First 5 Contra Costa Evaluation Report: Assessing the Impact of Mental Health Clinical and Mental Health Wraparound Services

March, 2012

Description of Services

Since FY 2002-03, First 5 Contra Costa has provided funding for Mental Health Therapeutic Services for children under age six years with severe social, emotional, behavioral and/or developmental issues. This funding has been provided to Contra Costa County's Behavioral Health Services Division (formerly Health Services/Mental Health Division) and to the three subcontractors: Early Childhood Mental Health Program, Contra Costa ARC/Lynn Center, and We Care Services for Children. In FY2010-11, a total of 254 children received Mental Health Therapeutic Services, of which 139 were new to the program and 115 were continuing cases. Of the new cases, 70% were enrolled for Mental Health Clinical Services only, 20% for Wraparound Services only, and 10% for both services. Please see Appendix A for further information about the children and families participating in this program.

Clinical Services

Mental Health Clinical Services are intensive individual (child) and family treatment services provided by clinical therapists in the home or at the agency. In some instances, services also may be provided to preschool or family childcare staff. These services are typically provided over a long period of time – approximately one year.

Wraparound Services

Wraparound Services use a team approach to help families of client children with multiple needs or complex situations achieve family-determined goals. Wrap Facilitators and Family Partners bring together family members, their informal support network (such as relatives and friends), and formal supports (such as special needs consultants and social workers), in order to plan how to meet goals the family has set for itself, so that the family may be better able to care for the child.

The Evaluation

In 2009, MHTS supervisors, First 5 Program staff, and Evaluation staff developed a logic model for services and agreed upon methods for extensive data collection that includes assessments of family functioning, parent-child interaction, and child behavior conducted at intake, annually, and exit.

By the end of FY 2010-11, sufficient data have been recorded to enable statistical analysis of the changes in the families and children. However, an insufficient number of cases documenting changes from intake through discharge exist to enable an analysis of the effects of Clinical Services and Wraparound Services separately.

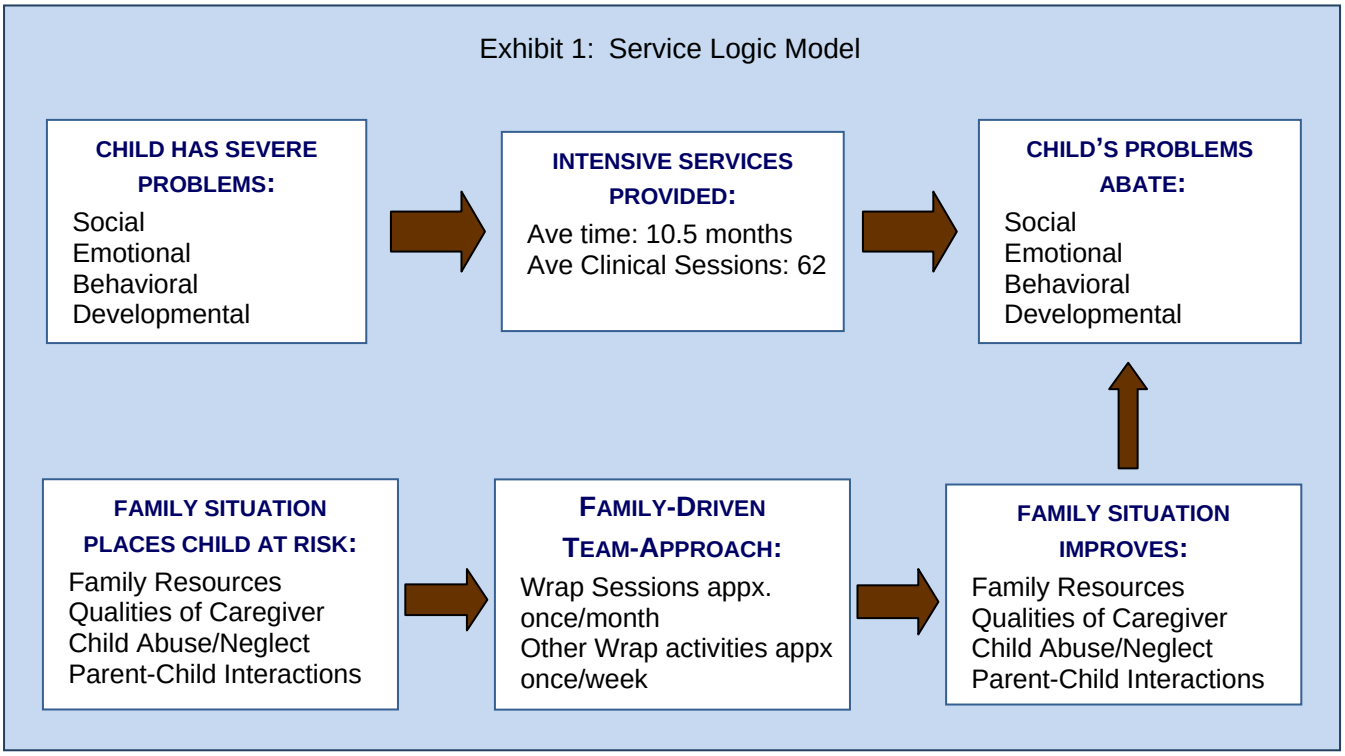
The findings presented in this report come from analysis of 15 in-depth interviews with parents (all but one of whom successfully exited the program), 72 Family Surveys with demographic information, 72 Family Situations Forms at two points in time, and 96 Child Behavior Check List (CBCL) scores at two points in time. Together these provide evidence of the impact of the Mental Health Therapeutic Services Program funded by First 5 Contra Costa.

