Integrating Mental Health, Education, and Child Welfare Interventions for Preschoolers With Severe Maltreatment Histories: Ohio's Therapeutic Interagency Preschool (TIP) Model

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In this article,[1] we describe the Therapeutic Interagency Preschool (TIP) program, a comprehensive, promising program that has operated in Ohio for the past 18 years. TIP is a county-level, collaboratively funded, intensive, integrated Head Start day treatment program developed specifically to target highly disadvantaged children who have experienced various and/or multiple forms of sexual abuse, physical abuse, emotional abuse, neglect and domestic violence. The four Ohio communities and county agencies operating TIP programs recognize that seamless, interagency pathways and policies are essential if young, severely maltreated children are to escape the lasting consequences of abuse (Haugaard & Freerick, 2002). This article describes the TIP treatment model and outlines the results of this program for the children it serves.

The Need for Integrated Treatment

Traditional mental health treatment programs that serve families with young children in which domestic violence and child abuse are co-occurring are expensive and rare, in spite of high levels of need. Further, trauma-based, therapeutic intervention programs that are integrated into the family's natural caregiving environment (e.g., home and preschool/child care setting) are virtually nonexistent (Joseph & Strain, 2003; Egeland, Yates, Appelyard, & Van Dulmen, 2002). Very few local and state programs have centered on early interventions in an effort to reduce prevalence and poor long-term outcomes among the youngest victims of child maltreatment (Kotch et al., 1997; Kotch et al., 1995; Kotch, Browne, Dufort, Winsor, & Catellier, 1999; McGuigan & Pratt, 2001; Zelenko, Lock, Kraemer, & Steiner, 2000; Papin & Houck, 2005). Children and families with complex, co-occuring needs require innovative, complex, and individualized service systems to address those needs (Marks & Lawson, 2005).

Involving Early Childhood Education

In children's early years, social and emotional competence is a better predictor of academic performance than are cognitive skills or family background (Ladd & Burgess, 1999; McClelland, Morrison, & Holmes, 2000). Children exposed to severe maltreatment are most likely to exhibit social and emotional problems, such as problems with conflict management, social skills, emotional regulation, and making friends (Joseph & Strain, 2003). These children also have high levels of classroom behavior problems, they disrupt the learning environment for other children, and they learn less and attend school less than other children (Shonk & Cicchetti, 2001). Preschool teachers report that children's disruptive behavior problems are the most important challenges they face (Joseph & Strain, 2003). Research has demonstrated the effectiveness of early intervention and preschool services for improving children's language and cognitive skills, in decreasing behavior problems, and in promoting future academic success among these children (Martin, Ramey, & Ramey, 1990; Lee, Brooks-Gunn, & Schnur, & Liaw, 1990; Reynolds, Temple, Robertson, & Mann, 2001).

Head Start revised its performance standards in 1997 to emphasize the importance of early detection of vulnerable preschool children with psychological adjustment problems. Yet, most research contends that this population of children and their families are the most vulnerable and "difficult to engage" (Burns et al., 2004). While many of these children may be identified early, delays in providing intervention by several years undermine any potential benefit inherent in intensive early interventions (Forness et al., 2000). And, because emotional and behavioral problems in children are less amenable to intervention after the age of 8 (Huesmann, Eron, & Dubow, 2002), service delays often precipitate the long-term negative life course trajectories of these children. However, by reorganizing county-level services, the TIP program has demonstrated its capacity to engage this population to consistently participate in early childcare programs and has shown evidence of significant improvement in children's academic, language, social, emotional, and behavioral skills, as well as increased family stability and reduced subsequent incidents of abuse and neglect.

The Therapeutic Interagency Preschool Model

The TIP model was originally established in southwest Ohio in the greater Cincinnati area, and it is now operating in four counties across Ohio. The program holds great promise as an effective early intervention treatment model to serve young children with histories of severe maltreatment and high-environmental-risk factors. TIP is a county wraparound program that combines integrated, interagency service coordination and treatment management (Dunst & Brady, 2006; McWilliam, 2006) with the placement of children in enhanced, existing community programs such as Head Start.

