3: How do families perceive the value of the SART process for their child and their family?

Chapter 3: Method

The study sought to understand how the DM model functioned by detailing the program's processes for identifying students' needs and the services provided to meet those needs. Examining these details provided the researcher with multiple opportunities to cross-reference information with participating families while identifying the social importance of the intervention for those families.

Study Design

Yin (2014) recommended using a case study when "your questions seek to explain some present circumstance or require an in-depth description" (p. 4). Since the Desert Mountain Diagnostic Clinical CARE Model (DCCM) was the case (or unit of) study, the researcher observed and described the diagnostic clinical services that Desert Mountain provided, the delivery systems for these services, how the delivery model adjusted to specific needs of students and their families, and the outcomes after the student completed the 10-week formal session.

The researcher studied the effects of the intervention on the families through a "social-validation" framework. Leko (2014) urged scholars in behavioral science "to ensure interventions were important to clients' lives and could be sustained in community settings" (p. 275). Numerous studies have defined social validation as the process of quantifying the value of the research findings by engaging the consumers to determine the worth of the research to the client (Francisco & Butterfoss, 2007; Wolf, 1978; Kadzin, 1977). Prior to the Wolf publication, the managing editor of the *Journal for Applied Behavior Analysis (JABA)* asked Wolf, "What was the purpose of our journal?" Wolf responded, "It is for the publication of applications of the analysis of behavior to problems of social importance" (Wolf, 1978). Wolf expanded on this statement in the *JABA*'s 1978 summer edition, stating, "Social importance was a subjective value

judgment that only society was qualified to make, and *JABA* needed to develop better systems and measures for asking society whether we were accomplishing this objective" (Francisco & Butterfoss, 2007; Wolf, 1978; Kadzin, 1977). The process proposed by Wolf involved asking consumers about the:

- Social acceptability or significance of the goals – is this what society wanted?
- Social appropriateness of the procedures – do the ends justify the means? and
- Social importance of the outcomes or effects – are the consumers satisfied with the results (Kadzin, 1977)?

Social-validation studies provided a format for this researcher to ask how these interventions affected the lives of the participants or recipients.

Phase 1: Staff

In the first phase of the study, the researcher interviewed and observed staff as they conducted their day-to-day activities in the program's assessment process and service delivery. A comprehensive review of documents related to the organization and the process followed. These documents included manuals, websites, forms, and correspondence from staff announcing public events such as training sessions.

Setting.

The Desert Mountain Children's Center (DMCC) is located in Apple Valley, California, approximately 100 miles northeast of Los Angeles and 176 miles from its furthest partner school district, Needles Unified, which touches the California-Arizona border. In addition to the DMCC, the facility includes state-funded general- and special-education preschool classrooms. The DMCC's suite includes a classroom, an occupational therapy (OT) and sensory processing room, a speech therapy room, and a parent-child interaction therapy (PCIT) room. Interviews,

observations, and data collection occurred at this center or in the CAHELP central office, located in another nearby building.

Participants.

The target population for Phase 1 was the Desert Mountain Children's Center's administrators and staff who provided direct services to children enrolled in the 10-week Diagnostic Clinical CARE Model (DCCM) process. Administrators included one of the two individuals credited with designing the program, who is currently executive director of CAHELP, the administering organization. In addition, interviewees included the current director of the DMCC, who was actively engaged in refining the model, and members of the trans-disciplinary team that provided direct services to participants. This team included a pediatrician, a pediatric neuropsychologist, a clinical psychologist, a school psychologist, a speech-language pathologist, an occupational therapist, a public health nurse, a licensed clinical social worker, a marriage and family therapist, and employees trained in applied behavioral analysis (ABA) techniques. Participating staff received a description of the study.

Data collection.

Phase 1 used three different processes to document how Desert Mountain Children's Center staff assessed, evaluated, and assigned students to its CARE Clinic program. The researcher interviewed staff, observed them providing services, and collected written documentation created by the agency to describe the program's processes, policies, procedures, and implementation guidelines. All data were transcribed, verified, and cross-referenced with staff for accuracy.

Interviews with staff.

The researcher conducted semi-structured interviews with program staff members to learn what they do and how they do it (Richards & Morse, 2007, p. 113). Staff members

answered two to three broad questions developed to elicit their anecdotes and descriptions of their workday, using the prompt, "Please describe what you do." Interviews covered two to three sessions. In the first, the researcher sought a general understanding of what the person did in the program. For example, a description of a day or a week in the work of a DMCC psychologist. All initial sessions lasted approximately 30 to 45 minutes. A second session clarified and verified information shared in the first session and provided an opportunity to gather additional information. The second session, lasting 20 to 30 minutes, was scheduled and conducted after reviewing documents provided and observing staff members' interactions with students and other staff members during the workday. If needed, a third session followed to further verify information.

Document review.

Staff were asked to provide any written documents that pertained to their role in the treatment process, such as job descriptions, policies and procedures, flyers, brochures, and board reports. All documents were copied and cross-referenced with information gathered during interviews, and non-confidential documents were shared with parents and community partners.

Observations.

A benefit of Phase 1 observations was allowing the researcher to see what regular activities the program staff took for granted (Richards & Morse, 2007, p. 116). These were duties that staff members carried out and assumed were obvious to everyone, and therefore omitted mentioning in interviews. The researcher observed each staff member at key points of the 10-week formal sessions, including transition segments. The observation points in the process were selected with staff assistance. Observations were scheduled to ensure the researcher saw the Screening, Assessment, Referral, and Treatment (SART) process; the transition process into the DCCM; the beginning of the CARE Clinic process; the middle of

clinic; the end of clinic; and, the transition out of the DCCM. Since the DM Children's Center is a training facility, parents signed a consent form as part of the enrollment process, giving the DMCC permission to allow ongoing observations. For this study, the researcher observed 10 staff members conducting their work with families and students on seven days over a four-month period. The observations were conducted in 30- minute blocks for a total of 28 observations.

Phase 2: Families

The second phase of the study involved collecting and analyzing parents' perceptions of the system's assessment process, services and outcomes. Surveys and follow-up interviews were used to obtain the families' firsthand account of how the DMCC assessment process affected their child and their family. Data collected from families were used to affirm (or deny) information provided by the staff. The family data provided the researcher, Desert Mountain staff, and others interested in replicating the model insights into the families' perceptions and feelings about the process.

Participants.

The study surveyed families who participated in the spring 2016, 2017, or 2018 cohorts of the Desert Mountain CARE Clinic. The spring session occurred from April through mid-June, after which the children transitioned to a school setting. This selection of families provided the researcher with data from the same time frame but in different years. Each CARE Clinic session included 10 students for a maximum of 30 potential families over three years. All of these families were asked to participate in the survey. The Desert Mountain Executive Director mailed a recruitment letter to parents (see Appendix A: Parent Recruitment Letter). The letters were mailed on two different occasions – July 18 and August 3, approximately three weeks apart (see Appendix A). The families were encouraged to contact the researcher directly or, if they felt

more comfortable, to notify DMCC of their interest. All participating families contacted the researcher directly, at which time the researcher answered all their questions. Finally, procedures for signing the consent form, disbursing and returning the questionnaire, and processing credit cards for payment for participation in the study was discussed with each family.

The researcher hoped to survey as many of the families in the program as possible, but recognized that some families probably would not participate. A family may have moved, for example, or current contact information was not available for other reasons. The program used a progressive definition of family, defining it as any significant adult in the child's life. The significant adult could be a biological grandparent, aunt, uncle, sibling, or a caring adult given guardianship through human services. It was therefore possible that the adult who participated in the parent trainings, transported the child to sessions or was the legal guardian during the 10 weeks of the program may not have been the same person who cared for the child when it was finished. Thus, the researcher took extreme care to identify the appropriate adult during the pre-survey process. While documents were available in Spanish, no families requested translation or an interpreter during the study.

All families were offered a $100 VISA gift card for participating in the survey. Parents received a study description before being asked to sign the confidentiality agreement and an informed consent form (see Appendix C: Letter of Consent). Thirty families received a recruitment letter, after which 11 families agreed to participate. These families first participated in a 15-minute pre-survey telephone call. During the call, parents could ask questions or express concerns about the study. All 11 families agreed to participate and were asked to sign the consent form and forward it to the researcher. Eight of the 11 families completed the survey.

Seven of these eight families received an additional $100 VISA card for participating in a follow-up interview.

Setting.

The participants self-administered all but one of the initial surveys through Google Surveys. The researcher administered the remaining survey by telephone. Follow-up interviews were conducted by ZOOM, a self-described video conferencing software platform that connects participants by desktop or IOS device, such as phone, tablet (ZOOM, 2018). Therefore, surveys and follow-up interviews were conducted in the homes of the families.

Data collection.

Three major trends in survey data-collection methodology influenced the study's collection process. These are a shift from interviews to self-administered surveys; an increased reliance mixed modes rather than a single mode; and survey designs that reflect characteristics of different populations (Dillman, 2016; Dillman, Smyth, & Christian, 2014). New technology and the use of the internet to conduct what was considered very personal business, such as banking transactions, purchases for small-to-large items (such as toothpaste to a car), job applications and credit payments, have modified how surveyors view self-administrated questionnaires (Dillman, 2016; Lavrakas, 2008). A practice is now seen as a credible research tool (Brick, Williams, & Montaquila, 2011; Brick, Montaquila, Han, & Williams, 2012). Therefore, the reliance on an in-person or telephone interview was no longer considered necessary to motivate respondents.

In their research Brick, Williams, and Montaquila (2011) used a two-step process that combined a pre-survey phase to ensure appropriate participants were identified for the survey and later followed up with the actual survey. In this study, a pre-survey process was integrated into the survey process. Besides giving the participants an opportunity to answer and ask questions, it ensured that the appropriate persons took the survey. During the pre-survey phase,

the researcher described and answered questions about the study, identified the appropriate adult in the family to participate in the study, explained the survey and follow-up interview process, and described the VISA gift card distribution.

The final part of Phase 1 involved the participants selecting their preferred methods for completing the main study survey. The options were self-administered (mail or internet) or interview (in-person or telephone). In the last step, the researcher forwarded to each participant a "family code" to be used when completing the survey. Families were asked to replace their name with the code and use pronouns when referencing their child, family members and to use job titles for Desert Mountain staff.

Survey.

The questionnaire included sections on participant demographics, child's behavior before participating in CARE process, the CARE process, and child and family's experiences after participating in the CARE process.

San Bernardino County's residents and terrain are very diverse. Understanding the Desert Mountain CARE Clinic model through the experiences of individuals who live in high country versus the more densely populated eastern Los Angeles County area was necessary to achieve a more accurate portrayal. The survey was organized to understand the families' experiences before, during, and after completing the CARE process. It asked the family members to describe the experience and how they felt about various parts of the process, such as assessments. For example, "Do you agree that the Desert Mountain assessment process was fair?" Aligned with a social-validation question, the study examined the outcomes by asking the family to report on the child's behavior and the parent's discipline strategies before and after completing the CARE process. Embedded throughout the survey were questions asking families how they felt about the process (see Appendix E: Family Survey).

Specific strategies were selected to combat some typical design flaws with questionnaires. These flaws included failing to account for common method bias, failing to use appropriate, if any, control measures, and failing to test alternative models of the data (Friedrich, Byrne & Mumford, 2009). To protect against method bias (a problem with using only one process to gather data, which inflates or deflates findings), the questionnaire was available by mail, internet, in-person, and telephone. The diverse availability of the survey was a response to parents working various shifts, living anywhere in the county, or with limited resources and was an attempt to equalize opportunity to respond to the questionnaire.

The overall design approach prevented and clarified another potential issue – ambiguous or confusing questions. The tool was pretested with a nonparticipating parent before it was distributed to participating parents. This first step controlled for potential errors. Because multiple modes were used to collect the data, controls were put into place to limit self-administered surveys and phone surveys being treated differently. For example, during the interview processes it was possible for the interviewer to ask follow-up questions. Because this was not available for the participants using the internet, the researcher only asked survey questions on the telephone with no follow-up or clarifying prompts. Follow-up questions were limited to the follow-up interviews.

Lastly, failing to test alternative methods was the third critical issue observed in questionnaires (Friedrich, Byrne, & Mumford, 2009). The study addressed this issue by analyzing the data in multiple ways and triangulating findings from staff and parent interviews.

Follow-up interviews with families.

The researcher conducted semi-structured interviews with family members to expand and clarify survey responses. All families answered two to three broad questions developed to elicit their perceptions of the CARE process. The prompt, “Before CARE, please describe a typical

day in your child's life?" was always followed by the prompt, "After CARE, describe a typical day in your child's life." The ZOOM application conducted the 1-hour interviews. Families that shared extensively on their survey were also more likely to share more data during the follow-up interview. The ZOOM function that transcribes conferences was also utilized for this study. The researcher checked the transcriptions for accuracy at the end of each interview by checking the transcription with the researcher notes. Figure 4 illustrates the data-collection process for this study.

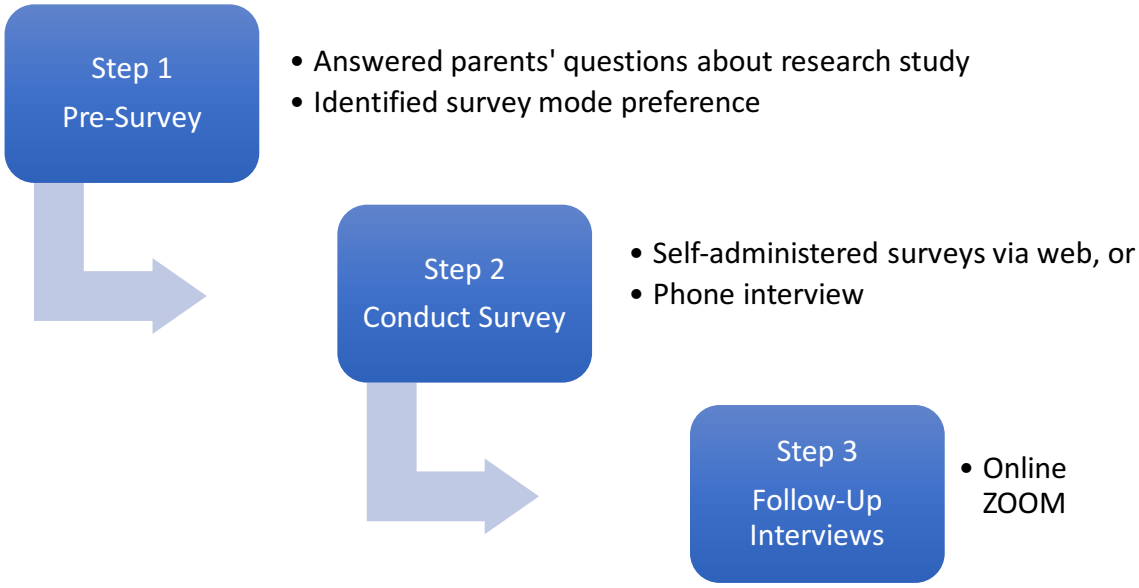

Figure 4 Data-Collection Process

Analysis.

Data were analyzed in three stages. Stage 1 was coding the staff interviews, observations, and supporting documents. Stage 2 involved collecting, coding, and summarizing the questionnaires. Stage 3 included cross-referencing and triangulating the parents' experiences with the staff interviews regarding how the processes and services were implemented; coding parents' impressions of the intervention; and organizing the data into overarching themes.

Data validity and reliability.

Creswell (2003) suggested that reliability plays a minor role in qualitative research but validity is a strength, and thus accurate findings are essential. This study used four strategies to increase validity: (1) triangulation, (2) member-checking, (3) peer debriefing, and (4) acknowledging researcher bias. Triangulation, the examination of multiple data sources or information (surveys, interviews, document review, and observations) was used to answer the study questions (Richards & Morse, 2007; Creswell, 2003). Staff interviews were compared with parents' perceptions of the intervention process and description of what parts of the intervention they felt were the most useful. While it was possible that the parents may remember feeling great about a singular event, such as a parent training, this did not guarantee that they remembered the details of the actual intervention. According to Stake (1995) triangulation can improve accuracy of descriptions and explanations of events while simultaneously providing multiple perspectives. Table 2 illustrates data-triangulation processes for research questions 1 through 3.

Table 2

Data Triangulation

Source	Staff Interviews	Observations	Document Review	Parent Survey	Parent Interviews
Research Question 1					
What is the DM Children's Center's early-education, multi-tiered model or SART model?	X	X	X	X	X
Research Question 2					
What is the impact of the SART process for families?	X	X	X	X	X
Research Question 3					
Social Validation: How do families perceive the value of the SART process for their child and their family?				X	X
Theory of Change	X	X	X	X	X

Participant- or member-checking was used to improve the accuracy of interviews, transcription, and analysis (Creswell, 2007). Participants (staff and parents) were offered the opportunity to review summaries, add relevant details not shared during the original interview but triggered due to the review process, and interpretations that appropriately reflected parents' thoughts and feelings.

Lastly, acknowledging researcher bias (for, as Creswell stated, "Self-reflection creates an open and honest narrative that will resonate well with readers" (2007, p. 196)), the researcher had a professional and personal interest in this study. As the chief/associate superintendent of early education for one of the largest school districts in the San Francisco Bay area, the researcher was responsible for ensuring that the approximately 1,400 students who entered kindergarten every fall were "kindergarten-ready." Unfortunately, a significant percentage of the students did not meet this goal. One of the main reasons was inappropriate behavior, according

to a committee that included parents as well as educators. Subsequent months of research identified the Desert Mountain DCCM as a potential solution, but missing from the recommendation was a clear description of the program or follow-up reports on how the children who participated in it were performing. In addition to adding to a body of research, the researcher wanted to know what parents thought about CARE.

Data analysis and interpretation.

Creswell (2007) recommended six steps to analyzing and interpreting data. These six steps were used in this study in conjunction with analytical techniques that assisted the researcher with reporting the findings (Yin, 2014).

Step 1 was to transform observational and verbal data into written text by transcribing notes. Saldana (2016) recommended organizing these data by transcribing descriptive and narrative passages in regular font and quotations in bold font. Additionally, provocative or powerful quotes or observations were highlighted. These quotes were so rich that they clearly stood out.

Step 2 involved an open-ended process called eclectic coding (Glaser & Strauss, 1967) where "first impressions" or phrases of the text are selected from the transcribed notes (Saldana, 2016). Eclectic coding was considered appropriate when initially reviewing data from a variety of sources, such as interviews, observations, documents, and surveys. The use of various collection processes also led to different coding processes, such as attribute coding of the demographic data and descriptive coding from interviews with staff. These notes were arranged into categories and coding schemes.

Step 3 was the identification of categories and coding schemes. Morse (1994) described this as "linking seemingly unrelated facts logically into categories one with another" (p. 25).

Coded data were recoded, organized, reorganized, and reconfigured to develop a "smaller and more select list of broader categories" (Saldana, 2016, p. 234).