Evaluation Questions

1. What problems were children having? How severe were these problems?
2. What, if anything, improved for children and for parents?
3. Is there a statistical connection between amount of service and improvement in children's problems?
4. What guidance did parents offer about how to improve services?

In theory, the Mental Health Therapeutic Services program provides intensive clinical and/or wraparound services for children with severe emotional, social, behavioral, and/or developmental problems, and expects that children's problems will abate over time. For children in families with few psychosocial and financial resources and/or those at risk of child abuse/neglect, the service model approach includes addressing the family situation; for these families, the expectation is that if the family situation improves so will the child's problems. This service model, or logic model, is diagramed in Exhibit 1.

Exhibit 1: Service Logic Model



Is there evidence that supports this logic model? Were the child's problems severe? Was the service intensive? Did the child's problems abate? Did the family situation improve? Did this improvement (if any) statistically relate to improvement in the child's problems? Analysis of forms and assessments was conducted by staff of Applied Survey Research (ASR), an independent evaluation firm, to examine each of these elements. In addition, ASR staff conducted lengthy telephone interviews with a representative sample of families who had received the services. This report combines findings from both the forms/assessments and the interviews to examine these questions.

Were children's problems severe?

EVIDENCE FROM INTERVIEWS:

Moderate to severe problems were found for all families including: tantrums, defiance, emotional withdrawal, speech delays, and medical issues including rare genetic disorders and severe weight loss. Two families experienced the death of a parent (categorized as an emotional issue); one of these families received Wraparound services, the other Clinical Services. Several families in the Wraparound program faced preschool expulsion or required close monitoring of a life-threatening medical issue.

During the interviews, parents told of the types of problems exhibited by their children. They related their need for family support, stress relief, and information to help with their issues and concerns. Parents reflected that they were "in over their heads", and recognized their need for additional guidance and support.

One parent said,

> *"[I]t was a little bit worrisome because he didn't talk and he had situations where he was really angry and upset. His dad and I were really worried because we did not know why he didn't talk and why he had those angry moments."*

Another parent facing a behavioral issue with her child stated,

> *"He had been kicked out of preschool after two weeks. I couldn't go to work. I was having to leave early like two or three times a week because the school couldn't deal with him. I felt like I needed to get him into a school that could deal with whatever kind of challenges he had."*

Another parent described her difficulty keeping her son safe.

> *"It was extremely hard. We had to put alarms on all of our doors, because he would literally… just leave and go down the street to one of our neighbor's houses, or he would just walk around the vacant lot, which was only one house away, to go to the park because he wanted to. So it got to where he actually piled a bunch of stuff in the backyard to climb over the fence that… I just, I had it. I didn't know what to do."*

FINDING: Parents reported being at their breaking point; ***feeling overwhelmed*** with their circumstances and ***not having*** the ***knowledge*** of where to go or what to do.