While effective early childhood interventions for these "difficult to engage" children and families legally must exist in most counties (U.S. Dept. of Justice), these services often remain unused or underused due to the severity of families' personal and environmental risk issues. Had these children attended other preschools, many would likely have been expelled for reasons such as extreme violence, severe mental health issues, and sexual acting out. Other typical child and family problem areas include parental addiction, legal problems (incarceration, open warrants), low-cognitive functioning of parents, transient housing or homelessness, absence of reliable transportation, and failure to comply with entry-level criteria for early childhood programs, such as immunizations and assurances that children are free from communicable diseases and infestations.

The prevalence of developmental and behavioral disabilities in this population of children recently challenged schools and child welfare agencies to share information and to coordinate their service plans (Bowen & Bowen, 1998; Crozier & Barth, 2005). Schools contend that they need to know the trauma histories of children in their care because these factors strongly influence educational outcomes. The challenge for professionals is to adopt clear, ethical, program guidelines that will allow agencies to fully share information about the maltreatment and violence histories faced by these children and their families (Crozier & Barth, 2005).

Using many recommendations made by Schonkoff and Phillips (2000) in *From Neurons to Neighborhoods*, the TIP program has successfully engaged this targeted population by providing a model that blends both funding and service delivery mandates of key county agencies. The TIP Quality Assurance Service Guidelines (Table 1) reflect a seamless, interagency, family-friendly, one-stop model needed by young, severely maltreated children to escape the consequences of abuse (Haugaard & Freerick, 2002). Enrollment in TIP requires applicants to meet one or more of the following presenting problems: developmental, emotional, or behavioral problems, placement instability, a court mandate, or need for a more intensive level of service than is available in traditional community preschool treatment models. These criteria are potent identifiers of children who may benefit most from the long-term, year-round, multimodal, and interagency intense intervention services of a TIP model.

Program Description and History

The opportunity to develop this community-based, comprehensive treatment program came in 1989 in the wake of a local political backlash, when two young preschoolers in active care and custody of a county children's services department died within days of the home placement made by the agency. The community was outraged with what was perceived as a failure to protect these children. Through the collaborative efforts of Cincinnati Children's Hospital and county agencies, the first interagency-funded "community safety net" TIP model started in April 1989. This marked the beginning of continued, new collaborative partnerships within the county that led to a community-wide response to tragedy. This Ohio county realized that one agency, alone, is unable to assume the responsibility for protecting the safety of vulnerable children and their families (Austin, 2005). In 1991, the TIP model was merged with the county's Head Start model, thereby enhancing the program's ability to expand services to an additional county site, improve salary