Step 4 was "theming the data," or transforming the categories into landscapes or outlines, while Step 5, as a precautionary measure, implemented a coding-scheme test to develop and validate the process. Two additional coders (a social worker from a California school district and a retired school psychologist) joined the process to discuss and reflect on the coding scheme. Low levels of consistency triggered further discussion, a coding-rule revision or a modified definition for the theme. All coding issues were discussed and resolved.

Because coding proceeded while new data rolled in, new themes and concepts emerged and were added. Step 6, final coding rules, occurred after consistency was achieved and all data had been collected. Final coding rules were applied to all data.

Chapter 4: Findings

This study explored the perceptions of parents or families whose children had completed the Desert Mountain CARE Clinic program during the spring of 2016, 2017, or 2018. The study examined these perceptions through a two-phase process. Phase 1 described the SART and CARE Clinic processes by interviewing and observing staff and reviewing documents. During Phase 2, information shared by parents was collected, analyzed, and triangulated. It included a survey of the experiences of parents or legal guardians with the SART/CARE Clinic process and its short-term impacts on their families.

Collection of these experiences with the CARE Clinic process was achieved through a survey and follow-up interviews. In both administrations, the researcher used these study questions to organize the findings.

Q1: What is the DM Children's Center early-education, multi-tiered or SART model?

Q2: What is the impact of the SART process for families?

Q3: How do families perceive the value of the SART process for their child and their family?

Aligned with the tenets of a social-validation study (Schwartz, 1991; Kadzin, 1977), parents shared demographic information, descriptions of pre- and post-process child behaviors, the impact of the CARE Clinic process on the family, and the outcomes or value of the process to their child's current behavior. In other words, was the CARE Clinic program worth the effort?

Yin (2003) provided three different ways to present a mixed-method study, and his following recommendation was used to report the findings of this study: "The quantitative and qualitative data collection may be presented in separate sections, but the analysis and interpretation combines the two forms of data to seek convergence among the results" (p. 222).

Phase 1: SART Description

Question 1 was, "What is the DM Children's Center early-education, multi-tiered or SART model?" The Desert Mountain Children's Center is part of a larger agency that serves over 20 school districts in a large geographical area (California Association of Health & Education Linked Professions, 2018). The agency serves infant/toddler to high-school students through a complex, multi-tiered system organized by age ranges. The goal of this study was to answer questions directly related to the CARE Clinic process, which is only one part of the SART assessment system. Yin (2014) recommended bounding the research to clarify what will be studied. Thus, the descriptions considered for this study cover only the parts of the SART process that lead directly to the CARE Clinic (see Figure 5). That includes all unshaded boxes in Figure 5, while the blue-shaded boxes illustrate the decision-making process, and the green-shaded boxes show the CARE Clinic process.

Description development included staff interviews, observations, and document review. Program manuals, brochures, websites, and outwardly facing memos were referenced and cross-referenced to identify points of alignment. The researcher then used these documents to provide focus for the observations and to summarize the process. Cohort 2016 families described the initial assessment process differently from families participating in spring 2017 and spring 2018. Desert Mountain staff noted the change in Medicaid regulations governing the time frames for starting and completing child assessments attributed to the modifications in the assessment process. Other than this anomaly, Figure 5 accurately depicts the process as understood and explained by the parents and cross-referenced with the DM staff.

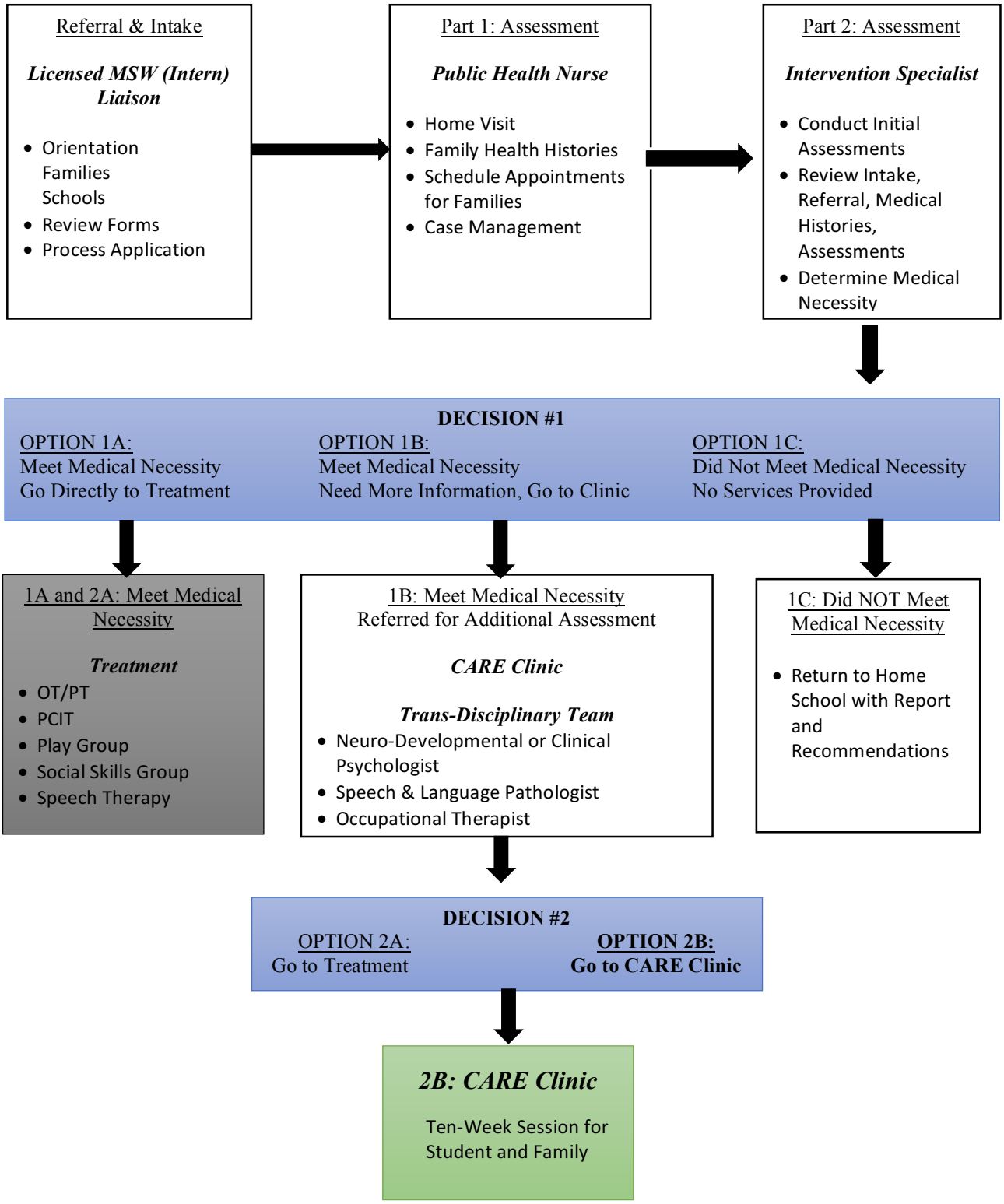

Figure 5 Screening, Assessment, Referral, and Treatment (SART) Process

The current Desert Mountain (DM) SART brochure describes the process as a "comprehensive screening, assessment, and referral process for students experiencing behavioral problems and difficulties maintaining appropriate behaviors in preschool settings and the child's home." During the past three years (school years 2015 – 2018), SART received approximately 45,000 referrals per year for mental health assessments, of which 10% were children between 3 and 5 years old for a total of 4,000 to 5,000 preschool screenings and assessments. The preschool referrals came from school districts, health care staff, social service workers, and parents. Desert Mountain has a contract with San Bernardino County's Office of Health & Human Services (HHS) to conduct the state-required intake assessments for children taken into State Protective Services (Child Welfare Information Gateway, 2015). Though all of DM's referrals do not come from the county's HHS office, the time sensitivity of the federal regulations and funds influenced the entire assessment process. In addition to students referred from HHS, children with active IEPs participated in SART due to their home school's inability to stabilize behaviors or because they needed additional assessment to determine more appropriate services. After completion of the SART process, DM staff prepared a report with recommendations and referrals to appropriate providers when needed.

Pre-SART (referral and in-take).

Students referred to SART came from a variety of settings, such as home, general and special-education classrooms, and were between 3 and 6 years old. Receipt of the referral generated the following steps:

- Referrals received by DM were processed by a clerk who forwarded an enrollment packet to the parent or legal guardian.

- Enrollment packets included an application, permission forms, an "ages and stages" form, a questionnaire (ASQ), and releases.
- The clerk scored the returned ASQs and forwarded the completed enrollment packet to the public health nurse (PHN) to initiate the clinical assessment.

The pre-SART process from start to finish could take from a few hours to multiple days, depending on the families' response time.

Assessment by public health nurse.

The public health nurse (PHN) followed up on every referral by conducting a home visit with every family or legal guardian. Initially, the home visit was a 6- to 8-hour interview that covered prenatal experiences, post-birth health, and biological mother and father's health history. In the past 18 months, the home-visit interview replaced the center-base interview to ensure the process aligned with the new timeline. The PHN started the session by reviewing the pre-SART application, ASQs, and forms. The PHN discussed maternal pregnancy, labor and delivery, the child's health history, the mother's and father's family history, and any current health problems for the child. Once the PHN completed the interview, the children and families were referred to a licensed therapist for Phase 2 of the clinical assessment. The time between the PHN and the licensed-therapist assessments differed by cohort, with the 2016 and 2017 groups having a longer span in between than the 2018 cohort. Once again, this reflected the changes in federal regulations.

Assessment by licensed interventionist and staff.

After the PHN gathered the medical histories, the second portion of the assessment started with a licensed therapist (LT) or interventionist. The LT's role was to interview the participants and identify issues in the family's environmental and developmental history and relatedness. If appropriate, the LT also conducted an infant/toddler mental status examination.

Originally 20 to 24 hours over two to three days, the process was shortened to one day after the federal regulations changed.

The assessment team gathered the data from the LT, the PHN, and other sources as a team in one sitting. The staff then observed the family with the child, after which the appropriate staff member would pull either the family member or child aside to get more in-depth information. All data collected during the assessment process were summarized and analyzed to make the first decision: Do the needs identified through the assessment process meet "medical necessity" for treatment? The Board of Trustees of the American Psychiatric Association and American Medical Association (2015) jointly define medical necessity as,

> Services or products that a prudent physician would provide to a patient for preventing, diagnosing, or treating an illness, injury, or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice, (2) clinically appropriate in terms of type, frequency, extent, site, and duration, and (3) not primarily for the convenience of the patient, physician, or other health care provider (p. 1).

As reported by staff, over 90% of the students referred to SART met medical necessity. The remaining 10% received an extensive report of all assessment results with recommendations, but these students were typically not provided services at Desert Mountain. Students meeting medical necessity went into either treatment or were forwarded to the CARE Clinic for a more in-depth assessment.

Treatment.

Students referred for treatment received specific services such as speech, play, and occupational therapy, assigned to one or a combination of services as determined by their assessments. In keeping with RtI practices, students who moved directly to treatment received

ongoing monitoring to ensure interventions were effective (Buysse, 2013). The services available in treatment were not part of this study.

For students referred directly to treatment, additional assessment data were summarized in a report with recommendations called the SART Trans-Disciplinary Summary. Of the students assigned to SART for mental health assessments, all but a small fraction received services in Treatment.

CARE Clinic.

The remaining 1% of students participated in an even more specialized assessment process called the CARE Clinic. Children were referred to the CARE (Comprehensive Assessment, Research, and Evaluation) Clinic because more information was needed to understand how best to improve service; the complexity of the child's life circumstances or the student's behavior significantly affected his or her ability to maneuver through a day. The CARE clinic has a trans-disciplinary assessment team that includes an occupational therapist (OT), a speech and language pathologist (SLP), a pediatrician, a neurodevelopmental or clinical psychologist, a licensed therapist, and a public health nurse, ensuring a wide range of experience and follow-up.

Before a student was assigned to the CARE program, families toured the facility, met with the CARE team, and learned about their role in the process. After the team met with each family, it decided on the best student mix for each cohort, striving for a mix of situations and avoiding, placing too many students with the same needs, such as behavioral problems into one cohort.

Components of the CARE Clinic.

A parent described the CARE process as, "…they [CARE staff] have to figure out what works by pushing the children to see what [strategies] works." As previously mentioned,

students who were referred directly to treatment received a prescribed set of services or strategies based on the results of the assessments. Students referred to the CARE Clinic, however, participated in a more intensive assessment cycle that involved the interventionist documenting the student's responses to specific interventions, called progress monitoring (Buysse, 2013). This 10-week cycle of assessment, intervention, document review, and re-assessment assisted the staff in identifying appropriate strategies for each child. A DM administrator stated,

> I must remind people what the acronym CARE stands for – Comprehensive Assessment, Research, and Evaluation, with an emphasis on research. We do not treat, but we research what interventions work best for each child. We do it in as much of a real-life situation as possible by documenting the effects of treatment in a classroom structure and when possible with the families during PCIT (parent-child interaction therapy).

Best student mix.

At the end of the CARE Clinic screening, the team identified a group of 11 to 13 students who would benefit from the process. To determine the best mix of students for each cohort, the prospective participants and their families spent a few hours at a CARE meeting with staff, learning how the process works. Families rotated through the facility to meet with specialists, ask questions, and learn the function of assessment. The specialists observed the children and their interactions with the family members. Once each child completed his or her visit, the team decided which families would be offered a placement in the CARE Clinic. Students who did not receive an offer after their initial visit were sometimes asked to participate in a future cohort.

Various DM staff members expressed the importance of having "a good mix" in each cohort "not too many students with hyperactivity or too many low activities," one staff member said, and the need for children to have peer models in their group. The process of deciding who got an invitation became a source of confusion for some families, and the need for a balanced

cohort added to the misunderstanding. "What were the criteria for ensuring balance?" one parent asked. Phase 2 of this study examined this issue.

Daily schedule.

Students accepted into the CARE Clinic program attended class four hours a day and rotated through seven to eight blocks per day, receiving treatment and practicing the strategies taught in the blocks (see Table 3). The blocks included discrete trials, workstations, occupation/sensory therapy, speech therapy, parent-child interactions, and group interactions.

Table 3

CARE Clinic Classroom Schedule

Daily Routine	Staff Member
Parent-Child Interaction Therapy (PCIT)	PCIT Specialist
Speech Therapy	Speech Pathologist
Occupational/Sensory Therapy	Occupational Therapist
Discrete Trial Training (DTT)	Interventionist
Workstations	Interventionist
Group Interactions (students practice and demonstrate skills) • Meals • Play Therapy • Circle Time • Transitions	All Staff

At least five staff members facilitated the schedule every day. Staffing included a speech pathologist, an occupational therapist, a certified PCIT specialist, and an interventionist. Interventionist was a title used for various types of licensed therapists, including a licensed clinical social worker (LCSW) and a licensed marriage and family therapist (LMFT). The minimum requirement for that position was licensed therapist or an intern under the supervision of a therapist on the CARE staff. Each child participated in all activity blocks, but the number of times per week varied. The students' needs and how they responded to the interventions

determined the frequency. The students were systematically rotated through the blocks for 10 weeks until the CARE team identified the appropriate set of strategies for each student (see Appendix F: Photograph of CARE Clinic Block Rotation).

Parent child interaction therapy.

PCIT is a "therapeutic approach based on behavioral principles and attachment theory that increases attunement between the parent and the child" (Thomas, Abell, Webb, Avdagic, & Zimmer-Gembeck, 2017, p. 2). The PCIT program works with parents and children together to improve the quality of their interactions and to teach positive discipline strategies necessary to understand and manage the child's behaviors. In learning these skills, they learn to establish and maintain age-appropriate limits and to decrease oppositional and noncompliant behaviors. Per staff interviews and observed weekly schedules, parents were required to participate in PCIT two to three times per week, and families' response to the therapy was generally good, with a few exceptions. The parents' comments are discussed in the survey results and parent narratives later in this chapter.

Speech therapy.

Communications development for young children included gaining the skills to understand and to express thoughts, feelings, and information. The connection between language problems and behavior is well documented (Hartas, 2012; Spira, Bracken, & Fische, 2005; Cohen, 2001). At Desert Mountain, the mental-health benefit in decreasing frustration and improving attunement by assisting a child with language was evident. Language expression progressed to words, sentences, and conversations through many methods, including gestures, spoken words, sign language, pictorial language systems, and communication boards. DM staff believed it was essential that a child had one of the ways as mentioned above of expressing language, as all relationships begin with communication. Multiple studies (Eichenberger &

King, 1995) have shown that during the early childhood years, responsive adults are critical for rich stimulation of children's communication skills. Unfortunately, the preschoolers who are at risk of failure usually did not have this type of responsive environment (Hollo, Wehby, & Oliver, 2014). DM treatment and its CARE Clinic process worked to remediate and rehabilitate in this area, which can vastly improve a child's behavior. DM used the Picture Exchange Communication System (PECS), a behavior analysis program designed for early nonverbal symbolic communication training for students (Bondy & Frost, 2001). Multiple parents shared stories of how PECS continued to be one of the lasting strategies they learned during the CARE Clinic process.

Occupational therapy with sensory integration.

Various studies have utilized one person's description of sensory integration (Ayers, 1979; Cohen, 2001; Dunn & Westman, 1997; Case-Smith, & Bryan, 1999). Sensory integration is a framework first described by occupational therapist A. Jean Ayres, in the 1970s. It refers to the body's way of handling and processing sensory inputs from the environment. A well-organized sensory system can integrate input from multiple sources (visual, auditory, proprioceptive, or vestibular). Ayres postulated that sensory integration dysfunction occurs when sensory neurons are not signaling or functioning efficiently, leading to deficits in development, learning, or emotional regulation.

Cohen (2001) characterized the issues associated with sensory integration dysregulation as *over-responsivity* (i.e., exaggerated, negative responses to typical sensory experiences in daily life) and *under-responsivity* (i.e., muted or delayed responses to daily sensory events). Studies have shown sensory dysregulation directly affects preschoolers' social participation, play, and engagement in home and school routines (Bar-Shalita, Vatine, & Parush, 2008). Families participating in the CARE Clinic process identified these behaviors as concerns, and studies have

identified a strong link between sensory processing and future impacts on adolescents (Polatajko & Cantin, 2010; Koenig & Rudney, 2010; Miller et al, 2007). DM placed a strong emphasis on the effects of occupational and sensory integration therapy and taught the concepts of sensory integration throughout the parent trainings, so much so that DM dedicated an entire classroom to occupation and sensory integrated assessment therapy (see Appendix G: Photograph of Occupational/Sensory Therapy Room). In addition to speech, occupational/sensory integration therapy had the most positive comments in this study. Parents described the parent workshops and listening sessions with the occupational therapist as being the most impactful, and they provided specific narratives about how it felt to have someone listen to them and affirm their feelings. DM staff provided individualized activities that assisted children with modulating, organizing, and integrating sensory information in their day-to-day activities. Children practiced their newly learned skills during play therapy, in which staff facilitated the students' efforts.