EVIDENCE FROM ASSESSMENTS:

Children were assessed using the Children's Behavioral Check List (CBCL) at intake and at regular intervals, thereafter. Among children in this program, the average overall score for mental health syndromes at intake was the 80th percentile, which means that only 20% of children nationally have problems as severe as those in this program. (More information from the CBCL is presented later in this report.)

FINDING: ***Children's problems were severe at intake***. Parental statements and the CBCL assessments confirm this. Both Internalizing and Externalizing Syndromes were in the clinical range at intake.

Were services intensive?

Intensive services were provided to children and their families. The average length of time between intake and exit from program averaged 10.5 months. On average, children received 62 mental health clinical sessions. Those enrolled in Wrap Around received an average 12 Wrap-around facilitated sessions and 64 other wraparound activities.

Did children's problems abate?

From both parent report and clinician assessment, most children's problems did abate between intake and exit from the program. An exception was Somatic issues, such as complaints of stomach aches, which showed no statistically significant change.

EVIDENCE FROM INTERVIEWS:

During the analysis, parental responses from the interviews were categorized according to type of problem. Exhibit 2 displays the categories, provides examples at intake, and examples of improvements by exit from the program.

Exhibit 2: Types of problems children experienced at intake and exit

Problems	Examples at Intake	Examples of Improvement by Exit
Behavioral: *aggression, defiance, school expulsion*	Biting, hitting and kicking parents, teachers and/or peers, tantrums, ignoring parents' requests	Children who had been expelled from preschool for disruptive behavior were in schools that were better suited to their needs. Less impulsivity, aggression, and/or defiance with parents and teachers.
Emotional: *withdrawal or tantrums*	Frequent crying, lack of interest in activities and others, problems separating from parents, social isolation, lack of friendships	*Less anxiety; more sociability.* *"He started to relate with unknown people. He doesn't cling to me anymore, he doesn't pull my hair, he is a little bit shy but much more calmed."*
Speech/ Communication: *absent or delayed speech*	No speech, frustration when trying to communicate, speech well behind peers	*"Now I am able to communicate better with the kid. Now he speaks to me; I felt better, and I could see he also felt better, because he used to get frustrated since he couldn't say a thing."*
Medical/Health: *Genetic disorder, failure to thrive*	Weight loss problem requiring a feeding tube, specialized diet required, long or frequent hospitalizations	One mother was able to move into a shelter away from a domestic violence situation. Her child began gaining weight soon after.

Parents reported that children with **anger issues** had fewer episodes of impulsivity, aggression and/or defiance with parents and teachers. Below are two examples of comments about how parents helped their children learn to gain control over their anger.

> *"When she is angry and I sit her down […]and I tell her 'Sit down and breathe and until I come for you to see if you are calmed down, and you yourself will know when you are feeling*

better'. And then she says 'Okay mom I'm fine' and she thinks that what she has done was not right and she tries to calm down."

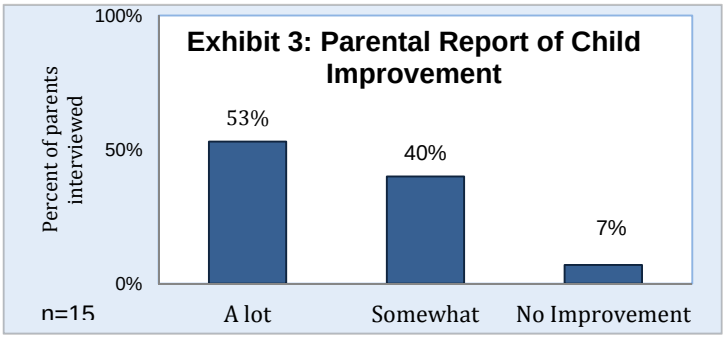
"[S]he listens to me more, I am able to talk to her and tell her 'Look, things are not the way you say they are, I don't want you to get hurt', she understands and she calms down a little bit more. Before it wasn't that way, before she would say 'No'."

Below are two examples of comments about how **withdrawn/anxious children** became more sociable and less anxious.