Table 1

Cincinnati Children's Hospital Medical Center TIP Model Guidelines

TIP Quality Assurance Service Guidelines

- Referral of preschool aged children and their families by children services agency on issues of (1) developmental, (2) behavioral, or (3) placement instability concerns
- Interagency participation/agreements: preschools, children's services, early intervention, mental health, for collaborative program development and funding
- Low-number-of-children to staff ratio (recommended 4:1) with a classroom of no more than 12 children
- Full-year program operation (with seasonal and holiday breaks)
- Eighty-five percent attendance of TIP children (assistance from all partnership agencies, even juvenile court if necessary)
- Interagency-funded, blended services, coordinator position with fiscal and outcome data responsibilities to all contributing community agencies
- Increased home visits (Head Start, family service worker, TIP coordinator, TIP mental health therapist, daily bus monitor, teachers), minimum of one visit per month
- School-based provision of mental health, speech therapy, special education, and other services
- Child and family TIP assessments (pre- and post-9–12 months of programming)
- Mental health screening and consultation in the home and at visitations with families as requested by children's services or court
- Daily transportation for children, with informed staff on the bus and communication of observations to TIP staff
- Transportation of parents and children to appropriate appointments (MFE/IEP, immunizations, clinics, etc.) (caseworker, GAL, Head Start family services worker)
- Monthly reports and documentation of client observations and contacts shared with all participating agencies, with guardian's consent
- Access to and communication with all current community service providers with the parent/child, with use of a universal release form for all community agencies.
- Minimum of monthly treatment plan reviews and reports on family/child (includes staff, community professionals, parents as appropriate)
- Program credibility and visibility in the community: frequent contact and sharing of data with community service providers; well-trained staff, court appearances as requested
- Access to crisis-related treatment assistance: hospital emergency rooms, names and phone numbers of all emergency contacts (GAL, children's services, approved family and friends, doctors, etc.)
- Ongoing consultation and training from knowledgeable professionals (forensic centers, juvenile court, therapists, physicians, educators, etc.)
- Program evaluation: fiscal accountability and evidence-based outcomes on TIP and agency partners' guidelines

Model Variations (not known to change anticipated outcomes)

- Interagency agreements regarding funding, service provision, and coordination requirements to achieve above guidelines
- Full-day or half-day classroom program design for children
- Choice of preschool model: federal Head Start sites, Title I preschools, community preschools, special education preschools, and day care.

Source: Adapted from Sites and Cooper (2006).

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and personnel structure, and add the full Head Start components to TIP programming. From 1996 to 2006, neighboring counties requested to be replication sites of the TIP model. Today, TIP exits in six sites across four counties in Ohio and the program serves around 110 preschoolers and their families, all of whom have open cases in the county children's services departments. All enrollment eligibility and service criteria are maintained for all the collaborative agency partnerships, including the Head Start 85% attendance requirements. Fifty-five percent of the children and families participate in one full year of programming and 38% continue for more than a year of service. Only 7% of the children leave the program before completing the recommended one-year service.

What makes TIP unique is that through minor policy changes, it is able to integrate already existing county-based services and funding to address children's service, mental health, and school readiness concerns. Each of the three major contributing agencies spends essentially the same amount per family or child for the TIP model as it typically would spend on traditional single agency delivered services. Each financially committed agency (children's services, Head Start, and mental health) contributes to the TIP pool of money, which is then used to finance interagency TIP staff salaries and expenses through one fiscal cooperative agency, usually Head Start.

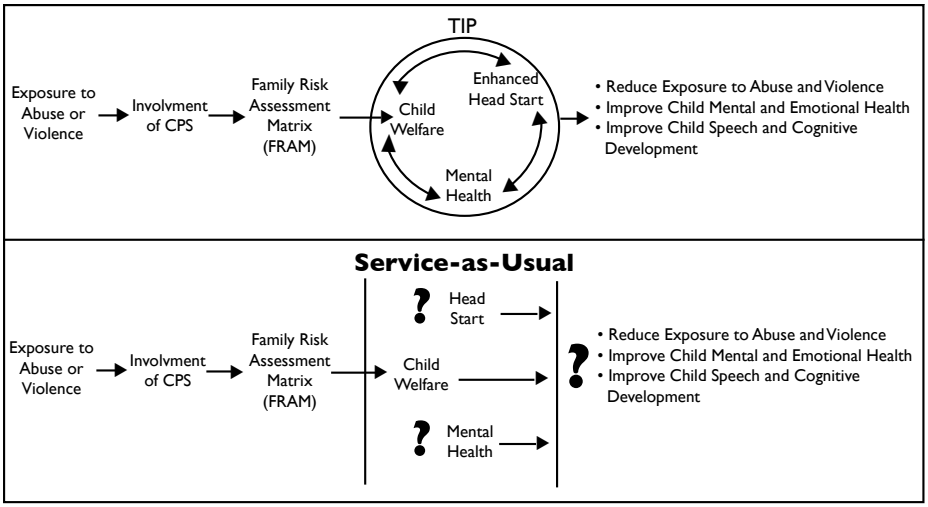
The county agency partnerships agree to a core set of integrated TIP model guidelines (Table 1) that provide the framework for the integrated community child and family wellness model (Figure 1), where safety is the number-one priority. The TIP program's goals are to help children with histories of and resulting disorders from abuse and neglect (1) to experience sustained, safe, nurturing environments and relationships, (2) to accept and interact with positive adult and peer role models, (3) to become stabilized both physically and mentally, and (4) to make significant developmental and social-emotional progress.