Discrete trials training (DTT).

DTT was used to teach developmentally appropriate communication, social, adaptive, and self-help skills (Joachim & Carroll, 2018). DTT breaks skills down into smaller steps and teaches one specific skill at a time until mastery. Also, DTT utilizes appropriate reinforcement procedures and allows for promoting and prompt fading as necessary. Buckman (1997) described the process as a four-step method that includes the trainer's presentation, the child's response, the consequence, and a short pause between the result and the next instruction (between interval trials). The DM process added an additional step to the process. Students practiced the lessons learned during the workstation block. No parents commented on DTT.

Workstations.

Incorporated into the daily CARE Clinic schedule, children had the opportunity to work independently on previously mastered skills. The goal of the workstation was for the child to

demonstrate full independence in completing tasks specific to his or her level. Once children mastered a skill within DTT, they were assigned tasks to achieve without the help of staff or peers. The child was required to travel to a designated workstation, follow a specific schedule of tasks, and eventually complete tasks without prompting or assistance from the interventionist. While two to three children were sitting together at their desk or pod, there was limited or no interaction between them. While they worked independently, the adult took notes and assessed the children's behavior.

Group interaction/play therapy.

Play therapy allowed children to practice their newly acquired forms of communication, turn taking, waiting, sharing and requesting items, social enjoyment of a meal with peers, and assistance as they desired it. The interventionist or DM specialist provided ongoing feedback that included descriptive language that was repeated by the child. During multiple observations, two to three children were observed working parallel with each other, problem-solving, role-playing, or directing the other students. The interventionist took notes while providing the students with differentiated feedback. For example, when two students argued over a play phone, the interventionist assisted them toward agreeing on the way to solve the problem of one phone for two students: They took turns.

The same type of social support was provided at meal and circle time. Children were encouraged to try new foods and communicate with their peers at the table or lead a song during circle. Most of all, staff members were observed throughout the day actively participating with the students and record-keeping, documenting each student's behavior or response to an intervention. At the end of each day, the team gathered to go over the effectiveness of the day and plan for the next day.

Typical student schedule during CARE process.

Before discussion and evaluation, the CARE Clinic's trans-disciplinary assessment team observed students' daily routines, which mimicked a typical preschool structure. Daily schedules were organized into individual, small, and large group settings facilitated by an interventionist, an occupational or physical therapist, or a speech and language pathologist. Upon arrival, each student signed with an adult and then went to the large group circle, where one of the above-listed adults conducted group discussion while two other adults modeled specific strategies with the children, such as using a Picture Exchange Communication System (PECS) card to communicate expectations.

Once circle time was over, the students and adults reviewed each child's posted schedule. One child, for example, went to discrete trials training (DTT), where an interventionist worked with him on appropriately playing a small, manipulative, counting bears card game. The interventionist modeled and supported the child numerous times until he responded correctly, as she documented each attempt. After completing DTT, the child moved to the workstation, where he worked independently on small manipulatives that were introduced previously in DTT. He sat at a booth next to another student with minimal interactions from either the other student or the adult.

This ritual of moving from one small group to another was repeated three more times, as the student participated in play therapy with an interventionist and two other students; speech therapy with a speech pathologist, and occupational and sensory-integration therapy with an occupational therapist. During play therapy, the student was reminded to use strategies learned or modeled during speech or occupational therapy. For example, he wanted a phone that another child was using. The interventionist modeled appropriate language along with ways to position his body by slowly moving towards the other child and verbally requesting a turn on the phone.

Lastly, staff (interventionists, occupational therapist, speech pathologist) participated in meal times with the students. Each staff was assigned two or three students, and each worked on a specific strategy, such as speech or behavioral cues. At the end of each day, staff documented how students responded to the intervention and noted changes needed for the following day.

Phase 2: Families

Using both surveys and interviews, participant narratives were created for each family that typically covered six overarching topics a participant's personal story; a typical day in their child's life before the CARE Clinic; how the child was referred to Desert Mountain; the parents' expectation of the CARE process; the student's current status; and a typical day in the child's life after the CARE process. Direct quotes were used to appropriately state a participant's beliefs. Additionally, the families' responses to the surveys were summarized question-by-question, except for demographic data summarized in a table.

Survey results.

The survey results were reported in four sections: (1) Demographics, (2) Before/After CARE, (3) During CARE, and (4) After CARE. The demographic survey data were compiled into a table for review, while the other three categories were summarized question by question. The Before/After CARE questions asked parents to rate either the child's behavior and their response to the behavior before and after participating in the CARE process. The During CARE category questions asked parents to rate or describe various methods that occurred during the CARE process and share their thoughts about their effectiveness. Lastly, the After CARE questions asked what happened once the child and family completed the CARE process (see Appendix E: Family Survey) and, as parents, if the outcome was worth the process

In Sections III and IV, the survey questions were organized in two parts – a Likert rating scale-like starter question with follow-up questions asking the participants to describe or explain their response to their rating on the Likert-like scale. This rating process was a quick way to assess the participants' attitudes about the SART and CARE Clinic processes (Arnold, McGroskey, & Prichard, 1967). Though the Likert-type questions were easy to administer, the downside is the overuse of the end points by participants, which can create a biased high or low score (Rocereto, Puzakova, Anderson, & Hyokjin, 2011) or the use of the midpoint when a question does not apply to the participant (Kulas, Stachowski, & Haynes, 2008). To counter these limitations, participants were asked to further explain why they felt this particular way about the program. The summaries of the questions are a combination of both the result of the Likert-type question and the participant's explanation, descriptions, and examples in the response. The survey questions with both styles of queries are discussed with both a chart and summary of the written responses.

Section I – Demographics.

Information was extracted from various survey questions to identify and better understand potential themes, such as, did the family agree with the assessment process and results – was it fair and accurate? Who agreed and who disagreed? What did each group have in common, such as college degrees, ethnicity, income level? Was the outcome worth the effort? Was there a support system in place for the child, such as grandparents, older sibling, or community kinship relationship like a neighbor?

Eight families participated in the survey and follow-up interviews. The families did not demographically represent the San Bernardino County general or special education population as reported on California Department of Education Dataquest School Year 2017-2018. For example, the Hispanic population for general education was 65% and 63% for special education,

but only two of the eight families self-identified as Hispanic, for 25% representation. African American representation was higher than the general population, especially if biracial families were counted as African American. While the study's "n" was too low to determine if the study's families represented the demographics of the county and the actual CARE population, based on three years of observations of the CARE Clinic classrooms, the study's gender profile was not representative of a typical CARE cohort, either. Of the three cohorts observed, there were more male than female students, but never in the7-to-1 ratio of the study population.

In addition to racial data, the survey collected data on languages spoken in the home, highest education level obtained by the family member completing survey, and marital status. Only one family reported English as a second language but preferred the category of dual language or proficient in both Spanish and English. Six of the eight participants attended college, with half receiving at least an associate's degree. One person obtained a professional degree in another country and a bachelor's degree in the U. S. Marital status was 50% married and 50% single, one of whom was widowed. Once again, it was not clear if this was representative of all CARE Clinic participant families. A summary of the study family demographic information is presented in Table 4.

Table 4

Participating Family Demographics

Participant	Parent Ethnicity	Child Ethnicity	Language Spoken in Home	Child Gender	Highest Education Level	Marital Status	Cohort
Amy	Portuguese	White	English	Male	Some College	Married	2016
Carmen	White	White	English	Female	Bachelor's Degree	Married	2016
Sharon	White	Biracial Hispanic/White	English	Male	High School Diploma	Married	2016
Susie	African American	African American	English	Male	High School Diploma	Single	2017
Cathy	Hispanic	Hispanic	Spanish	Male	Professional Degree	Married	2017
Robin	Hispanic	Hispanic	Bilingual Spanish English	Male	Associate's Degree	Widow	2018
Trina	Biracial Black/White	Biracial Black/White	English	Male	Bachelor's Degree	Single	2018
Mary	White	Biracial Black/White	English	Male	Some College	Single	2018

Sections II.1 and IV.4 – Child's behavior.

The survey had five questions that asked participants to report the before- and after-CARE Clinic behaviors of either their child or their own parenting practices.

Interview questions II.1 and IV.4 asked parents to describe their child's behaviors during a typical day ("What did the parent observe daily before starting CARE and directly after CARE?") During follow-up interviews, families who completed the CARE process in the spring of 2016 and 2017 were also asked if that child's behaviors continued in the year directly after program completion and if they continued currently.

The list of behaviors named included six positive and 14 negative behaviors (see Table 5 and Table 6). These behaviors were intermingled on the survey the parents completed, but were reported on two different tables, separating positive from negative behaviors. Participants identified how frequently in a week that they observed the behavior – always, often, sometimes, or never. The two tables show how often the eight families observed that behavior, always or often, before- and after-CARE. For example, before CARE four families stated their child made friends easily. After leaving the CARE program, two additional families noticed an increase in their child's ability to make friends. Of the six positive items listed, all eight families reported at least some increase in their child's behaviors (see Table 5).

Table 5

Pre- and Post-CARE Positive Behaviors

	Always & Often	
Description	Pre-CARE	Post-CARE
a. Makes friends easily	4	6
b. Enjoys learning	3	5
c. Likes to try new things	3	5
d. Shows imagination in work and play	4	8
e. Comforts or helps others	3	5
f. Accepts friends' ideas in sharing and playing	4	5
Total	21	34

All families also reported a decrease in negative behaviors. Only one of the 14 negative behaviors showed no change – "Is unhappy, sad, or depressed." No families reported observing this behavior pre-or post-CARE. While the behavior "has temper tantrums or hot temper" was originally seen as an issue pre-CARE by five of the eight families, post-CARE only one family reported that their child still exhibited temper tantrums always or often. The table below lists

how many of the eight families observed these behaviors always or often both before- and after-CARE (see Table 6).

Table 6

Pre- and Post-CARE Negative Behaviors

Description	Always & Often Pre-CARE	Always & Often Post-CARE
a. Has temper tantrums or hot temper.	5	1
b. Cannot concentrate or pay attention for long.	5	3
c. Is very restless and fidgets a lot.	5	3
d. Is unhappy, sad, or depressed.	0	0
e. Hits and fights with others.	2	0
f. Worries about things for a long time.	3	2
g. Does not get along with other kids.	3	1
h. Feels worthless or inferior.	1	0
i. Has difficulty making changes from one activity to another.	4	5
j. Is nervous, high-strung, or tense.	3	3
k. Acts too young for (his or her) age.	3	2
l. Is disobedient at home.	6	3
m. Is disobedient in public settings, such as bus, mall.	5	3
n. Does not follow directions.	6	3
Total	51	29

Sections II.2 and IV.5 – Household rules.

Parents were asked, “Were rules and routines established in the home?” The purpose of this question was to gather information on participants' parenting routines both before and after undergoing the CARE Clinic program. For example, did the family provide their child with guidance on day-to-day activities, such as watching television or bedtimes? Before CARE, three families did not have consistent expectations for their child in all five of the listed areas. This included the only female in the study, who had rules regarding the food she ate, but otherwise no

expectations. That family and the remaining two families did not expect their children to have chores, either. But after going through the CARE Clinic program, the number of families providing guidance in the listed areas increased. After CARE, six of the eight families had expectations in all five of the areas, with two families listing expectations in four of the five. The two families that were not listing all five areas were part of the three who did not have rules in at least two of the areas (see Table 7).

Table 7

Pre- and Post-CARE Household Rules

Household Rules	Pre-CARE	Post-CARE
a. What TV programs can [CHILD] watch?	7	8
b. How many hours can [CHILD] watch TV?	7	8
c. What kinds of food does [CHILD] eat?	6	7
d. What time does [CHILD] go to bed?	7	8
e. What chores does [CHILD] perform?	5	7

Sections II.3 and IV.6 – Parenting practices.

Parents were asked, "Sometimes children follow directions (i.e., mind) and sometimes they don't. What strategies did you use to get your child to mind? Check all that apply." No value or judgment was placed on the question. Any parent who checked "Other" was asked to explain or describe what other methods were used. In each situation, the parent provided more detail on the previously listed practices. During the follow-up interview, the researcher listened for strategies learned during the CARE process and how those strategies were integrated into the parent's practices. Overall, families did not modify their practices but changed the frequency of the practice, such as timeout. Parents reported using timeout less and using modeling and describing as the preferred strategies. Though not listed as a potential strategy on Questions II.3

and IV.6, the parents identified predicting behaviors as strategy. Anticipating and predicting issues before entering an environment (such as public transportation, shopping centers, grocery stores) was identified by four of the eight participants as a post-CARE modification in their parenting practices. Descriptions of these modifications are highlighted in the participant narratives. The reduction of misbehaviors reduced the need to use other methods, such as ignore behavior or use time out.

Table 8

Pre- and Post-CARE Parenting Practices

Parenting Practice	Pre-CARE	Post-CARE
a. I do nothing, ignore behavior.	2	2
b. I use time out, ask child to sit/stand.	7	5
c. I describe the behavior I wanted to see.	8	6
d. I model the appropriate behavior.	6	6
e. I wait patiently for the child to discontinue the behavior.	7	6

Sections II.4 and IV.7 - Frequency of parenting practices used.

The researcher was not able to use the data from these questions because the questions were poorly worded and parents' intent or responses could not be properly determined. The questions asked participants to estimate how frequently in a week they used a specific parenting practice before and after completing the CARE process. The parents reported not remembering the frequency, but spoke more of how likely they were to use one strategy over another, which was answered in Sections II.3 and IV.6. As demonstrated in the summary of the previous question, the parents felt they did less yelling and more often used strategies such as modeling the appropriate or expected behavior instead. The participants' narratives provided further evidence that parents were using the listed strategies in a more strategic manner.

Section II.5 – Parent reflections on parenting practices used.

Parents were presented with this prompt: “Here are some statements that parents of young children say about themselves. Read the statements, and after each one, please CHECK which ones reflect your beliefs.”

This question was a continuation of the previous question. It asked parents to reflect on their feelings, state of mind, or beliefs when implementing a parenting strategy. Statements like, "I believe children should be seen and not heard" or "I encourage my child to be independent" are examples of statements parents had to consider (see Appendix E: Family Survey). Once again, there was no judgment or right or wrong answer. It was one more way of understanding how parents perceived discipline in their home.

The follow-up interview with the parents explored this question was explored in more detail. During these interviews, several parents shared their difficulty with this question, saying they struggled with identifying frequencies of use for each strategy. It was easier for them to state what they believed they did most often. For example, Trina stated she was so frustrated with her child that she simply ignored or pretended to ignore the behavior because she did not know what to do, acknowledging that she did a lot of guessing. Her response was not uncommon.

Did going through the CARE Clinic process alter their parenting beliefs pertaining to discipline? In most cases, the parents expressed an alignment with the strategies learned during the 10-week program. One parent commented on learning "the science behind the strategies." In general, the parents strongly believed in their child’s independence and allowed exploration, while adhering to their own expectations when it involved following rules.

Sections II.6 and IV.8 – Special need(s) identified.

Families were asked, **"**Did a doctor or other health or education professional ever tell you that [CHILD] had any special needs or disabilities – for example, physical, emotional, language, hearing, learning difficulty, or other special needs BEFORE or AFTER participating in the Desert Mountain 10-week program?" This question also required additional probing during the follow-up interview. Participants had different definitions or understandings of a "professional." One parent viewed any person working in the education field as a professional, and so a teacher stating the child might have an attention-deficit disorder (ADD) was taken as a fact. After the CARE program, participants had written assessments with identified needs signed off on by a qualified professional. Every child had a need, but the need did not necessarily qualify the child for an Individualized Education Program (IEP). The results of the assessments are discussed in the participant narratives in this chapter.

Sections II.7 and IV.9 – Identified special need(s).

Parents were presented with the prompt, "How did the doctor or other health or education professional describe [CHILD]'s needs BEFORE and AFTER the CARE Process?" As stated in Section II.6 and IV.8, the parents identified multiple needs, some of which were identified by a qualified professional. Some items where checked because a trusted person said it looked like a need of the child. The first column of Table 9 shows the number of families identifying a category, such as a specific learning disability, as a need of their child.

After going through the CARE program, families checked fewer items as a need, and they had documentation supporting their child's identified need. Four categories had a decrease of 50% or more (sensory overload, behavior disorder, speech impairment, and other health impairment). Two families reported completing the 10-week CARE process with no identified special need (see Table 9).

Table 9

Identified Special Needs, Pre- and Post-CARE by Number of Families

Description	Pre-CARE	Post-CARE
A specific learning disability	2	1
Mental retardation	0	0
An emotional/behavioral disorder	3	2
Post-traumatic stress disorder (PTSD)	0	0
Attention-deficit disorder/attention-deficit hyperactivity disorder (ADD/ADHD)	4	3
Sensory overload	4	2
Behavior disorder	4	1
Speech impairment	6	3
Language impairment	3	2
Dyslexic	0	0
Deafness	0	0
Another hearing impairment	0	0
Blindness	0	0
Another visual impairment	0	0
An orthopedic impairment	0	0
Another health impairment lasting six months or more	0	0
Autism	3	3
Traumatic brain injury	0	0
Non-categorical/developmental delay	2	2
Other health impairment	2	0
Some other issue, please list	0	0
Prefer not to respond	0	0
Total	33	19

Section III.1 – Would recommend CARE process.

Parents were asked, “Would you recommend the Desert Mountain 10-week CARE process to my family, friends, and community because I trusted the process?" Six of the eight

families strongly agreed with the statement, and one family somewhat agreed (see Table 6). One family stated, "I liked all of it – would not change anything." One family strongly disagreed with the statement, however. Counter to the families who felt the program was exceptional, this family thought the program was too short for everything the agency wanted to do. The family that liked all of it and the one that did not completed cohorts in spring 2016 and 2018, and both had bachelor's degrees. This was notable since three of the eight family participants had bachelor's degrees or higher.