"[The problem] improved because he learned to listen to other persons, to open up, to play, because I got the advice that I needed to take him to a friend at least one time a week so he could share. I had to leave them alone for a while. That way he could learn to share and have fun so he would play with other kids of his age, and that helped me a lot."

"I did not know what he wanted and he would cry a lot and for anything he would cry and give me hard time… He has started to say to me what it is that he wants, he doesn't cry as much, he plays more. Before he did not like to play or get involved, he would be by himself and play by himself…"

Children with **communication problems** made impressive strides in their expressive language skills.



During interviews, over one-half (8) of parents told interviewers that their child's symptoms improved "a lot" after receiving services. Six other parents said the problems abated "somewhat" and only one parent reported that the child's symptoms did not improve. See Exhibit 3.

EVIDENCE FROM CHILD ASSESSMENTS

The Child Behavior Checklist (CBCL) is used in this program to assess children's risk of poor outcomes due to emotional and/or behavioral problems. It is a validated and frequently used instrument of 100 items that can cluster into several syndromes and DSM-IV codes. Children are ranked according to the severity of behavior, thus, percentile rankings tell us how a child, or group of children, compare to the general population. **Higher percentile rank indicates more problematic behavior**. Rankings between the 65th and 70th percentile--'Borderline Clinical'--indicate the child is at risk for a clinical diagnosis; the 70th percentile rank and above denote the clinical range. Clients who score at or near the clinical range are more likely to have or develop a clinical diagnosis.

The CBCL **serves as an indicator of clinical *risk*** based on the degree of similarity with other children who have received (or have not received) a diagnosis. **A significant drop in percentile rank indicates a decrease in clinical risk.**

Among children in the MHTS program, average CBCL rankings were well above the clinical range at intake (above the 70th percentile)[1]. At the most recent observation, average rankings were below the clinical range, and just above the borderline clinical range. See Exhibits 4 and 5.

[1] Dates of intake ranged from 8/15/2007- 3/23/2011. The sample included 60 boys and 36 girls. The average age at intake was 49 months (range 15 – 79 months) and the average length between CBCL observation at intake and most recent observation was 10.5

Exhibit 4: Children's Behavior Check List, average scores

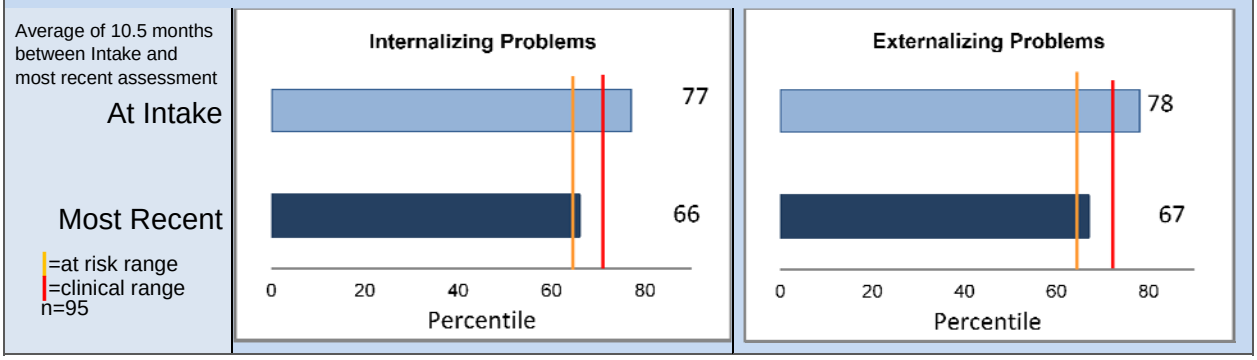


Exhibit 5 provides specific detail about the syndromes and DSM IV scores for the CBCL intake and the most recent observation.