An essential aspect of TIP is the seamless, cost neutral integration of child protection, mental health, and Head Start preschool resources both in terms of services and dollars (1) to ensure and monitor the continued safety of the child's environment, (2) to provide intensive home and preschool mental health services, and (3) to enhance developmental and cognitive outcomes through a Head Start preschool curriculum. While each of these services already exists in most counties, each is generally funded by various sources of federal or state dollars, or both, and often works separately.

The TIP program operates as a year-round, interagency, center-based therapeutic preschool with school and home-based services, including assessments (e.g., speech, special education, and mental health), diagnosis and treatment, home-based parent education services, center-based classroom services, daily client transportation, and interagency treatment coordination and case management. Because of the community-based TIP interagency agreements (Table 1), all referrals are initiated by children's services departments. The children are initially screened for developmental and behavioral problems and for concerns about placement stability. For all children enrolled in TIP, there are weekly phone calls with a parent and caseworker, a minimum of one home visit a month, daily staff scrutiny of the home situation when the school bus picks-up and drops-off the child, weekly individual sessions with mental health staff, and semi-monthly case review and planning. The Childhood Trust, the Department of Psychiatry, and the Division of Developmental and Behavioral Pediatrics, all affiliated with Cincinnati Children's Hospital, provide administrative leadership and oversight for training and replication of the model to assure fidelity.

Interdisciplinary treatment teams, guided by mental health therapists and developmental specialists, are assigned to each family and provide assistance to the parents or guardians and other significant adults in the child's life. The treatment team coordinator (an interagency-funded position) cultivates and maintains a seamless approach to intervention in the face of interagency challenges between child welfare, school, family, and law enforcement agencies (Marks & Lawson, 2005). Further, since many families have difficulty accessing or engaging in outpatient therapy, TIP offers daily transportation, as well as intensive home-based and school-based treatment for developmental delays, behavioral problems, and trauma-related symptoms for the children, and supportive, mental health screenings and parental education treatment for the parents. TIP merges an early intervention or preschool curriculum for children with mental health treatment goals. This promotes psychological and developmental functioning in ways that other agencies and comprehensive treatment programs do not.

Figure 1
The 'TIP' Model vs. 'Service-as-Usual'



The classroom program curriculum used by the TIP program is established by the Federal Head Start Performance Standards on Early Childhood Development and Health [1304.21 Education and Early Childhood Development and 1304.21(a) Child Development and Education Approach for All Children (Early Childhood Quality Network, www.ecqnet.org)]. The early childhood mental health interventions used by TIP adapt cognitive-behavioral therapy and victim trauma approaches with traditional early childhood supportive mental health therapy (Bahl, Spaulding, & McNeil, 1999; Cohen & Mannarino, 2003; Cohen & Kaufman, 2000; Donahue, Falk, & Provet, 2000; Saunders, 2003; Hewitt, 1999; Wickham & West, 2002).

Qualified mental health staff in social work, counseling, or psychology are governed, supervised, and monitored by their respective county mental health departments or agencies. Intense mental health services (early childhood relationship-based intervention) are infused into the child's daily school and home environments to address typical diagnoses of children in the TIP program, including reactive attachment disorder, posttraumatic stress disorder, oppositional defiant disorder, depression, anxiety, sexual reactive behaviors, and dissociation. The children are seen both privately and in small group settings each week by their therapists. Evidence exists that children's social and emotional competence (more cooperation and less aggressive behavior) is strongly linked to their cognitive and academic competence, leading to success at school (Raver & Knitzer, 2002).