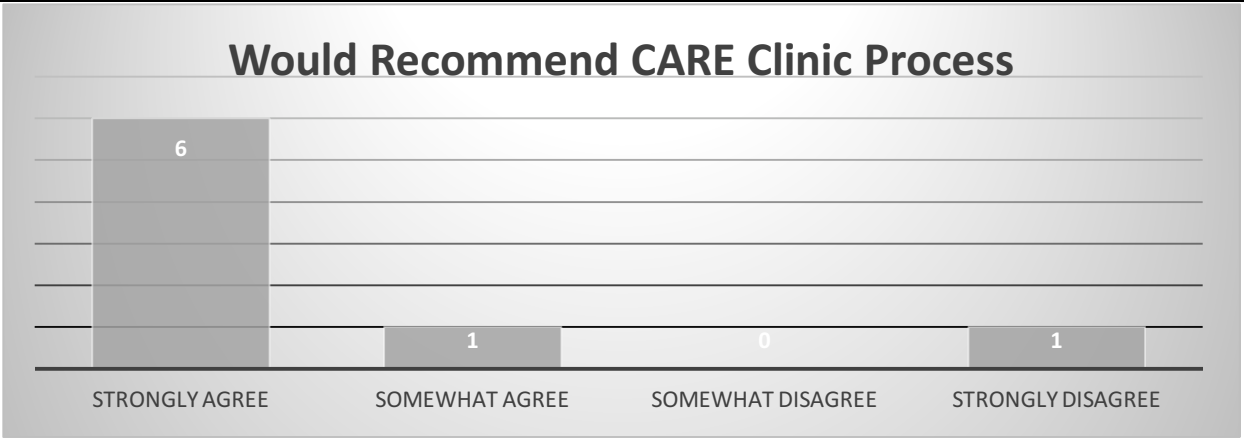

Figure 6 Would Recommend CARE Clinic to Family and Friends

Section III.2 – Liked or disliked process.

Parents were presented with the prompt, "I feel as though the Desert Mountain student assessment process was fair." The same family who would not recommend the process also felt it was not fair. The parent expressed frustration with the process of identifying a CARE prospect, stating, “There is no clarity in who gets in and who does not.”

This issue of how children were selected to participate in the process was consistent throughout the survey, even mentioned by some who still felt the process was fair. A participant who felt strongly the process was fair wrote, “I liked the time, patience, and respect at the time of

the evaluations by the professionals. I did not like it [when] I had to wait to get the first evaluation appointment." As noted in Figure 7, six out of eight participants strongly or somewhat agreed with the statement, "CARE process is fair."

Figure 7 CARE Process Is Fair

Section III.3 – Agreement with assessment findings.

Parents were asked, "Did you agree with the assessment findings?" Of the five CARE questions, accuracy of assessments had the largest number of participants who strongly or somewhat agreed with the process and results of the CARE program (see Figure 8). All eight of the participants agreed with the assessment process and shared a common sentiment. The following statement was representative of their comments:

> Confirmation that my son has an Autism Spectrum Disorder and the level it is at. Before Desert Mountain, doctors and psychologists just kept giving us the runaround and not doing anything to help, and Desert Mountain helped, confirmed along with reviewing

other things such as sensory disorder, receptive language delay, and behaviors of ADHD and to further evaluate as he gets older for ADHD to be ruled out or confirmed.

Others identified specific DM staff who helped them understand their child's assessment and needs. The one participant who somewhat disagreed did not explain on the survey or during the follow-up interview.

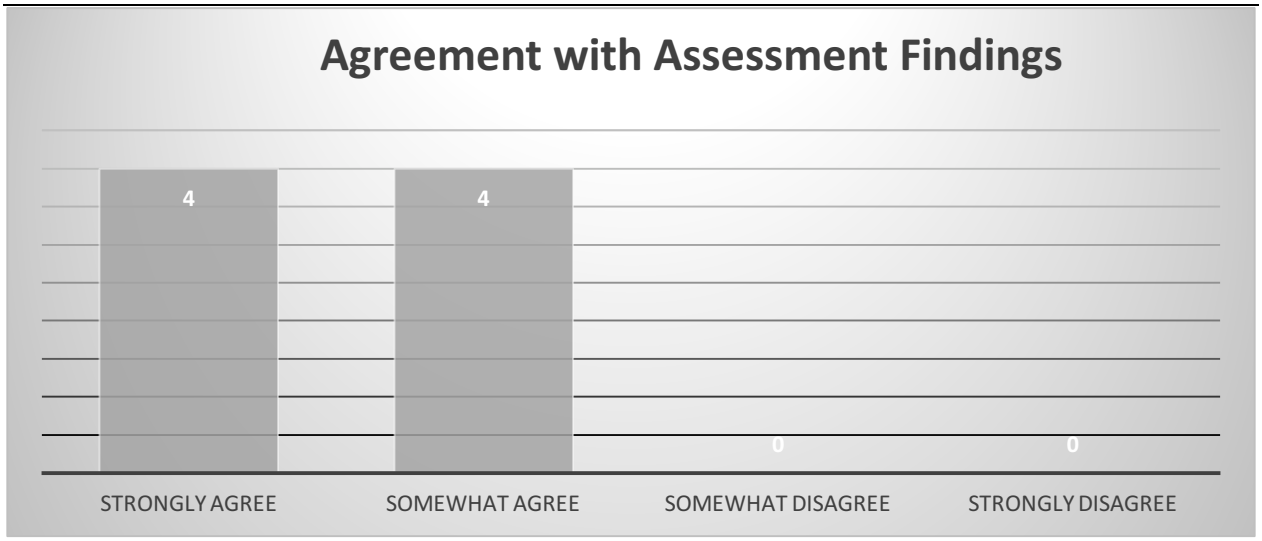

Figure 8 Agreement with Assessment Findings

Section III.4 – Helpful services or strategies.

Parents were asked about the extent to which they agreed with the statement, “I feel as though the 10-week CARE process has given me strategies to support my child’s behavioral and mental health needs.” Consistent with previous responses, the same five to six families who expressed satisfaction with the process (see Figure 9) also agreed with the statement, "…process gave [me] strategies to support my child." Examples of strategies learned during CARE included modeling, patience, use of visual aids, reduction of incomplete or complex verbal commands, and the Picture Exchange Communication System (PECS). The participant who did not agree

with the statement provided one-word examples on the survey but provided more details during the follow-up interview. Those statements are integrated into the participant narratives.

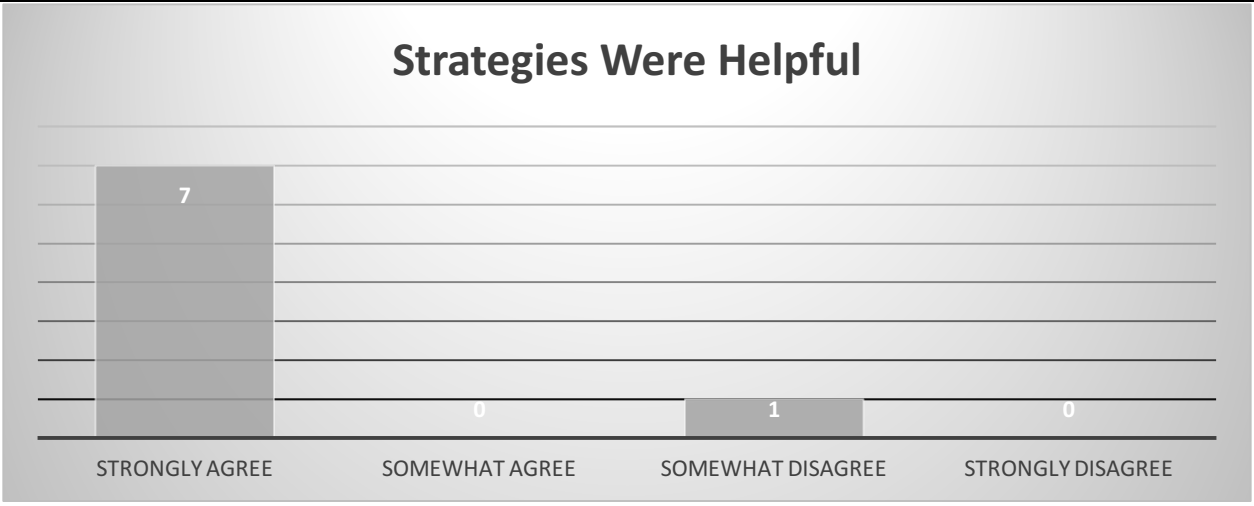

Figure 9 Strategies Were Helpful

Section III.5 – PCIT services.

Parents were presented with the prompt, "I felt the parent monthly information groups and one-on-one parent-child interaction therapy (PCIT) sessions helped me learn positive strategies to interact with my child." Besides assessing and identifying the best strategies for each child, the CARE program integrates parents into the process. In general, the participants rated this as the most helpful aspect. Six of the eight families strongly or somewhat agreed with the effectiveness of the parent activities. Among comments on the survey were, “learning to lead when doing PCIT and being taught patience” and “speech therapist talked about how language is formed and what ages certain sounds are made.”

The two participants who marked somewhat disagreed with the statement (see Figure 10) completed the CARE process spring 2018, and both had some college or a bachelor's degree.

One of them said, “The meeting with the findings for my child was most helpful to me. I felt like I knew all the other information from the other meetings already.”

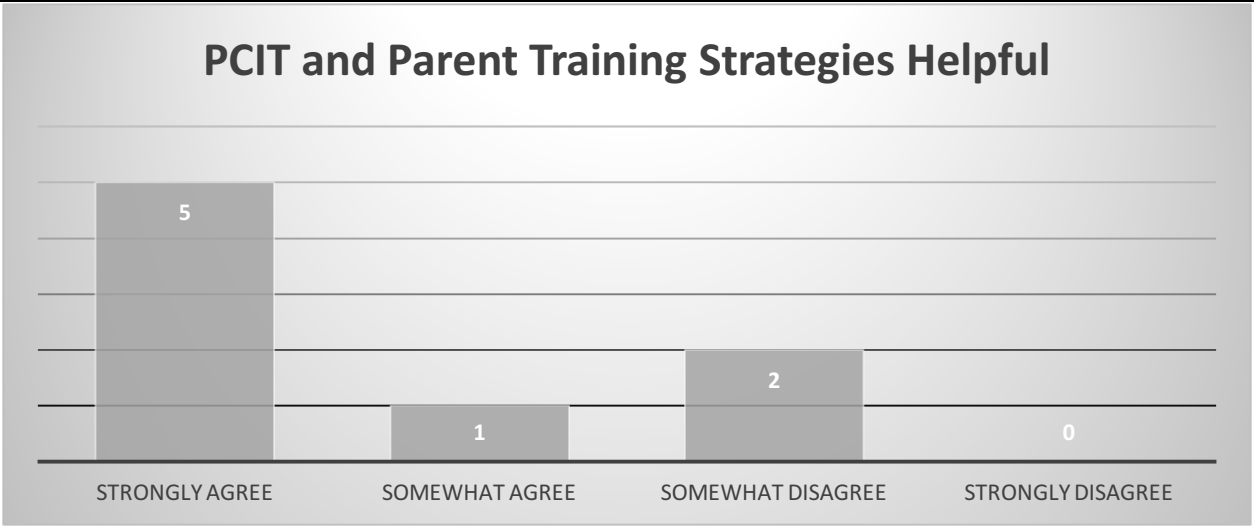

Figure 10 PCIT and Parent Training Strategies Helpful

Section IV.1 – Schools attended after completing CARE.

Parents were presented with the prompt, "Where did your child attend school(s) after completing the CARE program?" The next three questions dealt with what happened after the students completed the 10-week CARE Clinic sessions. DM staff reported students participating in the CARE process were expected to attend a formal education setting (such as preschool, kindergarten) upon completion. For two of the three students who attended spring 2018, this did not occur, as the families decided to homeschool their students instead. The third student was old enough to start first grade in fall 2018. All students from the 2016 and 2017 cohorts attended formal settings in either a charter school or traditional public school. Both students from cohort 2017 attended state preschool after completing the CARE process and attended transitional kindergarten in the 2018-2019 school year. The 2016 students attended either preschool or transitional during school year 2016-2017, followed by transitional kindergarten or kindergarten

in school year 2017-2018, and are in kindergarten or first grade in 2018-2019. Each one attended his or her current school at least two years. Thus, six of the eight families reported on the support they received from the school or classroom teacher their child had post-CARE program.

Section IV.2 – Knowledge of school supports.

Parents were asked, "In your child's school, what student behavioral, mental health, etc.… supports exist? Check all that apply." Families were asked to identify supports for every year their child attended a formal education setting. Children in only six of the eight families studied attended public school. One of the families stated, "DM supports my child." The five remaining families represented all three cohorts and attended different schools. Two of the five felt confident there were supports available, especially if the family requested assistance, but neither had utilized the services. Their children were either doing all right or received services in the classroom. The remaining families did not know if specific supports were available. The researcher reaffirmed this during follow-up interviews. The parents had limited knowledge of actual supports in their schools, even if they needed them.

Section IV.3 – Knowledge of classroom supports.

Parents were presented with the prompt, "In your child's classroom, what student behavioral, mental health, etc… supports exist? Check all that apply." The experiences shared by the families regarding school supports were different for the classroom. Every parent listed a support they received from their child's classroom, ranging from teachers maintaining consistent expectations and routines to positive behavior supports. Parents reported the same level of support for multiple years. Overall, the parents felt their child received support from the teaching staff and, when needed, additional support was offered. This was especially noted for the students who had IEPs. If the student did not have an identified need, the family got the

needed support from the teacher, but not necessarily from the school. Even during the follow-up interviews, the parents were not clear about what they expected from the school or classroom.

Section IV.10 – Parent perceptions of short-term outcomes.

Parents were asked, "It has been approximately four months (spring 2018), 14 months (spring 2017), or 26 months (spring 2016) since your child and family completed the Desert Mountain 10-week process. Were the outcome(s) for my child and family worth the effort?" Seven of the eight families strongly agreed with the statement, "The outcome was worth the effort." One parent wrote the following statements on her survey, "Yes, finally able get help for my son. Taught me things to do and look for. I can advocate for my son. They really pushed my change to his max, and I learned."

This was a common sentiment of the seven families who felt the process was beneficial (see Figure 11). One parent summarized the process by identifying multiple reasons for her son's behavioral changes, her personal growth in parenting, and her new role as an advocate for her child. She said,

> Yes, it is worth it! The outcome was better than I expected. My son was driving me crazy. I was asking family members for help, I talked to everyone – my sister, mother, friends. I needed help. He is in childcare doing well, and I am telling teachers how to be successful with my son. I am his biggest advocate! I know what to do and why I am doing it!

The one parent who somewhat disagreed had mixed perceptions of the overall value of the process, stating, "I don't feel like it was worth it, though I really enjoyed the speech therapy."

Figure 11 Was Outcome Worth the Effort?

Participant narratives.

During the follow-up interviews, families provided explanatory information to various questions asked on the survey. For example, on the survey, Robin identified as a Latina female, widowed, and raising a male child. However, during the follow-up interview she shared that her husband died when she was in her twenties, and she was left to raise three young children alone – two boys and a girl. It was her daughter's son (her grandson) who attended the CARE Clinic. Her daughter did not assist with her son's participation in the CARE process, and she did not have family to help her with the responsibilities associated with CARE. The grandmother's landlord helped with transportation and participated in some family activities. Not all families shared personal stories or elaborated on questions in the same way. The narratives below reflect survey responses and each family's individual stories.

Participant narratives and the survey question summaries shared two things in common. First, the comments from the survey and transcribed quotes from the follow-up interviews provided evidence of the families' thoughts or beliefs. Therefore, quotes taken from the survey are presented as written by the family member. The only exception is if the family member used

the actual name of the child. In these instances, all names were replaced with pseudonyms or removed. Second, the organization of the narratives was aligned with the order of the survey: demographic data, before- and after-CARE behaviors, CARE process, and after-CARE outcomes.

Participant 1 – Amy.

Amy was a Portuguese, married, stay-at-home female with three children aged 7, 9, and 11 years old. The 7-year-old completed the CARE process spring 2016. The parent described her child pre-CARE as sweet, nonresponsive, unable to get along with other children, restless, inflexible, and extremely disobedient in public settings. He would not play with other children. He had an IEP when entering the CARE process. The areas of concern were autism, sensory overload, speech and language, and an undiagnosed learning disability. Amy spent two years trying to get her child into CARE. After hearing about CARE from her pediatrician, the parent completed the pre-SART, Phase 1, Phase 2, and Clinic. After Clinic, the parent reported receiving a summary of the assessments along with recommendations for next steps that included participating in the CARE process. She did not receive any response from the agency for two years, she stated,

> I feel like they forgot about him, and I was not clear about the process. Someone said they were waiting to fit him into the right cohort. I did not know what that meant. Did they only take so many children in each category? What were the categories? How does my child get in?

While she waited for someone to let her know when he would start the CARE process, her grandson did participate in speech therapy and Applied Behavior Analysis (ABA) strategies provided by the child's current school through an IEP. Unfortunately, he was not having the amount of success she felt was possible.

Amy decided to call Desert Mountain Children's Center one more time. It was during that call that she learned that her child had been admitted into the CARE process. When she notified the current school that she was taking her child out of its program, the school expressed displeasure and felt it was a bad decision. The parent was reluctant to disregard this advice, but she felt starting CARE was the right decision, especially after she had waited so long. Once the child started, the parent was pleased with CARE. She said,

> The speech part of the CARE program was amazing. The therapist gave me a lot of ideas on connecting with my child and getting him to speak more. The occupational therapy was also helpful in giving me ideas on how to hold utensils and teeth brushing.

As part of the CARE ongoing assessment process, the parent learned her son had a severe learning disability, and DM integrated the new finding into the child's IEP.

Ultimately, Amy felt the process was worthwhile, although she had some serious concerns. First, she thought the time frame for student attendance was too short. With further dialog, the parent explained how she saw CARE not as an assessment process, but as the place where the child received the IEP services. The disconnect between the assessment process and what the parent saw as a "stay-put assignment" created some confusion for her (stay-put being a term used in special education to describe where child receive services). Desert Mountain staff reported that if they were not careful about identifying CARE as an assessment process, a family could present a case to maintain services at DM past the 10-week session, but there are multiple issues associated with a child staying past the program's 10 weeks, such as directly influencing the number of students they could assess. The second issue Amy had was the communication process, or the miscommunications about the process, such as How were cohorts built? and What were the "qualifications" for acceptance into the CARE Clinic program?

Amy also was not pleased with the outcomes for her child. After taking her child out of his former preschool to start CARE, she described the results as,

> I don't feel like it was worth it. I really enjoyed the speech therapy part of the program and felt the therapist was amazing. As previously stated, I thought the program was too short for everything they were trying to accomplish. I don't feel like much change was made in my son and would have just kept him in his preschool classroom.

Amy followed up her comments with the lack of support she receives from her son's school and that his time in CARE was like he never attended it. She described his current behavior as the same or slightly worse, such as restless, poor concentration, poor interactions with other kids, difficulty with changes, nervous, and disobedient in public. Amy's last words were, "There were no lasting benefits."

Participant 2 – Carmen.

Carmen was a White, married female with three children, one of whom completed the CARE process in spring 2016. Carmen's daughter entered CARE when she was 3 years old. She had no IEP and no formal referral or assessments, but there were speech concerns, so the mother made a self-referral. She reported that her daughter was "so far behind in writing she could barely hold a pencil."