Exhibit 5: SYNDROMES and DSM IV Codes	**Percentile Rank** Intake	Most Recent	**Statistically Significant**
Total Syndromes	80th	67th	**
Internalizing Syndromes	77th	66th	**
Emotionally Reactive	77th	72th	*
Anxious/Depressed	77th	72th	*
Somatic Complaints	68th	66th	
Withdrawn	80th	73th	**
Sleep Problems	70th	65th	*
Externalizing Syndromes	78th	67th	**
Aggressive Behavior	82th	74th	**
Attention Problems	78th	71th	**
DSM IV			
Affective Problems	75th	70th	*
Anxiety Problems	77th	71th	*
Pervasive Developmental Problems	82th	75th	*
Attention Deficit Hyperactivity Problems	75th	69th	*
Oppositional / Defiant Problems	78th	73th	*

n=81 to 96 children per item
**Improvement is statistically significant at p<.05;* ***Improvement is statistically significant at p<.01*

Participation in the program was associated with a statistically significant decline in percentile rank on every scale except Somatic Complaints, indicating movement towards more normative behavior (defined as percentile rank below 65). In fact, children's percentile rank moved below the clinical cutoff on five scales including Internalizing, Externalizing, and Total Syndromes.

FINDING: Between intake and most recent assessment, ***children's*** percentile rank on the ***CBCL moved below the clinical cutoff*** on five scales including Internalizing, Externalizing, and Total Syndromes.

months (range 4 – 25 months).

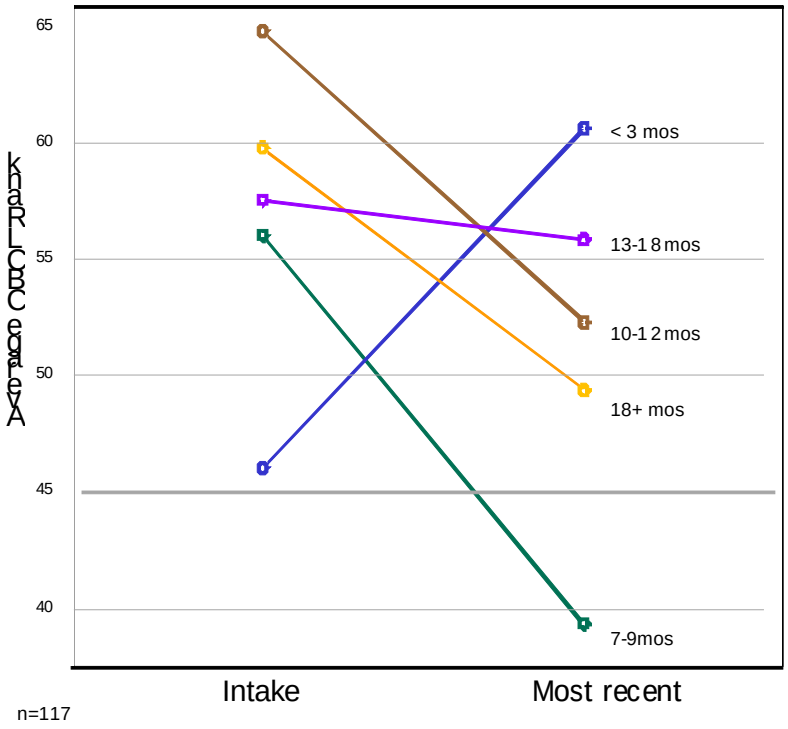
DOES DOSE MATTER?

Change in CBCL percentile rankings between intake and most recent observation were analyzed to see if there were differences according to how long children had received the services.

FINDING: On average, children who received services for ***more than three months improved***. Generally, those with more severe problems at intake received services for a longer period of time.

This analysis shows that the average CBCL ranks improved for those who received more than three months of service. Generally, children with more severe behavioral problems at intake received services for a longer period of time. (**Caution**: Because more than three-quarters of children in this analytic sample received services for seven to twelve months, the numbers in the other dose categories are too small for further interpretation.)

Exhibit 6: Change in Average CBCL Rank by Length of Service



n=117

Did parents/families change?

EVIDENCE OF CHANGE IN THE FAMILY BASED ON INTERVIEWS:

Fourteen of 15 parents felt that their problems would not have improved as much (or at all) had they not received therapeutic services. Over half of those interviewed reported large improvements as a result of their participation in MHTS. A parent of a child with separation anxiety stated,

> *"I feel that if I hadn't asked for help I would probably be in the same situation, in the same stage in which I wouldn't be able to deal with the problem and my kid would be more anxious. The program helped us a lot."*

Finding: ***Parents*** who reported ***gaining*** communication and ***parenting skills*** as a result of services also ***reported*** significant ***decreases in children's problem behavior***.