The program's administrative success is partly a result of its cultural sensitivity. Cultural sensitivity and program flexibility are core requirements for any program that seeks to establish itself successfully in a variety of settings. TIP has been implemented successfully at six sites whose enrollment ranges from 18% African American and 81% Caucasian to 80% African American and 20% Caucasian, with ethnicity of participants having little effect on program results. Because TIP utilizes established services that have already been shaped by the culture within each community, it does not impose outside values and curricula, nor does it compete with existing services. Implementation of TIP involves promoting cultural competence through unique community adaptations to the fidelity requirements in the TIP model guidelines. The evaluation measures, program fidelity process, twice-monthly peer review, and interagency treatment plan revisions address staff and client desire, cultural awareness, knowledge, skill, and personal encounters (Camphina-Bacote, 2002). The comprehensive system of care TIP provides is based on each community's common vision, the seamless delivery of child and family services, easy access to all supportive and required services, and accountability to the community through appropriate outcome and performance measures that provide continuous quality improvement efforts (Papin & Houck, 2005).

Process Evaluation Data and Findings

Participation Rates

One of the central strengths of the TIP model is its ability to increase family participation, access to services, and utilization compliance through a one-stop, integrated system. After one year in TIP, only half of the 50%–60% IEP-eligible children remained eligible for special education. Head Start attendance of TIP children averages 95%, exceeding the 85% class attendance goal set by Head Start, even though prior to their enrollment in TIP, fewer than 5% were engaged in any preschool or educational program. Of the few children who had been enrolled prior to TIP referral, two thirds were in the process of being expelled from their preschool program at the time of their enrollment in TIP for behaviors such as extreme recklessness, aggression, sexual acting out, extreme harm to themselves or others, and/or noncompliance with attendance or health standard guidelines. Moreover, fewer than 10% were engaged in any mental health services prior to TIP, and of those referred and receiving services, the average compliance rate was about three sessions.

Demographic Characteristics

In 2000, the Ohio Department of Mental Health (ODMH) Children's Services and Prevention Division funded an internal, prospective, longitudinal outcome evaluation of the four TIP sites in Greater Cincinnati. The Cincinnati Children's Hospital Medical Center (CCHMC) successfully gathered baseline and one-year postdata on 168 program participants over a period of 5 years (4 one-year, pre-post cycles). Data were collected from multiple sources, including official children's services case records, parent/guardian proxy assessments, speech and language pathologist evaluations, and preschool teacher observations. All parent/guardian assessments of the child were administered by TIP coordinators, who had been trained by CCHMC to complete these tools. TIP coordinators read the questions aloud to all informants to rule out attention deficits or limitations in reading skills of the caregiver. The CCHMC Institutional Review Board approved the use of these program evaluation data for subsequent analysis and publication.

The TIP population comprised 59.1% males and 40.9% females, of whom 40.5% were 3 years old, 43.5% were 4 years old, 13.1% were 5 years old, and 2.4% were 6 years old at the time of referral to TIP. Of these children, 50.6% were Caucasian and 48.7% were African American. At baseline, over 77% of these children had been previously removed from their biological homes. These children had at least one out-of-home placement, and 13.1% had three or more placements. At the time of follow-up, home placement stability had improved, and only 44.2% had an additional placement, with most of those to achieve permanence. Further, at baseline, 42.2% of the children were currently living with one or both biological parents, while 37.9% were living in foster care and 19.9% were living with relatives, such as grandparents and aunts, or with friends of the family. At year one, 43.8% were with one or both biological parents, 28.9% of the children were in foster care, and 27.3% were with other relatives or family friends. The data reflect a reduction in the number of children in foster care and an increased number of children placed in relative care.