Additionally, the mother reported her daughter made friends quickly, but would eventually bite, hit, and scratch her playmates. Her daughter's unpredictable behavior changed the interactions into a more aggressive playtime with the other kids. Temper tantrums usually accompanied the daughter's physical actions, which prevented the family from participating in family or community events. Before CARE, the strategies to correct the behaviors (e.g., modeling, describing appropriate behavior, timeout) did not work, no matter the number of times

the parents tried to reinforce the behavior they wanted to see. As Carmen said, "We needed help!" But the daughter adapted to the CARE process. Her parent reported that,

> I think her behavior was improving by the third week. She looked forward to playtime with parent during PCIT and at home. Playtime with parent became the prize for good behavior. She realized she had to treat people with courtesy if she wanted to play with them.

The parent learned strategies to address the undesirable behaviors along with rationales for when to use what method. Carmen also described the importance of learning how language formed and affected sounds. At the end of the process, DM staff determined that the daughter's speech would continue to improve without clinical intervention and the concerning behaviors would eventually cease. On her survey, Carmen checked that the program was worth the effort.

Two years later, her daughter was attending kindergarten at a charter school, and she infrequently exhibited the behaviors that got her referred into CARE. Therefore, the family had no reason to know anything about support services offered by the school. When pressed about the prevention supports provided at the school, the parent again stated she knew nothing about what services were provided, but she strongly agreed that the process was worthwhile.

Participant 3 – Susie.

Susie was a single, African American female with a high school diploma whose son participated in the spring 2017 cohort as a 3-year-old. Before starting the CARE process, Susie worked full-time, but she changed employers in the middle of the 10 weeks, so she was not able to participate in all the parent activities. Susie and her grandmother shared transporting her son, participating in PCIT, and attending parent meetings. Susie described the process of getting her son to CARE and participating in family activities this way:

> I had started with a new company and was only able to change my days off to Thursdays and Fridays to where I could take [my son] to attend the program. His [grandmother] took him Mondays through Wednesday to attend the program, which was a commute of 40 miles away from where we live, but so worth it. She would take him to Apple Valley, come back to Barstow, drop him off at daycare, then drive to Fort Irwin, which is where we both work and another commute of 40 miles, work until 9 p.m., commute back home, and then wake up and do it all over again. We made it work for [my son] 'cause it was what he needed, and he was finally getting real help from a wonderful team who loved, enjoyed, and were passionate about helping children.

According to Susie before CARE her son made friends, enjoyed learning, and showed imagination in work. She maintained household rules and routines and tried multiple strategies to assist him with following the rules when he had difficulty. She sometimes would ignore the behaviors, use timeout, model and describe the behaviors she liked to see. While Susie noted that she did not learn a lot of new strategies during CARE (she felt like she entered CARE already knowing some of these strategies), but she did find learning the rationale behind each approach and when to use what strategy for what situation was beneficial. For example, she learned:

> How to handle behaviors, that all children are different, how to adapt in different environments, and the needs of a special-needs child, how to handle school as the time approached closer.

Susie found the entire process intense, corrective and helpful. The DM staff identified what was best for each child versus assuming one strategy was suitable for all children. In the following comments, she summarized the process of determining her child's needs.

> [My son] improved significantly, [he] was 3 years old, unable to talk, not at age milestones barely at a 2-year-old level, unindependent, tantrums and behaviors that were unexplainable as to why, picky eater, unable to sit and so much more. [He] came out [of] the program able to use PECs by the third week, and by the 10th week was using verbal sentences to communicate his needs or wants. We learned [he] had a sensory disorder and things made sense of sounds, places, and touch that may of bothered him. We also learned activities to help [him] with his sensory needs. PCIT helped myself as his mother [learn] how to interact with him that is going to be more significant and encourage him to behave in ways that are appropriate by encouraging them and modeling, while praising him when he completed them. [He] also learned how to sit longer and focus more with the use of the workstations. The CARE team is AMAZING, all of them truly helped [him] to succeed, and [this] is why he is a happy, helpful, independent, joyful, fun, intelligent child.

After CARE, Susie's 4.5-year-old son attended transitional kindergarten. She was not sure of the supports available from the school, but she felt that classroom supports were available for both her and her son. When comparing her son's behavior pre-CARE to his current actions, she noted changes such as, enjoys learning, shows imagination in play, accepts friends' ideas in sharing and play, and recognizes the needs of others. Susie also said her son, "comforted or helped others." Before CARE, Susie believed her son had autism. At the last contact with Susie, her son did not have an IEP identifying any special needs, and the she agreed with the DM assessments.

Participant 4 – Sharon.

Sharon was a married, White, foster mother with a high-school diploma raising six children. Two were biological and four foster, ranging from 2 to 15 years old. The child in the

CARE program was one of two biracial siblings placed in Sharon's home. The younger sibling, a 2-year-old male, was referred to the Desert Mountain infant-toddler process for the same issues identified with the older male sibling. Sharon had prior knowledge of the SART and CARE processes due to her work as a foster care mom. The first son participated in CARE in spring 2016 at 3.6 years of age.

As part of California foster-care regulations, all children are assessed within 45 days of placement. Sharon's son was immediately moved through the SART process and placed in CARE at the next cohort that started after he completed screening. Sharon homeschooled her non-school-age children, stating

> I never was a big fan of state preschool. I prefer to teach them and get them ready for school. I only needed help with speech.

Sharon thought the CARE program would be great for her foster son. Pre-CARE, she described him as “a little pistol.” He made friends easily, would try new things, but could not concentrate or pay attention for long. She thought it was the consequence of being homeless. It was not clear how long he was homeless or how this experience may or may not have traumatized him. He did not have an IEP when he entered and exited CARE.

Sharon found the CARE process, "okay" and "helpful." She loved the staff and identified nothing that would improve the experience. A Health & Human Services (HHS) caseworker helped with transportation and attended few parent workshops. When her child completed CARE, Sharon homeschooled him until he started kindergarten. He did all right in kindergarten at the beginning of the school year but struggled after the teacher who started the year left. Sharon reported her son yelled at the new teacher, who described his behavior as noncompliant. The teacher wondered if he had attention-deficit hyperactivity disorder (ADHD), sensory

overload issues, and some behavior disorder. Sharon stated that the change in teachers set her foster son behind. The behaviors identified before CARE were all but gone, then returned with the changes in staff. Sharon reported the school did offer schoolwide behavioral support that could be requested by the parents or guardian of record, but she was not clear what other services (such as PBIS, ABA, or sensory/occupational therapy) were offered. She also wished the CARE program was available for older students.

Participant 5 – Cathy.

Cathy was a married Latina with two sons, 7 and 5 years old. Both sons attended a charter school in the high desert region. She had a law degree earned in Mexico and a bachelor's degree from a U. S. university. Cathy described her life before CARE, "I was frustrated and did not have answers. I could not help my child." She asked everyone, "What was I supposed to do?" Her younger son did not like to be touched, parallel played next to other children and typically disliked being in the room with people, especially his brother, yelling and biting his brother when he touched his toys. Cathy referred to this son as “obsessive,” and added he would wake up in the middle of the night and roam around the house. Finally, she described how in the car he would take his seatbelt off and jump from seat to seat.

Her son's behavior changed her daily plans with both sons. She stopped taking them to the playground because the younger one would bite other children. The best she could expect at the playground was that he would play alongside other children without doing any harm and not throw a temper tantrum. Her son did not have an IEP before participating in CARE, but various people suggested her son may have had autism, ADD, sensory issues, and a behavior disorder.

Cathy worked from home doing taxes and assisting friends with maneuvering various systems, such as health care. It was through these connections that she learned about CARE.

She quickly moved through the assessment process, which she found thorough and informative, although she did not like one part of the process. She explained that,

> I liked the time, patience, and respect at the time of the evaluation by the professionals. I did not like it, the time I had to wait to get the first evaluation appointment.

Cathy's son participated in the spring 2017 cohort. She declared, "CARE was perfect," and reported that her son loved everything about the process. Within two weeks he became sociable and started to get along with the other students. Other aspects of CARE that Cathy valued included,

> …speech therapy, because as my son is high functioning and speaks a lot, other people said that he had no problems because he spoke, but the language evaluation found his deficiencies and really helped him to improve his speech skills. And also play therapy helps a lot with him and OT and PCIT.

The PCIT sessions went so well, that Cathy started to take both sons to the sessions. She learned to play with one son and how to facilitate interactions between the sons. The sensory therapy helped her son sleep through the night, and she learned how a family tradition contributed to her son's behavior problems. Cathy explained that,

> I would take my son to jumpy houses, but I learned that my child got even more hyper when he was jumping. He responded more appropriately when he was climbing. He loves to climb. It calms him down.

At the end of CARE, the negative behaviors that Cathy's younger son previously exhibited stopped. Therefore, the family enrolled him in a general education, transitional kindergarten classroom. After three months in the program, he had made friends with three children, with no or few complaints of hitting, biting, or defiance. There were still some issues

between the siblings, but not as bad as the pre-CARE behavior, and Cathy was still using strategies she learned during CARE, such as how to,

> …direct [my son's] bad behaviors to antithetical behaviors, to model behaviors and to reaffirm the appropriate ones. I learned to help my son with breathing and pressure techniques so that he can control his temper tantrums, and help our son with sensory procedures, etc.

Despite the previous concerns with autism and previously described behaviors, Cathy's son had an IEP, but only for speech. She was not sure what services were offered through the school or the district because Desert Mountain provided the speech therapy. Because of the assistance she received from Desert Mountain, Cathy decided to help other parents with getting services for their children. She volunteered for a parent advocacy agency part-time. She said, "CARE changed [my] family's life."

Participant 6 – Robin.

Robin was a widowed Latina grandmother of three children, two boys and one girl. At the time of the survey, she was working on an associate's degree and hoped to finish by summer 2019. In 2017, Robin's daughter sent her son from Mexico to the United States to live with his grandmother. The preschool teachers in Mexico noted that the child was not meeting developmental milestones and that he could get more assistance in the United States. Robin's daughter and grandson are United States citizens, and sending him to the U.S. was a viable option. As soon as he arrived in the U.S., Robin started the SART assessment process. With assistance from her extensive support system of friends and community members, she maneuvered the process comfortably. Her grandson entered the CARE program in spring 2018.

Pre-CARE, Robin described her grandson's behaviors as bad-tempered, worrier, tense, young-acting, and stubborn. She explained further that,

> Everything was new. We had to teach my grandson how to lick a lollipop. Would stand in one place and skip for at least 45 minutes. Would organize his cars in one place; if you moved them, he would be upset. He loved a routine! He could watch the same thing on TV over and over again. You could tell he seem to worry about something. He also had temper tantrums.

The preschool staff and doctors in Mexico thought he should be tested for a learning disability, emotional/behavior disorder, attention-deficit hyperactivity disorder (ADHD), autism, and speech and language problems.

In the beginning, Robin was extremely worried. She described CARE as a “lifesaver” and "the best thing for my grandchild and any child and family lucky enough to have this opportunity." She reflected extensively on differences in services for children in the United States and Mexico. The services she liked the most were the speech and language therapies and PCIT, because “[The speech pathologist] really helped me understand my grandson’s way of processing words and how to model to him to increase his vocabulary.”

Before starting CARE, one of Robin's major concerns was her grandson's speech and lack of language skills. She thought he had autism. However, learning speech and language strategies in the CARE Clinic enhanced the PCIT sessions. It was during the PCIT sessions that Robin learned specific prevention activities, as a result she felt,

> PCIT is an excellent way to teach us how to act instead of react. Using Mr. Bear has helped me a lot to model [for] my grandson how to potty train and follow certain rules and learn consequences.

Robin’s grandson had struggled with toilet training. She told a story of an incident in Mexico where her grandson was traumatized when he could not use the bathroom. After the

incident, he refused to go to the bathroom. The PCIT therapy process gave the grandmother the communication strategies she needed to assist her grandson. She used a stuffed animal – the Bear – to communicate with her grandson, and the Bear continues to play a role in their home.

After CARE, Robin's grandson enrolled in a transitional kindergarten. He did not have an IEP, but received additional speech and language therapy from Desert Mountain. The school wanted to put him in a dual-language classroom, but Robin opted for an English-only setting, stating, "I can teach him Spanish. Their job is to make sure he can speak English!" Other than the dual-language classroom program, she was not aware of any services available through the school or district that would have assisted her grandson. At the time of this study, Robin's grandson was still receiving services through Desert Mountain.

Participant 7 – Trina.

Trina was a biracial, White/African American single mom with a bachelor's degree raising two children, a 7-year-old daughter and a son who attended CARE in spring 2018 at 4.5 years old. Trina described her pre-CARE son as friendly, accepting of friend's ideas, imaginative, liked to try new things, and enjoyed learning. However, she also said that he had an emotional disorder; behavior disorder, speech impairment, and developmental delays. Even though her son had a speech IEP, these issues were not formally identified by a professional but were suggested by an "expert" who visited her son's state-funded preschool classroom every six to eight weeks. When asked about this expert's background, Trina said she was not sure, but the staff had referred to her as the expert in working with at-risk children. She described her son's at-risk behaviors as, "a lot of tantrums, crying, demands, non-compliance, and whining." This behavior occurred with his sister, other children and in public. These behaviors continued in his state-funded, preschool setting. Trina described her frustration thusly,

> I did not know what to do! I was frustrated, I asked for help from my family and friends. I especially reached out to parents who I know had difficult children who turned out okay. I was tired 100% of the time dealing with my son's behaviors – I was so stressed out with everything.

The state-funded preschool staff referred Trina's family to Desert Mountain. That agency had previous experience with DM and spoke highly of the program. Once Trina's son was accepted into the CARE process, she had to adjust her work schedule and identify family members to babysit her son in the afternoons because the state-funded preschool program disenrolled her son when he started the process. Her employer allowed her to modify her start time and lunch breaks so she could drop off and pick up her son at the DMCC. She participated in PCIT sessions but had difficulty attending most of the family trainings. Her mother, aunt/uncle, and son's godparents helped-out when she could not transport her son or attend a parenting session when emergencies occurred. Trina stated, "I would not have been able to do the program without my family's help." Even with all the adjustments she had to make, Trina was extremely happy with the outcome, which she felt it was worth it. It was better than she expected. She stated, "I could breathe! It is good 90-95% of the time."

After CARE, Trina's son attended a private child-care facility, and she decided not to put him into transitional kindergarten, the first year of California's two-year kindergarten program. The private agency provided parent trainings, but not the specialized help that she would get in a public school setting, such as, speech therapy and PBIS. There was a person who observed the classroom, but the specialized help still came from Desert Mountain and the parent. Once a week, DM sent a behaviorist to visit their home and work with Trina and her son. At the childcare facility, Trina provided the teachers with the strategies she learned at CARE. During

CARE, she learned her son struggled with transitions, and she needed to prepare ahead of time by anticipating his needs. So she prepped the school before her son started, and this worked. By the third week of school, he had successfully transitioned into the new environment.

Trina found the CARE process worth it, but she was somewhat neutral about the assessment and transition process. Family members were supposed to receive a final report on their child's assessment results with recommendations after completing the CARE process. As of the last communication with the researcher, Trina had not received a final report, and no one from Desert Mountain spoke to the new school's staff about it. She continued to request the report, but in the interim she felt confident that she could appropriately advocate for son because of all that she had learned during the process.

Participant 8 – Mary.

Mary was a single White female raising a biracial son – White and African American. She lived with her mother, who helped her homeschool her son. She homeschooled her son because the preschool he attended determined it could not adequately meet his needs. As Mary explained:

> They could not handle him. He only attended two weeks, and during that time he told the teacher, "I hate you!" He screamed at the teachers and disrupted the lesson. So, either me or my mother had to go up to the school and sit every day. It was not working. He did not complete a full day! He did not make three weeks before we pulled him out of the program.

Mary described a typical pre-CARE day as "a nightmare." Her son was disobedient, restless, had poor concentration, horrible temper tantrums, and an inability to make changes during the school day. When he was at home, she described him as a different child – loving and kind to other kids. She described feeling exasperated by pediatricians and some professionals'

responses to her concerns. People kept telling her "everything was fine, just give it time, and he will grow out of it."

Mary worked for a company that accommodated her schedule, but it was too much to ask the employer to make continuous changes when she was not sure the school would be successful working with her son. However, these accommodations helped her get through the 10-week CARE process. The teacher at the preschool told Mary about CARE, and after researching the program, she firmly believed she would find answers for her son. When Mary described the process from learning about CARE to entering CARE in spring 2018, she stated, "I needed to know what to expect and how it would assist my child." She explained that her son first saw a clinician from Desert Mountain once a week and was not getting anywhere, but she hoped additional assessments would give her the answers she was seeking. She had high expectations for the entire process, especially CARE, and ultimately she was not disappointed. Mary's description of CARE's effect on her family was:

> Dr. Jekyll remained, and we saw less of Mr. Hyde. From age 2.5 to 5, my child got worse and worse – CARE gave us hope. I knew to maintain the commitment to CARE was going to be difficult, but with my mom's assistance and my job's help we would make it work.

Mary defined CARE as, "an extensive assessment process that identifies ways for children to find success," and she identified what worked and what did not work for her son.

> PCIT was not effective! I kept retrying, but it did not work. Some sessions seemed to be hopeful, but the next meetings were useless. [My child] would refuse to participate. During the sessions, he would tell the clinician, "I can hear you."

While the PCIT sessions made Mary feel like her son did not like her, the parent trainings were helpful because,

> Parent meetings were used to explain how the brain worked, such as how my son's brain worked versus mine. He had explosions, and they helped me see how to reduce the behaviors.

Mary was also happy to learn strategies on how to prevent her son's negative behaviors by using visual aids because he struggled to compute verbal commands. The CARE process ultimately gave her the diagnosis she needed to get him help. He was referred to a special-education program and received an IEP.

After CARE, Mary enrolled her son in an inclusive, first-grade classroom. He entered with an IEP that listed emotional, behavioral disorder and attention-deficit hyperactivity disorder (ADHD) needs. Though placed in an inclusive classroom, she moved her son to a self-contained classroom with a smaller child population and more adults. He still struggled with some issues, but he received help from a Desert Mountain clinician. She could not list a single service offered by the school district, but she felt the classroom staff met his needs. When asked to summarize her experiences before- and after-CARE, Mary said, "Yes, I finally able to get help for my son. Taught me things to do and look for. I can advocate for my son." She also made the following recommendation, "They should open this process up to older kids. I had to fight to get my son in the program; it felt like it took two years. This program should be for all kids."

Summary.

Mary's comments reflected of the overall sentiment of the parents of the eight families. They reported that the CARE Clinic process helped their children to function better in their respective environments. The positive outcomes appeared to be maintained at least one year

after completing the process. Chapter 5 highlights the positive and modifiable issues that the parents identified.

Chapter 5: Summary, Discussion, and Recommendations

Summary

The purpose of this study was twofold. The first was to describe an early-education, multi-tiered, prevention, and intervention process called SART, with a focus on the third tier of the program, called the CARE Clinic. The study's second purpose was to gather participating families' perspectives of the outcomes and effects of the Desert Mountain Children's Center's Tier-3 CARE process on the children and families through a social-validation study.