Exposure to Maltreatment

All of the children included in the evaluation had an open case file with children's services. A chart review of the children's services caseworker files (made available through a standing universal release of information agreement that TIP programs have with sponsoring county agencies) provided information on alleged and substantiated abuse and neglect. In addition, at the time of program referral, each child's current legal guardian completed an inventory of traumatic events, the Childhood Trust Events Survey (CTES), identifying serious child abuse issues and other typical traumatic events. The format and questions were developed and first used in a study by Baker, Boat, Grinvalsky, and Geraciotti (1998). These two data sources identified children who had an indicated occurrence of a particular type of abuse (provided that the children's services caseworker had reported any alleged or substantiated event in the child's file), or this fact was provided by the caregiver in the CTES, that had been administered by trained TIP coordinators. The combination of the children's services case reports and the CTES inventory provided a more comprehensive representation of the children's abuse histories, with more incidents of violence and assaults reported. At baseline, 89.3% of the children who had completed 9–12 months of programming had previously experienced at least one form of type-specific victimization, with 15.5% having indicated sexual abuse, 25.6% having indicated physical abuse, 38.1% having indicated witnessing domestic abuse, and 54.8% having indicated neglect. In addition, 53.0% had indicated exposure to at least two types of substantiated/indicated victimization, 23.8% had indicated at least three types, and 7.1% had indicated exposure to all four major, reportable types.

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Outcome Evaluation Data and Findings

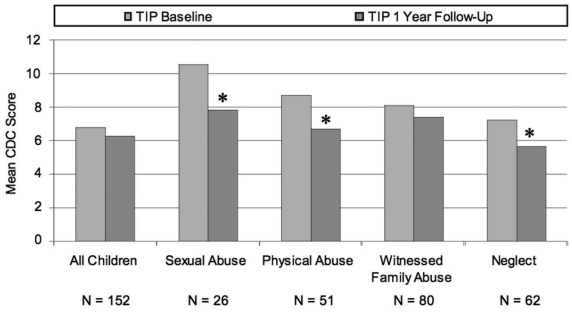
Behavioral and Mental Health Assessments

Assessment of changes in children's behavior and mental health problems were measured using the caregiver-administered Child Dissociative Checklist (CDC), Child Behavior Checklist (CBCL), and Social Skills Rating Scale (SSRS) (Putnam, Helmers, & Trickett, 1993; Kisiel & Lyons, 2001; Macfie, Cicchetti, & Toth, 2001; Hornstein & Putnam, 1992; Achenbach & Rescorla, 2000; Gresham & Elliot, 1990).

Tables 2 to 4 present the results of the pre-post outcome evaluation for all children, which are disaggregated across exposure to type of maltreatment for the CDC, CBCL, and SSRS measures. The overall pattern reveals significant improvements across most behavior and mental health assessments for all children and across all children by specific abuse exposure.

Table 2

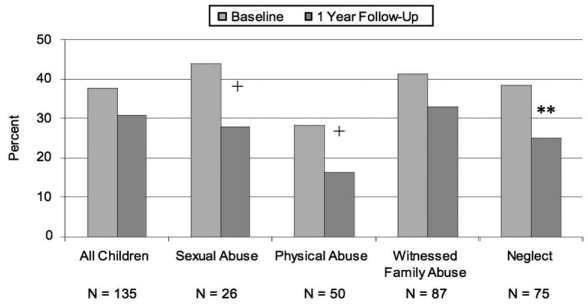
Change in Average Child Dissociative Checklist Score Over 1 Year Among TIP Children by Exposure



* p < .05; ** p < .01; *** p < .001 (two-tailed)

Table 3

Change in Percentage of Children Scoring Above Clinical Level on CBCL Total Scale Over 1 Year Among Children in TIP Programs by Exposure



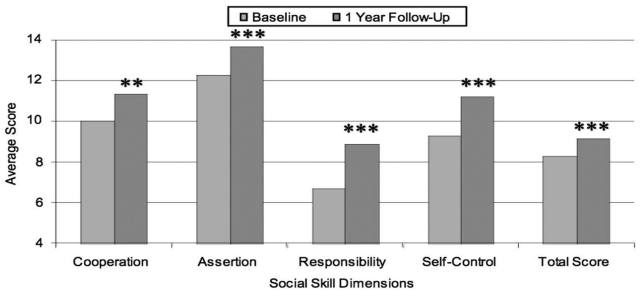
+ p < .10; * p < .05; ** p < .01; *** p < .001 (two-tailed)

Cognitive and Language Development

For two subsamples, we also completed speech and language assessments and a preschool teacher assessment of children's cognitive development. For speech and language, children were evaluated by a speech pathologist using the *Preschool Language Scales: Fourth Edition* (PLS-4) (Zimmerman, Steiner, & Pond, 2002), or the *Clinical Evaluation of Language Fundamentals: Fourth Edition* (CELF-4) (Semel, Wiig, & Secord, 2003) and the *Goldman-Fristoe 2: Test of Articulation* (GFA-2) (Goldman & Fristoe, 2000). While all children receive the articulation assessment, the use of the *Preschool Language Scales* or the *Clinical Evaluation of Language Fundamentals* is dependent on the child's baseline levels of skills, as one is more sensitive to lower skill levels than the other. For cognitive development, children were evaluated by the preschool teacher using the *Galileo Preschool* (Galileo Technology, 2002-2006), a standardized, observational assessment that gauged improvement across various dimensions of language and cognitive development.

Table 4

Improvements in Various Social Skills Over 1 Year Among Children in TIP Programs

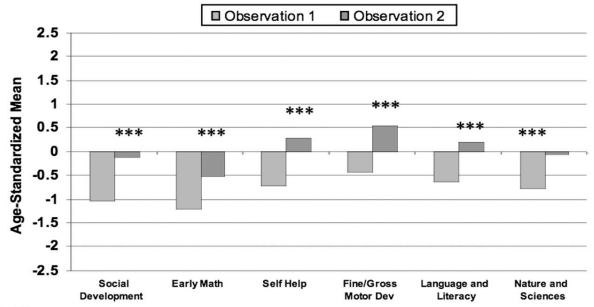


N = 150
* p < .05; ** p < .01; *** p < .001 (two-tailed)

The results of the cognitive/school readiness and language assessments are presented in Tables 5 to 6. Overall, the results show a significant improvement in language and articulation regardless of type of exposure to maltreatment. Moreover, improvement across all dimensions of cognitive development and school readiness, as measured using the *Galileo* through preschool teacher observations, was also significant for the total TIP population of children as well as for all children grouped by type of exposure to abuse.

Table 5

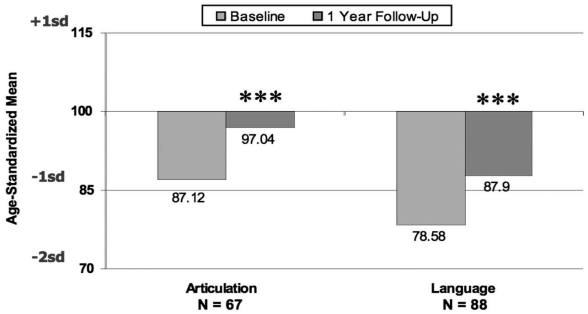
Change in *Galileo* Individual Development Scores Over 2 Observation Points Among Children in Cincinnati TIP



N = 58
* p < .05; ** p < .01; *** p < .001 (two-tailed)
Note: Data confined to Cincinnati TIP program from Summer 2001 to Summer 2003

Table 6

Change in Average Age-Standardized Speech and Language Assessment Scores Over 1 Year Among Children in TIP Programs



* p < .05; ** p < .01; *** p < .001 (two-tailed) Note: Data confined from Fall 2004 to Fall 2006

Discussion

Children enrolled in the TIP program are at an extremely elevated risk for adverse outcomes as a result of their experiences, including developmental disabilities, emotional disorders, and behavioral problems, all of which affect school readiness. Moreover, adverse childhood experiences that include abuse, neglect, and severe family dysfunction have been found to influence the origins of behaviors that underlie the leading causes of disability, social problems, health-related behaviors, and causes of death in the United States (Felitti et al., 1998).