Data was collected in two phases. The first phase consisted of observations, staff interviews, and documents to describe the DM Screening, Assessment, Referral, and Treatment (SART) process with an emphasis on the Tier 3 CARE program. The second phase consisted of families that completed the CARE program in spring 2016, 2017, or 2018 taking surveys followed by individual interviews. Results of the data collected, transcribed, and analyzed were used to answer the research questions, identify themes, and develop recommendations. Staff interviews and observation notes were compiled and transcribed immediately following data collection and shared with DM staff. Parent interviews were conducted via ZOOM, a web-based video-conferencing platform that works on a computer or any Apple IOS or Android OS device, such as cellular phones and tablets. ZOOM services included video recording and transcription.

Key research questions examined were:

- What was the DM Children's Center's early-education, multi-tiered model or SART process with a CARE focus?
- What was the impact of the SART process on families?
- How did families perceive the value of the SART process for their child and their family?

Embedded in these questions were the three dimensions of a social-validation study: goals, procedures, and effects. That is, were the participants satisfied with the goals of Desert Mountain Children's Center, with the actual CARE program, and with the outcomes and effects of the process? These questions aligned with Wolf's (1978) argument that procedures should be acceptable and feasible. In addition, Desert Mountain's procedures in relation to the recommendations from the President's Commission on Excellence in Special Education received special attention. Data gathered from observations, staff interviews, document review, the eight participant surveys and follow-up interviews resulted in the identification of seven emergent themes. These were (1) family sacrifices, (2) family shifts from participation to advocacy, (3) family impacts – promising short-term outcomes, (4) DM/SART assessment process – informative or not, (5) DM/CARE process length – too short, (6) DM/CARE system of support and strategies, and (7) the education system – maintenance and transition of services. These themes are discussed below.

Family impact – sacrifices.

Families were solely responsible for getting the student to the four-hour program every day in addition to participating in family training sessions and parent-child interaction therapy at least two to three times a week. Participant families spoke openly about the efforts it took to ensure their child attended every day. One parent made it clear she could not have done it without assistance from her support system – participant Susie's mother and employer.

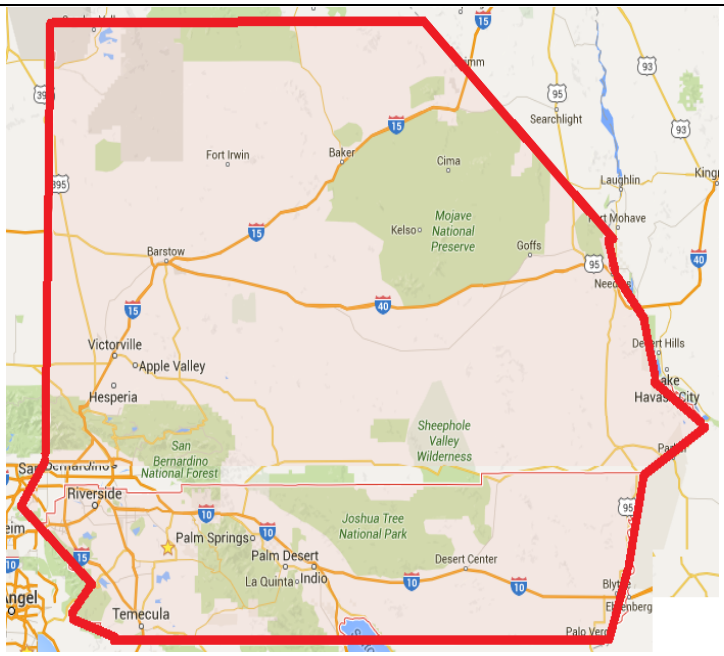

Figure 12 Detailed Map of San Bernardino County

Overall, the families felt the sacrifices were worth the results, even though it was a struggle for some of the parents. Financial cost and time constraints were examples of hardships the families cited.

What was not clear was what happened if a family could not make the necessary sacrifices to participate in the program. Did families opt out of the program when they could not transport their child daily to the center due to distance or finances? Did families drop out of the program, and, if so, what were the reasons? Could a family member with one or more risk factors complete the process? What were the risk factors that prevented a family from participating?

It was clear that completing the process put severe demands on the families. Parents entered the program understanding they had to bring their child to the center every day for the next 10 weeks and participate in family-training sessions. What was not known was what it took

for families to meet the requirements. Thus, did the CARE Clinic get families most in need of the program, or did it get the families who could meet its expectations and requirements? Even though the families experienced some angst about the process, six of the eight responding families said the benefits were "definitely" worth the sacrifices. Other families, however, may not have participated because the sacrifices required were considered too severe.

Family impact – shift from participant to advocate.

The importance of parent participation in a child's education process is well documented (Epstein, 1987; Green, Walker, Hoover-Dempsey, & Sandler, 2007; Grolnick & Slowiaczek, 1994). The research is just as robust when it comes to children at risk of a disability or school failure (Kim & Sheridan, 2015). The CARE Clinic process facilitated parents actively participating in their child's educational services throughout the assessment process. For example, parents had varying experiences with the PCIT (parent-child interactive therapy) process. One parent described it as her favorite part of CARE, while another parent found it not very effective for her son. Even though the parents shared the same experience, they both described how the PCIT process helped them learn about the importance of interacting with their child. While PCIT delivered mixed results, speech and sensory-integration therapy seemed to resonate with most of the parents. Parents learned the science behind the strategies and why particular methods worked for their child. Such examples demonstrate how going through the process is just as impactful as the results.

Parental comments from the interviews revealed deep layers of change and ownership for supporting their children. The families actively demonstrated investment by transporting their children to the center on a regular basis and actively participating in the required parent trainings for 10 weeks. Comments after completing the process, such as "taught me what to do and look for," "all children are different," and "gave me a lot of ideas" showed how parents could identify

the benefits of the individual strategies. But their comments did not end there. Some went further by describing how they became advocates for the community by either assisting other families with the CARE process or advocating for their child in other settings. For example, Cathy, mother of two sons, after completing CARE volunteered for a parent-advocacy agency and assisted parents with getting services for their children. Mary stated, "[CARE] taught me things to do and look for. I can advocate for my son." She further explained how the process pushed her thinking by teaching the "whys" behind his behavior. Participants Mary and Robin described how they learned how to act versus react to situations with their children. Thus, the CARE process did more than modify the children's behavior; it also provided parents with actual strategies, rationale behind the strategies, and, in some cases, the language to communicate these strategies to teachers, and, in one case, shared knowledge acquired with the community. According to Leko (2014) social validation is highly likely when the "intervention agents choose to continue to use the intervention even after formal support is removed" (p. 275). The advocacy by families is an example of continuation of intervention without formal support from Desert Mountain.

Family impact – promising short-term outcomes.

One of the key questions of a social-validation study is the participants' attribution of the value or outcomes to the intervention. All family representatives surveyed reported positive changes in their child after completing the Desert Mountain Diagnostic Clinical Care Model. This also included families who completed the process 12 to 24 months earlier. Participant Amy was the only family member who reported minimal or no impact after completing the program. Unfortunately, this study did not collect pre- and post-program student assessment data to quantify changes or therapy notes that would provide insights into the families' participation or fidelity to the process. Thus, any reports of change were registered as promising.

All parents surveyed believed their children were better off after completing the process, and the results from the interviews affirmed their thoughts. Based on parent observations, the students going through the CARE program exhibited fewer anti-social behaviors such as tantrums, hitting, fighting, or disobedience, and exhibited more positive behaviors such as making friends and enjoying learning. Parents were excited to share stories of basic, day-to-day activities being easier to do after completing the process, such as riding the bus or going to a children's amusement park. For example, one parent shared how she would take her son to places where he could use a jumpy (an interactive, inflatable plaything), with the idea of him using up some of his energy. She learned, however, that this activity overstimulated him, and he would do better with activities like swimming. This one modification changed her son's behaviors immediately and resulted in a clear outcome before the end of the process. Thus, the short-term impacts for this family were clear.

However, more research is needed to understand the overall goal and objective of the process. Is the goal to complete the process and provide solutions to behavioral issues and problems? Is the goal to reduce the number of students referred, placed or erroneously placed in special education? Are the short-term, mid-term, or long-term goals different? The importance of pondering the success of SART is understanding if its outcomes are meeting its goals.

DM/SART – informative assessment process, CARE eligibility confusing.

The President's Commission on Excellence in Special Education (2002) declared, "IDEA (Individuals with Disabilities Education Act)'s complex requirements are difficult to effectively implement. Nowhere in IDEA is this more complex than in the eligibility determination process" (p. 21). The complexity of the process can be seen in Figure 5, but the intensity is based on the child's level of need. For example, during Phase 1 of SART, children not meeting medical necessity are released from the process with recommendations for treatment, while

children who meet medical necessity were further divided into two groups for further assessment or moved directly to services with recommendations. At a minimum, parents received basic information – what were their child's needs or abilities in various categories. This did not always involve a special-education label, but could include the child's ability level in non-special-education categories. The parents also noted the SART process provided more than the outcome or a label. They learned the names and purposes of the assessments, how assessments were conducted, and how to use data collected. But more importantly, they learned how to use the data and results to assist their children. Ultimately, the parents found the process informative as it related to their child needs being addressed.

Echoing the President's Commission, the parents identified the CARE eligibility process as confusing. Gould (1996) wrote in the *The Mismeasure of Man*, "Objectivity must be operationally defined as fair treatment of data, not absence of preference" (p. 36). Parents could not explain how CARE cohorts were created. For example, Carmen's daughter entered CARE with speech concerns when she was 3 years old without an Individualized Education Plan (IEP) or a formal referral or assessment. Why she was selected is not clear. Staff explained the importance of having a balanced classroom, because they did not want a cohort with children who all had the same issues or challenges. Thus, they worked to ensure students had a variety of peer models, such as non-communicative versus talkative. Participant Amy summarized why the process was informative, but still expressed confusion with the selection process. Again, clarifying the goals of the program could assist the program with improved communication about selection.

DM CARE Clinic – a dynamic system of assessing effectiveness of strategies.

The President's Commission on Excellence in Special Education's report recommended implementing models during the identification and assessment process that are based on response

to intervention and progress monitoring and using the data to assess progress in children who receive special-education services. The DM process was and is the consummate RtI model while simultaneously implementing one of the Commission's recommendations – creating a process that treats all children as general-education students. Desert Mountain used the RtI model to serve children who had an identified special need, were at risk of being identified with a special need, or would not qualify for special education but were socially and emotionally at risk. Its process used promising and proven research-based strategies. The staff assessed the effectiveness for each student and family individually, not assuming a strategy proven useful for one child would work for another, and examples of the success of assessing the effectiveness of the strategies were numerous.

Once a child and family entered the CARE process, a plethora of services were available for them. It was through the delivery and assessment of the effectiveness of these services that parents learned the theory behind each strategy and its possible impact on their child's behaviors and responses. The families consistently identified positive results from speech/communication therapy, sensory-integration therapy, PCIT, and parent-training sessions. Every parent listed speech or communication therapy as one of the most effective strategies assessed by the DM team. Effective communication mitigated many behavioral issues. In one case, a child did not have a speech issue that would have qualified him for speech therapy through the traditional special-education system. His mother described her son as "high functionality and spoke a lot" and not needing speech therapy. Through the DM CARE Clinic process, however, some speech deficiencies were identified and addressed, so her son could communicate more "effectively."

Three other parents discussed how they learned how speech is formed, such as when specific sounds typically come in. For example, during the follow-up interview, Amy described

how speech was formed and its relationship or impact on behavior, which was of interest since she was neutral to negative about the overall impact of the CARE Clinic process except when it involved speech therapy. Overall, each parent interviewed articulated the "what," "why," and "how" of speech therapy as a strategy and its positive effect on a child's social-emotional development.

Students also participated in sensory-integration assessment/therapy two to three times a week for 30 minutes per session. One of two licensed therapists conducted the sessions, in which the therapists assessed the students' adaption to each new strategy and shared the success of any process with the parents. Participant Amy explained how the strategies helped her son complete day-to-day activities, such as brushing his teeth.

Parent-child interaction therapy (PCIT) was the most controversial of all strategies employed and assessed by the DM team. The parents either loved the process or found it not as helpful as the other processes. For example, Mary did not find it as helpful but recommended moving the room where the student and parent received instructions further away from the room where the therapists observed the interactions. Her son heard the therapist give instructions, and this distracted him from the actual process. On the opposite end of the spectrum, Carmen, Robin, and Susie found the process extremely helpful. It was Robin's favorite activity.

The DM staff conducted training sessions for all strategies (speech/communication therapy, sensory-integration therapy, PCIT, and parent-training sessions) in which parents learned the theory behind the strategy and how it could impact their individual child's behavior. No matter how technical the information, the parents described the DM staff as making the information understandable for them. They recognized that the ongoing trainings, in conjunction with weekly updates, affirmed the value of the actual services offered.

DM CARE Clinic – process length too short

According to the Desert Mountain staff, the CARE Clinic is an assessment process to identify appropriate strategies to serve struggling students. This definition was directly related to the funding of the services by Medi-Cal, "the state of California's program that offers free or low-cost health coverage for children and adults with limited income and resources" (Covered California, n.d.). To access the mental health portion of the funds, the patient must meet "medical necessity" as well as qualify financially. Covered California defined medical necessity as "services that an appropriate medical professional, exercising prudent clinical judgement, would provide a patient." Desert Mountain reported over 90% of the students and families in the CARE Clinic qualified financially. Families that did not qualify financially but met medical necessity were funded through other sources. The process used to determine medical necessity was the same for all students.

Desert Mountain also wanted to avoid a parent misunderstanding the assessment process for actual services, and potentially creating a "stay-put" situation in which a child would stay in the CARE Clinic process past the 10-week period. Part B of the Individuals with Disabilities Education Act explained stay-put as, "…the child shall remain in the then-current educational placement" (Boland, 2009, p. 1011). Some parents thought the purpose was to provide services instead of CARE being a process for identifying what services were needed. In all but one situation, however, the parents simply wanted more. They observed their children improving every week, and they wanted their progress to continue.

K-12 – transition and maintenance of services.

Pianta et.al. (2001) described the importance of transition from a preschool setting to kindergarten or formal educational as one of the key collaborative spaces in a child's education career because, "The change for families, children, and schools in which new expectations, new

relationships, and new competencies are formed . . . can have consequences for some time thereafter" (p. 117). When children transition from a setting in which the adults know a child is possibly entering with documented risk factors, it is imperative that there is a clearly articulated transition process (Carrington et al., 2016; Skouteris, Watson, & Lum, J., 2012).

Once a family completed the CARE process, the continuation of services or assistance seemed to be driven by the advocacy of the families or whether the next home school provided appropriate supports for the student. Desert Mountain staff reported spending at least a week after the families completed the CARE process interacting with the students' home schools. This involved visiting the home school or the home school staff observing the student at DM during the final weeks of the process. In both scenarios, the DM staff reviewed the final reports and recommendations with the home school staff, and sometimes met with both the parent and school personnel. None of the parents surveyed mentioned this step when describing their transition process. When asked about the transition process, parents mentioned either receiving services from Desert Mountain, the home school, or not at all. The only exception was when Desert Mountain itself provided the services. As participant Mary stated, "He still sees his clinician at the CARE program."

Seventeen years after the President's Commission on Excellence in Special Education report, the issues associated with educational transitions for children with special needs appear to exist in the DM transition process. During the Commission's 2002 investigation, parents reported "a lack of information regarding the purpose and processes associated with transition services, including information related to community agencies and resources" (p. 49). While DM staff attempted to explain a transition process, the implementation of the process did not align with the parents' expectations and experiences. For example, during follow-up interviews

one parent reported that six months after completing the CARE Clinic process she was still waiting for a final report with the assessment results and recommendations. The President's Commission recommended keeping the process simple, with open and frequent communication with parents. Even though the Commission report was specific to children with special needs, the strategies were applicable to all the children and families who participated in the CARE process.

Limitations of Study

This study had several limitations. First, it involved a small sample size (eight), although this sample size is within recommended guidelines for Yin's (2009) case-study methodology. The sample was selected from three cohorts out of a possible 12 from January 2016 through December 2018. While there were four cohorts per year for a total of 120 families, only 30 families were asked to participate in this study. The 30 families were selected from only the spring cohorts, and only 30% or 8 families agreed to participate in the study. It is not known if the other cohorts had different or similar experience during the CARE process, such as how transitions were handled in the middle of a school year versus over the summer.

The study participants only included women. The recruitment letter did not stipulate a gender and at no time did the researcher request or stipulate only mothers, grandmothers, aunts, or foster parent. The responding family members did identify individuals who assisted with transportation or participated in weekly trainings and meetings. No one identified a male as participating in the process, even though males were resided in some of the participants' homes. These individuals did not participate in follow-up interviews, and it is not known if they assisted with completing the survey. At some staff observations, male family members were present, but no data were collected, so a limitation of this study was that no males participated.

Since the survey was a self-report measure, the third limitation of the study was the use of retrospective, self-reported experiences of participants whose experiences were several months in the past. The use of retrospective, self-reported experiences is subject to participant bias (Gall, Gall, & Borg, 2007) and social-desirability influences (Klatt & Taylor-Powell, 2005), or the need to please the agency (Desert Mountain) or the researcher. The study would have also been stronger with actual pre-and post-child assessments for each participant.

The fourth limitation of this study concerned key informants who did not participate in the study, such as the elementary school staff. As reported by DM staff and survey results, most of the children attended an elementary school after completing the CARE process. To better understand the short- and long-term effects of CARE, the insights of teachers and other school staff at the next school would be helpful. Besides the parents, schools see the children practicing their new skills with adults and peers.

Implications for Future Research

The intersection of multiple specialties (special and general education, mental health, social services), provide many opportunities for future research. The President's 2002 Commission recommendations to attend to cost (p. 29), move away from a dichotomous special- or general-education designation for students to a single, multi-tiered system that identified all children as general education first when services are available for all children or robust Tier 1 structure (p. 9), and empowering parents (p. 35) to solve the three overarching issues provide a guide for other studies.

The Commission's report identified the cost of operating an ineffective and inefficient system of services for children with special needs as significant (p. 30). A variety of questions and methodologies could be employed to study the cost of SART and CARE on the any of the

previously mentioned systems. Does the cost of SART and CARE add value to the overall education system? Does the entire educational system save when children participate in such a process? Is a multi-tiered mental health or behavioral system cost -effective in multiple ways, such as improving quality of family life, social-emotional well-being, and various behavioral indicators of children and families served? What is the cost of SART and CARE situated in different systems, such as implementation in a school district, community based mental health agency, or nonpublic school for students with a behavior issues? Lastly, the SART assessment process focused on preschool students exhibiting at-risk behaviors or an identified special need, a study that examines costs of providing services before and after children are identified would add value to the field.