The preliminary results of the internal evaluation show that TIP holds promise as an effective intervention for these most difficult-to-engage children and families. Why does TIP potentially work? TIP appears to be succeeding on two levels: programmatic and administrative. First, it is producing significant improvements over a one-year time frame in the social, emotional, and cognitive competence of severely maltreated preschoolers with complex co-occurring service needs who were not being served by preschool education or mental health agencies, regardless of their eligibility. We argue that programmatic success can be attributed to the intensity and integration of services and interagency policies. The intensity of services arises from the degree of engagement elicited and requested by all involved organizations, such as courts, children's services, schools, and mental health providers; the continual and intense monitoring of child safety and family stability; and the full year, one-stop, inclusive nature of the program. The TIP program development guidelines for evidence-based quality assurance (Table 1) (Sites & Cooper, 2006) conform to each agency's best standards of practice with only slight changes in agency policies. However, collectively, they present a collaborative model for services that integrates mental health treatment, early childhood education, and child/family safety (Schmitz & Hilton, 1996).

Administratively, in the counties where TIP has been implemented, it has successfully secured and sustained 18 years of administrative and financial support. TIP offers the simplicity of combining current funding streams and utilizing existing services, while providing safety, mental health treatment, and academic preparation for the least engaged, most emotionally disturbed and disruptive preschool children and their families. TIP services are integrated administratively and fiscally, as well as through the interdisciplinary nature of the program and extensive cross-training of staff. It removes barriers associated with cross-agency referrals and enrollments. For example, a key requirement of the TIP Guidelines is the existence of on-site, full-year mental health services and consultation, which are funded through each child's insurance or through Medicaid (Yoshikawa & Knitzer, 1997). On-site mental health consultation provides a continuum of care within the classroom as well as supports teachers, parents, and related staff (bus drivers, daycare providers, etc.). The involvement of the family is vital and develops the critical parent-teacher linkages and shared responsibility essential to addressing each child's social and emotional problems (Sheridan, Eagle, Cowan, & Mickelson, 2001).

Limitations and Future Steps

While the outcome evaluation indicating program success has been conducted with a high level of rigor, it is not definitive with respect to the limitations of its one-group, pre-posttest design. Because it involves following only those children participating in TIP, we cannot say unequivocally that these improvements would not have occurred without the intervention or in a usual-care model. However, a study with a control group at this point is untenable because of ethical and liability constraints. Specifically, county agencies are not willing to identify high-risk families and note their children's developmental and mental health issues without providing care, solely for the purpose of assigning a comparison group. A second consideration is that a selection bias may exist for referrals to TIP. Any bias, however, would likely be toward inclusion of the children most seriously involved with the county's children's services agency, as children referred to TIP are triaged by virtue of presenting problems, such as legal issues, custody decisions, and the severity of children's behaviors.

To conclude, TIP is feasible, fundable, and sustainable at a county level. Once implemented, it is essentially cost-neutral, representing a new way of organizing existing resources rather than requiring new ones. It produces strong results promoting school readiness and enhances the social potential of children and their families who are severely disadvantaged. The model encourages local choices for stakeholders at a financial comfort level regarding development and policy changes necessary to achieve the comprehensive goals and guidelines of the program. TIP offers the simplicity of combining funding streams currently available in all counties in the United States to help children who are most vulnerable—no new funds are necessary. The desired result is an effective service delivery model and a pooling of community resources that are necessary to assist children with histories of severe abuse and neglect.

Notes

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