It would be extremely beneficial to conduct a longitudinal study that follows students as they move through the K-12 education system, such as primary, elementary, middle. What are the intermediate and long-term effects of preschool interventions? Which children and families benefit the most? At a minimum, a longitudinal study could follow a group of CARE graduates. Are the graduates able to maintain their gains with or without continued services? What school conditions increase the likelihood that students maintain their gains? Are positive outcomes sustainable? These are just a few of the questions that could be explored in a longitudinal study. Such a study could contribute to mental health, special education, and general education, as well as provide practical improvements for the SART and CARE Clinic processes and possibly inform the expansion of the CARE methodology into Tier-1 general-education settings.

Aligned with the President's Commission's recommendation of not waiting for students to fail, the process could be expanded by creating a model that prevents future problems by implementing a version of CARE in a general education setting with students that do not appear

to need intervention but may come from a community with multiple risk factors such as crime, poverty, and high unemployment. What SART and CARE strategies or process can effectively be implemented in a Tier 1 process? Can a transdisciplinary team process be implemented in a Tier 1 design?

A study could also explore the promise of parent advocacy identified in the findings and the Commission's report which stated, "Parents should be provided with meaningful information about their children's progress, based on objective assessment results, and with educational options (p. 35). What happens when the parents transition to the K-12 system? Will they continue to advocate for their children? Will the level of information shared during the SART and CARE process continue? What are the impacts to the education system when at-risk students' families actively engage in their child's education? If so, what other advocacy strategies will they display, such as classroom volunteering or school leadership, or will a study reveal their advocacy declined over time?

Researcher Statement

> Impartiality (even if desirable) is unattainable by human beings with inevitable backgrounds, needs, beliefs, and desires. It is dangerous for a scholar even to imagine that he might attain complete neutrality, for then one stops being vigilant about personal preferences and their influences – and then one truly falls victim to the dictates of prejudice (Gould, 1996, p.36).

Prior to conducting this study, the researcher participated in multiple information sessions about the Desert Mountain SART and CARE Clinic processes. The relationship included multiple observations, document sharing, and visits by DM staff to the school district where the researcher was formerly chief/associate superintendent of early education. The DM staff

consulted with this school district on several topics including implementation of schoolwide PBIS. Additionally, as a recent adoptive parent of two children affected by various risk factors, the researcher had a personal interest in the study. Therefore, the researcher took extra care to guard against possible bias. This was addressed by using member checks and external reviewers throughout the stages of data analysis.

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Appendices

Appendix A: Parent Recruitment Letter

RE: A Social-Validation, Single-Case Study of the Desert Mountain SART Tier 3 CARE Clinic Program

My name is Carla Bryant, and I am a doctoral candidate from the University of Washington in Seattle.

Background

I have over 20 years of experience creating policies, programs, and procedures for comprehensive early learning, preschool through third grade, elementary, family-support, and after-school programs as the Chief of Early Education for San Francisco Unified School District and the City of Seattle Mayor's Office for Education.

As the Chief of Early Education, I was responsible for administrating 12 early-education schools with prekindergarten (PK) through transitional kindergarten (TK) students, supporting 74 elementary schools to align curriculum and instruction PK-third grade, and integrating community-based pre-K and District practices with the assistance of city departments (i.e., First 5 SF).

Before joining SFUSD, I was a strategic advisor for the City of Seattle, where I co-created the Seattle Early Education Collaborative (SEEC), a community-based, early-learning system joining disparately funded programs (federal, state, local, and private) into one system that included joint assessment and accountability, professional development, and transition processes.

Proposed Study

I am conducting a study on the Desert Mountain Children's Center. As part of this study, I would like you to complete a survey. The study will help me learn about the experiences of

children and families who participated in the Desert Mountain Children's Center 10-week CARE Clinic process. I want to get your point of view on how your child was doing before and after participating in the process. This information will be used to help me better understand the families' impressions of the interventions after the child completed the CARE Clinic process. To thank you for your participation, you will receive **$75 VISA gift card** for completing the survey.

The survey will be conducted by mail, phone, online, or in-person, according to your preference. The survey is also available in Spanish, and it can be conducted with a certified translator.

I will not share your identifiable information with the Desert Mountain Children's Center. Your participation is completely voluntary and confidential. All personal identifiers will be replaced with pseudonyms. If you choose not to complete the survey and not participate in the study, it will not affect you or your child's participation in Desert Mountain Children's Center services. The survey will take approximately 60-75 minutes.

If you are interested in participating in the study, please notify me by text at (206) 455-5385 or email at carlambryant2@gmail.com. Any family contacting me and completing the survey on or before **July 24, 2018,** will receive an additional **$25 VISA gift card** for a total of **$100 VISA gift card**.

THANK YOU

Appendix B: Staff Recruitment Letter

RE: A Social-Validation, Single-Case Study of the Desert Mountain SART Tier 3 CARE Clinic Program

My name is Carla Bryant, and I am a doctoral candidate from the University of Washington in Seattle. I am interested in conducting a case study on the Desert Mountain Children's Center (DMCC) and would like to invite you to participate.

Background

I have over 20 years of experience creating policies, programs, and procedures for comprehensive early-learning, preschool through third grade, elementary, family-support, and after-school programs as the Chief of Early Education for San Francisco Unified School District and the City of Seattle Mayor's Office for Education.

As the Chief of Early Education, I was responsible for administrating 12 early-education schools with prekindergarten (PK) through transitional kindergarten (TK) students, supporting 74 elementary schools to align curriculum and instruction PK-third grade, and integrating community-based pre-K and district practices with the assistance of city departments (i.e., First 5 SF).

Before joining SFUSD, I was a strategic advisor for the City of Seattle, where I co-created the Seattle Early Education Collaborative (SEEC), a community-based, early-learning system joining disparately funded programs (federal, state, local, and private) into one system that included joint assessment and accountability, professional development, and transition processes.

Proposed Study

The study involves two distinct phases. Phase 1 seeks to describe the SART to CARE Clinic process. It will involve document review, observations, and one-on-one interviews with

staff. Phase 2 is a social-validation process to determine the families' perceptions of the short-term impact of the CARE intervention.

Your participation is completely voluntary and confidential. All personal identifiers will be replaced with pseudonyms. If you choose not to participate in the study, it will not affect you or your employment at Desert Mountain Children's Center. The observations and document review will not interfere in your day-to-day activities, but individual interviews may take approximately 60-75 minutes.

If you are interested in participating in the study, please notify me by text at (206) 455-5385 or email at carlambryant2@gmail.com.

THANK YOU

Appendix C: Family Consent Form

RE: A Social-Validation, Single-Case Study of the Desert Mountain SART Tier 3 CARE Clinic Program

What is the study about? This research is being conducted to gain an understanding of the experience of parents, their children and families who have participated in the Desert Mountain Children's Center SART (Screening, Assessment, Referral, and Treatment) program and services.

What will be asked of me? If you agree to participate, you will be asked to complete a survey. Each survey will take about 60-75 minutes to complete. The survey will cover three overarching topics: (1) Desert Mountain services and process, (2) impact of services on your family, and (3) your recommendations for how the process and services could be modified to better serve families.

You may select one of four methods to receive and complete the survey: in person, by phone interview, online, or hard copy mailed to your residence. Surveys received via internet or mail may need a quick follow-up call to ensure all questions are answered or clarified for accuracy. During a phone interview, your answers will be recorded so that I can transcribe your statements later exactly the way you responded. Your responses are confidential and will be used only for this study. Upon receipt of your survey, you will receive a $75 VISA gift card at the end of the interview and an additional $25 VISA gift card for completing the process on or before **August 3, 2018,** for a total of $100 of VISA gift cards.

Who is conducting the study? The following people are involved in this project and can be contacted if you have any questions:

Researcher Name: Carla Bryant

Researcher Email: carlab@uw.edu

Researcher Phone: (206) 455-5385

Dissertation Chair Name: Charles Peck, Ph.D.

Dissertation Chair Email: capeck@uw.edu

Dissertation Chair Phone: (206) 543-7834

Are there any risks? You may feel that some of the survey questions are personal. However, you can choose not to answer any question that you do not want to answer. A breach of confidentiality may be a risk if a non-research team member accessed information about you. Please see the next section for information about study confidentiality.

Is my participation confidential? We will keep identifiable information confidential. Your name will not be used in any written summary. Your name will be replaced with a pseudonym. The document containing names will be kept locked away and destroyed when the study is over.

What are some benefits? There are no direct benefits known at this time. I hope that your input will be valuable to this research and in helping to improve services in both the Desert Mountain Children's Center and any institution interested in implementing the DM model.

Can I stop participating in the study? Yes, you have the right to stop participating in the study at any time. You can also choose not to answer questions that you do not want to answer.

What if I have questions about my rights as a research participant or complaints? If you have questions or complaints about your participation in the study, please contact the researcher(s) identified in this form. Or if you prefer to talk to someone outside the study team or you feel you have been harmed by participating, you can contact the University of Washington Review Board, (206) 543-0098 or https://www.washington.edu/research/hsd/.

Thank you for participating in this study! We would be happy to answer any questions you might have. Please direct your questions or comments to Carla Bryant at carlab@uw.edu or dissertation chairperson Dr. Charles Peck at capeck@uw.edu.

Signatures

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions about the study.

Participant's Name: _____

Participant's Signature: _____

Date:_____

Researcher's Name: Carla Bryant

Researcher's Signature:_____

Date:_____

Appendix D: Staff Consent Form

RE: A Social-Validation, Single-Case Study of the Desert Mountain SART Tier 3 CARE Clinic Program

What is the study about? The research is being conducted to gain an understanding of the experience of parents, their children and families who have participated in the Desert Mountain Children's Center SART (Screening, Assessment, Referral, and Treatment) program and services.

The purpose of Phase 1 of the study is to answer, "What are SART and CARE?" The researcher will use information shared on the DM website, manuals, staff interviews, and observations to answer the question. The staff interviews and observations will be used to triangulate information and ensure the description is accurate.

What will be asked of me? If you agree to participate in the study, you will be asked to participate in an interview about your position. The interview will last 45-60 minutes. You will also be observed while you are conducting block schedules during CARE, such as circle, meal, sensory, group time, etc. The observations would occur in 30-minute increments. I would like to observe you one to two times. When applicable, you will be asked to share any documents that describe what you do, e.g. job descriptions, manuals, pamphlets.

Who is conducting the study? The following people are involved in this project and can be contacted if you have any questions:

Researcher Name: Carla Bryant

Researcher Email: carlab@uw.edu

Researcher Phone: (206) 455-5385

Dissertation Chair Name: Charles Peck, Ph.D.

Dissertation Chair Email: capeck@uw.edu

Dissertation Chair Phone: (206) 543-7834

Are there any risks? You may feel self-conscious during the observations. You can ask the researcher to stop observing at any time. A breach of confidentiality may be a risk if a non-research team member accesses information about you. Please see the next section for information about study confidentiality.

Is my participation confidential? We will keep identifiable information confidential. Your name will not be used in any written summary. Your name will be replaced with a pseudonym. The document containing names will be kept locked away and destroyed when the study is over.

What are some benefits? There are no direct benefits known at this time. I hope that your input will be valuable to this research and in helping to improve services in both Desert Mountain Children's Center and any institution interested in implementing the DM model.

Can I stop participating in the study? Yes, you have the right to stop participating in the study at any time. You can also choose not to answer questions that you do not want to answer.

What if I have questions about my rights as a research participant or complaints? If you have questions or complaints about your participation in the study, please contact the researcher(s) identified in this form. Or if you prefer to talk to someone outside the study team or you feel you have been harmed by participating, you can contact the University of Washington Review Board, (206) 543-0098 or https://www.washington.edu/research/hsd/.

Thank you for participating in this study! We would be happy to answer any questions you might have. Please direct your questions or comments to: Carla Bryant at

carlab@uw.edu or (206) 455-5385 or dissertation chairperson Dr. Charles Peck at capeck@uw.edu.

Signatures

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions about the study.

Staff Participant's Name:_____

Staff Participant's Signature:_____

Date:_____

Researcher's Name: Carla Bryant

Researcher's Signature:_____

Date:_____

Appendix E: Family Survey

A Social-Validation, Single-Case Study of the Desert Mountain SART Tier-3 CARE Clinic Program

Family Survey

Child/Family ID number: _____

Child's Name (CARE 10-week participant):_____

Birth date: _____

Child gender *(Check One)*: Female ❒ Male ❒

Interview Format (*Check One*):

Time 1: Mail ❒ Internet ❒ Phone ❒ In Person ❒ If in person, where_____

Time 2: Mail ❒ Internet ❒ Phone ❒ In Person ❒ If in person, where_____

Time 3: Mail ❒ Internet ❒ Phone ❒ In Person ❒ If in person, where_____

Date(s): Attempt 1 ❒ Completed: Yes ❒ No ❒ Date:_____

Attempt 2 ❒ Completed: Yes ❒ No ❒ Date:_____

Attempt 3 ❒ Completed: Yes ❒ No ❒ Date:_____

Interviewer:_____

Interviewer/Translator:_____

Introduction

My name is Carla Bryant, and I am a doctoral candidate from the University of Washington in Seattle.

Background

I have over 20 years of experience creating policies, programs, and procedures for comprehensive early learning, preschool through-third grade, elementary, family-support, and after-school programs as the Chief of Early Education for San Francisco Unified School District and the City of Seattle Mayor's Office for Education.

As the Chief of Early Education, I was responsible for administrating 12 early-education schools with prekindergarten (PK) through transitional kindergarten (TK) students, supporting 74 elementary schools to align curriculum and instruction PK-third grade, and integrating community-based Pre-K and district practices with the assistance of city departments (i.e., First 5 SF).

Before joining SFUSD, I was a strategic advisor for the City of Seattle, where I co-created the Seattle Early Education Collaborative (SEEC), a community-based early-learning system joining disparately funded programs (federal, state, local, and private) into one system that included joint assessment and accountability, professional development, and transition processes.

Proposed Study

I am conducting a study on the Desert Mountain Children's Center. As part of this study, I would like you to complete a survey. The study will help me learn about the experiences of children and families who participated in the Desert Mountain Children's Center 10-week CARE Clinic process. I want to get your point of view on how your child was doing before and after

participating in the process. This information will be used to help me better understand the families' impressions of the interventions after the child completed the CARE process. To thank you for your participation, you will receive a **$75 VISA gift card** for completing the survey.

The survey will be conducted by mail, phone, internet (web based) or in person, according to family preferences. The survey is also available in Spanish, or it can be conducted with a certified translator.

No one from the Desert Mountain Children's Center will see or hear your answers. Your participation is completely voluntary and confidential. All personal identifiers will be replaced with pseudonyms. If you choose not to complete the survey and not participate in the study, it will not affect you or your child's participation in the Desert Mountain Children's Center services. The survey should take approximately 60-75 minutes.

Before we begin the survey, let me read the following statement to you:

This study has been explained to me. I am voluntarily participating in this study. I have had a chance to ask questions, and if I have additional questions, I can contact the researcher listed on the consent form that I have signed.

If I have questions about my rights as a research subject, I can contact the Human Subjects Division at (206) 543-0098 or https://www.washington.edu/research/hsd/.

I. Demographic Data/Information

1. What is your race?

- African American or Black ❒
- American Indian or Alaskan Native ❒
- Asian ❒
- Filipino ❒
- Hispanic or Latino/a ❒
- Native Hawaiian or Pacific Islander ❒
- White ❒
- Two or More Races, please list ❒
  (Specify) _____
- Prefer not to answer ❒

2. What is your child's race?

- African American or Black ❒
- American Indian or Alaskan Native ❒
- Asian ❒
- Filipino ❒
- Hispanic or Latino/a ❒
- Native Hawaiian or Pacific Islander ❒
- White ❒
- Two or More Races, please list ❒
  (Specify) _____
- Prefer not to answer ❒

3. What language(s) do you speak most at home now?

- English ❒
- Spanish ❒
- English and Spanish ❒
- Other language, please list ❒
  (Specify) _____

Family Data

Now I'm going to ask you some questions about you and your family.

4. Including yourself, how many adults age 18 and older live in your household?

Number of Adults: _____

5. Including [child], how many children age 17 and younger live in your household?

Number of Children: _____

6. What is your current marital status?

- Single, never married ❒
- Married/Partner ❒
- Separated ❒
- Divorced ❒
- Widowed ❒
- Prefer not to answer. ❒

7. What is the highest grade or year of school that you have completed?

- Up to 8th Grade ❒
- 9th to 11th Grade ❒
- 12th Grade but no Diploma ❒
- High School Diploma/Equivalent ❒
- Vocational Tech/Tech Program After High School but NO Voc/Tech Diploma ❒
- Vocational Tech Diploma after High School ❒
- Some College But No Degree ❒
- Associate's Degree ❒
- Bachelor's Degree ❒
- Graduate Or Professional School But No Degree ❒
- Master's Degree (MA, MS, Med) ❒
- Doctorate Degree (PhD, EdD) ❒
- Professional Degree After Bachelor's Degree (Medicine/MD; Dentistry/DDS; Law/JD ❒
- Do not know ❒
- Prefer not to answer ❒

8. Are you currently working full-time, working part-time, in school, in a training program, keeping house, or something else? (Check One Response)

Working Full-Time (30 Hours or More Per Week)	❒
Working Part-Time (Less Than 30 hours Per Week)	❒
Looking for Work	❒
Laid Off from Work	❒
In School/Training	❒
In Jail/Prison	❒
In Military	❒
Something Else (Specify)	❒
Do not know	❒
Prefer not to answer	❒

9. Are you still working for the same employer for whom you were working before the 10-week CARE Clinic intervention?

YES ❒
NO ❒

10. Are you doing the same kind of work that you were doing before the 10-week CARE Clinic intervention?

YES ❒
NO ❒

11. Before your child enrolled in the 10-week session, did you…

	YES	NO	Know
a. Attend a general school meeting, for example, an open house, a back-to-school night, or a meeting of a parent teacher organization?	❒	❒	❒
b. Go to a regularly scheduled parent-teacher conference with [CHILD]'s teacher?	❒	❒	❒
c. Attend a school or class event, such as a sports event because of [CHILD]?	❒	❒	❒
d. Act as a volunteer at the school or served on a committee?	❒	❒	❒

Pre-Intervention Support System

We want to find out about your relatives and family members, [CHILD], and anyone who served as a part of your support network during the CARE Clinic process.

12. List yourself (RESPONDENT) and the names of individuals who supported your child during the 10-week CARE Clinic program (*check all that apply*).

	Type of Support				
Relationship to Child	PCIT	Parent Training	Parent Meeting	Transportation	Other, please list
Parent (birth)	❒	❒	❒	❒	❒
Parent (adoptive)	❒	❒	❒	❒	❒
Parent (step)	❒	❒	❒	❒	❒
Parent (foster)	❒	❒	❒	❒	❒
Parent's partner	❒	❒	❒	❒	❒
Grandparent	❒	❒	❒	❒	❒
Great grandparent	❒	❒	❒	❒	❒
Sibling (including. adopted, foster)	❒	❒	❒	❒	❒
Godparent	❒	❒	❒	❒	❒
Aunt/uncle	❒	❒	❒	❒	❒
Non-relative	❒	❒	❒	❒	❒
Other (SPECIFY)_____	❒	❒	❒	❒	❒

II. Pre-CARE Clinic 10-Week Intervention

Now I have a few questions about [CHILD]'s behavior and health.

Your Child's Behavior BEFORE the CARE Clinic 10-week Intervention

1. In general, thinking about [CHILD] prior to the CARE Clinic process, tell me how well the following statements describe [CHILD]'s usual behavior. For each one, tell me if it occurs always, often, sometimes, or never.

Behavior	Always	Often	Sometimes	Never
a. Made friends easily?	1	2	3	4
b. Enjoyed learning?	1	2	3	4
c. Had temper tantrums or hot temper?	1	2	3	4
d. Could not concentrate or pay attention for long?	1	2	3	4
e. Was very restless, and fidgeted a lot?	1	2	3	4
f. Liked to try new things?	1	2	3	4
g. Showed imagination in work and play?	1	2	3	4
h. Was unhappy, sad, or depressed?	1	2	3	4
i. Comforted or helped others?	1	2	3	4
j. Hit and fought with others?	1	2	3	4
k. Worried about things for a long time?	1	2	3	4
l. Accepted friends' ideas in sharing and playing?	1	2	3	4
m. Did not get along with other kids?	1	2	3	4
n. Wanted to hear that he or she is doing okay?	1	2	3	4
o. Felt worthless or inferior?	1	2	3	4
p. Had difficulty making changes from one activity to another?	1	2	3	4
q. Was nervous, high-strung, or tense?	1	2	3	4
r. Acted too young for (his/her) age?	1	2	3	4
s. Was disobedient at home?	1	2	3	4
t. Was disobedient in public settings, such as bus, mall?	1	2	3	4
u. Did not follow directions?	1	2	3	4

Household Rules and Parenting Practices

Now I'd like to ask you a few questions about how you interacted with your child at home before the CARE Clinic 10-week intervention.

2. In your house, were there rules or routines about…

Questions	YES	NO
a. What TV programs [CHILD] can watch?	❒	❒
b. How many hours [CHILD] can watch TV?	❒	❒
c. What kinds of food [CHILD] eats?	❒	❒
d. What time [CHILD] goes to bed?	❒	❒
e. What chores [CHILD] does?	❒	❒

3. Sometimes children follow directions (i.e., mind) and sometimes they do not. What strategies did you use to get your child to mind? Check all that apply.

Questions	YES	NO
a. I did nothing, ignored behavior.	❒	❒
b. I used time out, asked child to sit/stand.	❒	❒
c. I yelled at my child.	❒	❒
d. I described the behavior I wanted to see.	❒	❒
e. I modeled the appropriate behavior.	❒	❒
f. I waited patiently for the child to discontinue the behavior.	❒	❒
g. Other, please describe. _____	❒	❒

_____

4. If applicable, about how many times in a typical week did you use the following strategies?

Questions	# of Times	NA
a. Ignored behavior.	_____	❒
b. Asked child to sit/stand.	_____	❒
c. Yelled at my child.	_____	❒
d. Described appropriate behavior	_____	❒
e. Modeled appropriate behavior.	_____	❒
f. Waited patiently.	_____	❒
g. Other as described. _____	_____	❒

5. Here are some statements that parents of young children say about themselves.

Read the statements, and after each one, please CHECK which one is like you.

STATEMENT	Exactly like you	Very much like you	Somewhat like you	Not much like you	Not at all like you
a. I controlled my child by warning (him/her) about the bad things that can happen to (him/her).	1	2	3	4	5
b. There were times I just do not have the energy to make my child behave as (he/ she) should.	1	2	3	4	5
c. My child and I had warm intimate moments together.	1	2	3	4	5
d. I taught my child that misbehavior or breaking the rules will always be punished one way or another.	1	2	3	4	5
e. I encouraged my child to be curious, to explore, and to question things.	1	2	3	4	5
f. I did not allow my child to get angry with me.	1	2	3	4	5
g. I was easygoing and relaxed with my child.	1	2	3	4	5
h. I believed that a child should be seen and not heard.	1	2	3	4	5
i. I made sure my child knows that I appreciate what (he/she) tries to accomplish.	1	2	3	4	5
j. I had little or no difficulty sticking with my rules for my child even when close relatives (including grandparents) are there.	1	2	3	4	5
k. I encouraged my child to be independent of me.	1	2	3	4	5
l. When I decided how to deal with a misbehavior of my child, I followed through on it.	1	2	3	4	5

6. Did a doctor or other health or education professional ever tell you that [CHILD] had any special needs or disabilities – for example, physical, emotional, language, hearing, learning difficulty, or other special needs BEFORE participating in the Desert Mountain 10-week CARE Clinic program?

YES	NO
❒	❒

7. How did the doctor or other health or education professional describe [CHILD]'s needs?

DESCRIPTION	YES	NO
A specific learning disability	❒	❒
Mental retardation	❒	❒
An emotional/behavioral disorder	❒	❒
Post-traumatic stress disorder (PTSD)	❒	❒
Attention-deficit disorder/Attention-deficit hyperactivity disorder (ADD/ADHD)	❒	❒
Sensory overload	❒	❒
Behavior disorder	❒	❒
A speech impairment	❒	❒
A language impairment	❒	❒
Dyslexic	❒	❒
Deafness	❒	❒
Another hearing impairment	❒	❒
Blindness	❒	❒
Another visual impairment	❒	❒
An orthopedic impairment	❒	❒
Another health impairment lasting six months or more	❒	❒
Autism	❒	❒
Traumatic brain injury	❒	❒
Non-categorical/developmental delay	❒	❒
Other health impairment	❒	❒
Some other issue, please list	❒	❒
(SPECIFY…) _____		
Prefer not to respond	❒	❒

III. CARE Intervention: 10-week CARE Clinic Program

The next set of questions is about your experiences when your child attended the 10-week CARE Clinic program. Please respond to questions based on your personal experiences with the agency.

System

1. **I would recommend the Desert Mountain 10-week CARE Clinic program to my family, friends, and community because I trusted the process.**

Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1	2	3	4

What did you like and/or dislike about the process?

Identification Process

2. **I feel as though the Desert Mountain student assessment process was fair.**

Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1	2	3	4

What did you like and/or dislike about the Desert Mountain assessment process?

Where there any parts of the assessment process that you did not understand?

What would have improved this experience?

3. **I agreed with the Desert Mountain assessment findings.**

Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1	2	3	4

What assessment findings were most helpful and why?

Services

4. **I feel as though the 10-week CARE Clinic process has given me strategies to support my child's behavioral and mental health needs.**

Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1	2	3	4

Please list and describe the strategies that were the most helpful and why?

5. **I felt the monthly parent information groups and one-on-one Parent-Child Interaction Therapy (PCIT) sessions helped me learn positive strategies to interact with my child.**

Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1	2	3	4

Which topics discussed during a monthly group session did you find the most significant or useful?

Please describe your favorite session.

At what week during the process did you notice changes in your child's behavior or developmental areas, such as first, third, fifth? Describe the moment or incident when the shift occurred.

IV. Post-CARE Clinic 10-Week Intervention – Outcomes

1. Where did your child attend school(s) after completing the CARE Clinic program?

COHORTS	Grades PK TK K 1st	Name of District and School
June 2016: (Completed 10-week CARE process June 2016)		District: _____ School: _____
June 2017: (Completed 10-week CARE process June 2017)		District: _____ School: _____ If different than last year
June 2018 (Completed 10-week CARE process June 2018)		District: _____ School: _____

Please answer these questions based on your understanding of your child and family's experiences at their school and classroom. Each cohort will respond YES (Y), NO (N) or do not know (DNK) for each relevant year.

2. In your child's SCHOOL, what student behavioral, mental-health, etc… supports exist? Check all that apply.

School Behavioral Supports	June 2018	June 2017	June 2016
a. There is a school wide behavioral support team at your child's school.	Y N DNK	Y N DNK	Y N DNK
b. The behavioral support team includes an individual skilled at conducting functional behavior assessment.	Y N DNK	Y N DNK	Y N DNK
c. The behavioral support team responds promptly to students who present with chronic behavioral problems.	Y N DNK	Y N DNK	Y N DNK
d. Behaviors are monitored, and feedback provided regularly to support team, teaching staff, and relevant staff.	Y N DNK	Y N DNK	Y N DNK
e. A simple process exists for parents to request assistance.	Y N DNK	Y N DNK	Y N DNK
f. The school provides formal opportunities for families to receive training on behavioral support/positive parenting strategies.	Y N DNK	Y N DNK	Y N DNK
g. Family and/or community members participate on the team when appropriate and possible.	Y N DNK	Y N DNK	Y N DNK
h. Your child's school has a Positive Behavioral (PBIS) coach that is easily accessible.	Y N DNK	Y N DNK	Y N DNK
i. Your child's school has adequate funding for planned school wide PBIS activities?.	Y N DNK	Y N DNK	Y N DNK
j. If available, List behavioral supports at your child's school.			

3. In your child's CLASSROOM, what student behavioral, mental-health, etc… supports exist? Check all that apply.

Classroom systems	June 2018			June 2017			June 2016		
a. Expected student behaviors and routines in your child's classrooms are stated positively and defined clearly.	Y	N	DNK	Y	N	DNK	Y	N	DNK
b. Problem behaviors are defined clearly.	Y	N	DNK	Y	N	DNK	Y	N	DNK
c. Expected student behavior and routines in classrooms are taught directly.	Y	N	DNK	Y	N	DNK	Y	N	DNK
d. Expected student behaviors are acknowledged regularly through positive reinforcement.	Y	N	DNK	Y	N	DNK	Y	N	DNK
e. Classroom management strategies match schoolwide PBIS supports, e.g. picture exchange communications systems (PECS).	Y	N	DNK	Y	N	DNK	Y	N	DNK
f. Classroom procedures for expected and problem behaviors are consistent with school wide procedures.	Y	N	DNK	Y	N	DNK	Y	N	DNK
g. Classroom based options exist to allow classroom instruction to continue when problem behaviors occur.	Y	N	DNK	Y	N	DNK	Y	N	DNK
h. Your child's classroom teacher has access to Positive Behavioral (PBIS) coach.	Y	N	DNK	Y	N	DNK	Y	N	DNK
i. In your child's classroom, transitions between instructional and non-instructional activities are efficient and orderly.	Y	N	DNK	Y	N	DNK	Y	N	DNK
j. The behavioral expectations are specific and described for each setting in the building.	Y	N	DNK	Y	N	DNK	Y	N	DNK
k. The lesson plans teach the PBIS expectations, and the teachers are familiar with them?	Y	N	DNK	Y	N	DNK	Y	N	DNK
l. At your child's school and in the classroom, new students and families are oriented to school norms.	Y	N	DNK	Y	N	DNK	Y	N	DNK
m. If available, list behavioral supports at your child's school.									

_____

Your Child's Behavior AFTER the CARE Clinic 10-Week Intervention

4. In general, thinking about [CHILD] now or over the past month, tell me how well the following statements describe [CHILD]'s usual behavior. For each one, tell me if it occurs always, often, sometimes, or never.

Behavior	Always	Often	Sometimes	Never
a. Makes friends easily?	1	2	3	4
b. Enjoys learning?	1	2	3	4
c. Has temper tantrums or hot temper?	1	2	3	4
d. Cannot concentrate or pay attention for long?	1	2	3	4
e. Is very restless, and fidgets a lot?	1	2	3	4
f. Likes to try new things?	1	2	3	4
g. Shows imagination in work and play?	1	2	3	4
h. Is unhappy, sad, or depressed?	1	2	3	4
i. Comforts or helps others?	1	2	3	4
j. Hits and fights with others?	1	2	3	4
k. Worries about things for a long time?	1	2	3	4
l. Accepts friends' ideas in sharing and playing?	1	2	3	4
m. Does not get along with other kids?	1	2	3	4
n. Wants to hear that he or she is doing okay?	1	2	3	4
o. Feels worthless or inferior?	1	2	3	4
p. Has difficulty making changes from one activity to another?	1	2	3	4
q. Is nervous, high-strung, or tense?	1	2	3	4
r. Acts too young for (his/her) age?	1	2	3	4
s. Is disobedient at home?	1	2	3	4
t. Is disobedient in public settings, such as bus, mall?	1	2	3	4
u. Does not follow directions?	1	2	3	4

Household Rules and Parenting Practices

Now I'd like to ask you a few questions about how you interacted with your child at home after completing the CARE Clinic 10-week intervention.

5. In your house, there are rules or routines about…

Questions	YES	NO
f. What TV programs [CHILD] can watch?	❒	❒
g. How many hours [CHILD] can watch TV?	❒	❒
h. What kinds of food [CHILD] eats?	❒	❒
i. What time [CHILD] goes to bed?	❒	❒
j. What chores [CHILD] does?	❒	❒

6. Sometimes children follow directions (i.e. mind) and sometimes they do not. What strategies do you use to get your child to mind? Check all that apply.

Questions	YES	NO
a. I do nothing, ignore behavior.	❒	❒
b. I use time out, ask child to sit/stand.	❒	❒
c. I yell at my child.	❒	❒
d. I describe the behavior I wanted to see.	❒	❒
e. I model the appropriate behavior.	❒	❒
f. I wait patiently for the child to discontinue the behavior.	❒	❒
g. Other, please describe._____	❒	❒

7. If applicable, about how many times in a typical week do you use ….?

Questions	# of Times	NA
a. Ignore behavior.	_____	❒
b. Ask child to sit/stand.	_____	❒
c. Yell at my child.	_____	❒
d. Describe appropriate behavior.	_____	❒
e. Model appropriate behavior.	_____	❒
f. Wait patiently.	_____	❒
g. Other, please describe._____	_____	❒

8. Since completing the Desert Mountain 10-week CARE Clinic program, has a doctor or other health or education professional ever tell you that [CHILD] has any special needs or disabilities – for example, physical, emotional, language, hearing, learning difficulty, or other special needs?

YES	NO
❒	❒

9. If you answered YES, how did the doctor or other health or education professional describe [CHILD]'s needs?

DESCRIPTION	YES	NO
A specific learning disability	❒	❒
Mental retardation	❒	❒
An emotional/behavioral disorder	❒	❒
Post-traumatic stress disorder (PTSD)	❒	❒
Attention-deficit disorder/Attention deficit hyperactivity disorder (ADD/ADHD)	❒	❒
Sensory overload	❒	❒
Behavior disorder	❒	❒
A speech impairment	❒	❒
A language impairment	❒	❒
Dyslexic	❒	❒
Deafness	❒	❒
Another hearing impairment	❒	❒
Blindness	❒	❒
Another visual impairment	❒	❒
An orthopedic impairment	❒	❒
Another health impairment lasting six months or more	❒	❒
Autism	❒	❒
Traumatic brain injury	❒	❒
Non-categorical/Developmental delay	❒	❒
Other health impairment	❒	❒
Some other issue, please list	❒	❒
(SPECIFY) _____		
Prefer not to respond	❒	❒

Outcomes

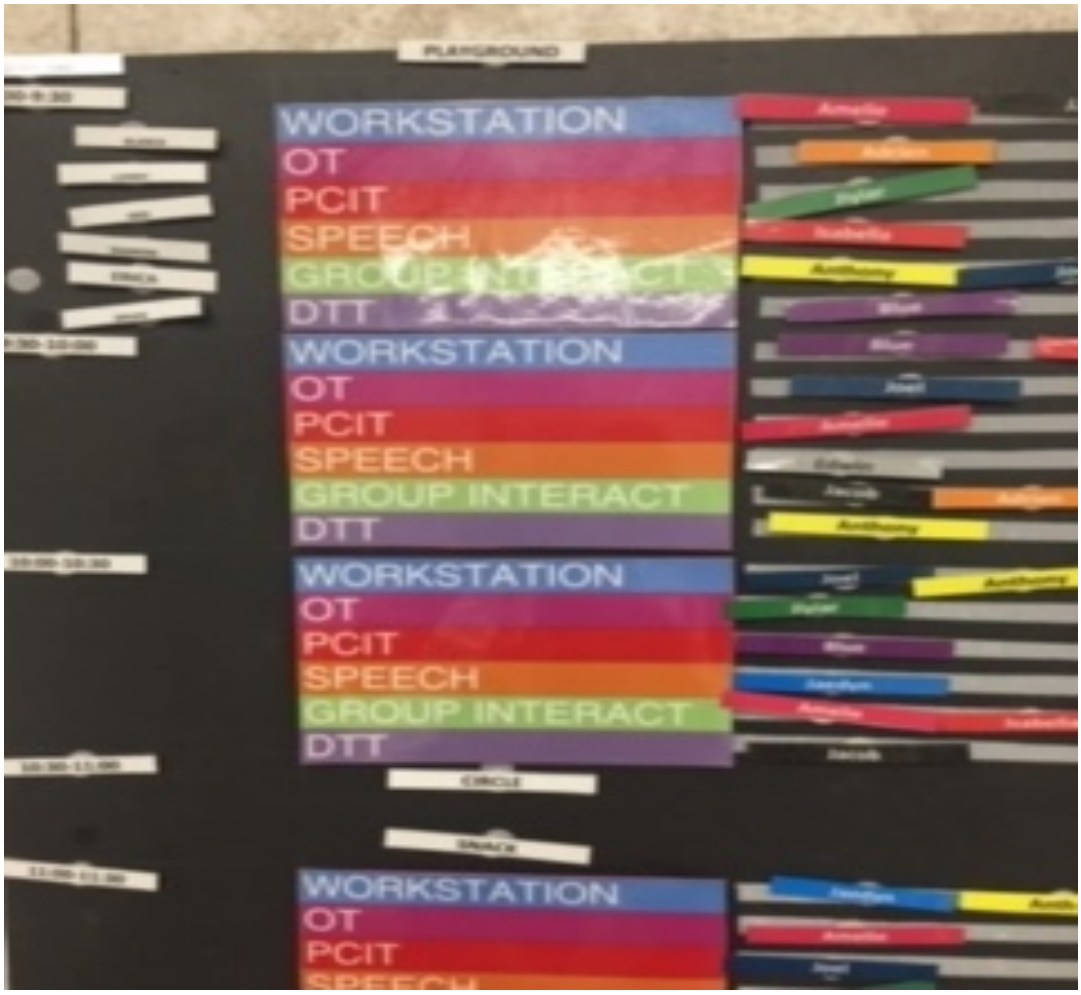
10. **It has been approximately four months (spring 2018), 14 months (spring 2017), or 26 months (spring 2016) since your child and family completed the Desert Mountain 10-week CARE Clinic process. The outcome(s) for my child and family was worth the effort.**

Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1	2	3	4

Please describe the changes or modifications your family had to do for your child to attend the 10-week sessions.

Was the process worth the sacrifices? Why or why not?

Appendix F: Photograph of Care Block Rotation



Appendix G: Photograph of Sensory Integration Room