Parents' comments indicated that family-level problems were prevalent and were addressed by MHTS, especially problems remedied by increases in parenting skills. Parents who reported gaining parenting and communication skills as a result of services also reported significant decreases in children's problem behavior. For parents facing child medical or developmental issues, their lack of knowledge about the care and treatment for their children produced stress, feelings of bewilderment, and the perception that they could not handle the challenges that came with their children's conditions. These parents reported that MHTS eased their fears, built confidence, and helped them gain greater agency in their children's care. In all cases, change in parenting behavior and emotional state improved children's problems and quality of care.

During interviews, parents discussed their behavior and emotional state before and after receiving services. **All but one parent reported gains in several key areas of parenting including**: growth in parenting skills, knowledge and understanding of their children's problems and needs, guidance/advocacy to help manage issues, emotional support, and increased safety. One comment exemplifies changes in parenting skills:

> *"The way in which I would get too upset when she was against me, I would get too upset and I would shout at her and now I don't. Right now I understand better that she is a child and that I have to treat her according to her needs, I have to understand her, and I have improved in the way I treat her."*

Four **parents** reported gains in their ability to **manage their anger** in response to their children's defiance. For example:

> *"I would do a lot of hollering at first, but now I talk it through with him, [being] more patient but still taking control of the situation rather than letting him drag me along. When I say 'no', I mean' no'. When I say I am going to do something, you know, when he's on punishment, he needs to go on punishment, but if I'm going to reward him, I'll reward him."*

Many parents report that they **felt less stress** associated with their children's care, feeling more patient and calm now than before MHTS. One parent who had a child who did not like to eat commented,

> *"I'm not so stressed about how much she'll eat, I'm more relaxed, they taught me that she will get enough to eat, so not to be so stressed about that."*

Often, decreased stress and **disciplinarily changes** went hand in hand.

> *"Right now I have more patience and when he was giving me a hard time I would try to be nice or to spoil him, but now I set boundaries."*

Parents reported that their stress levels dropped when they used new knowledge and parenting skills to manage problems, which resulted in reducing the probability of escalation and controlling their reactions when misbehavior occurred.

Fourteen of 15 parents told interviewers that **the quantity of interaction** between parents and children increased. Parents report greater enjoyment, including more play and shared positive emotion. A few parents reported engaging in more physical contact with their children.

One highly desired benefit of services is to help parents build a foundation of parenting knowledge and skills to resolve current issues, as well as decrease the likelihood (or severity) of problems in the future. When asked about their confidence level in handling problems after receiving services, 13 parents felt confident and two parents felt unsure.

EVIDENCE OF CHANGE IN THE FAMILY BASED ON ASSESSMENTS:

Because circumstances of the family can affect the child, clinicians, facilitators, and family specialists completed the Family Situations Form at intake and at regular intervals, thereafter. Exhibit 7 outlines the measurement on this form.

Exhibit 7: Family Situations Subscales

Subscales	Subscale includes measures of:
Family Resources	Residence and relationship stability, transportation, household conflict, financial resources, utilization of community resources, socio-cultural-spiritual resources
Caregiver Qualities	Organizational skills, substance abuse, mental health
Parent-Child Interaction	Parent looks at child, enjoyment of physical contact, child expression of emotion, parent reflects feeling back to child indicating attention, parent is calm and interactive when child is upset, parent encourages child vocalizations, parent able to identify child's needs, child enjoys play with parent, parent-child talk is affectionate and positive
Child Abuse/ Neglect	Neglect, emotional, physical or sexual abuse, domestic violence

Changes in Family Situations: On a scale of 1 to 4, with 4 indicating "No problem", the average scores for Family Resources, Caregiver Qualities, and Parent-Child Interactions among Wraparound and Clinical Services families were between 3.1 and 3.5, indicating only moderate problems, with one notable exception. **Families receiving Wraparound services had more problems at intake with Family Resources** than did those receiving only Clinical Services. This finding supports the need for Wraparound, and indicates that the program is serving families most in need of this type of service. Also, there was a substantial and statistically significant improvement in Family Resources among Wrap families at discharge, bringing down the mean score to 3.1—still higher than families not receiving Wraparound services, but noticeably closer.

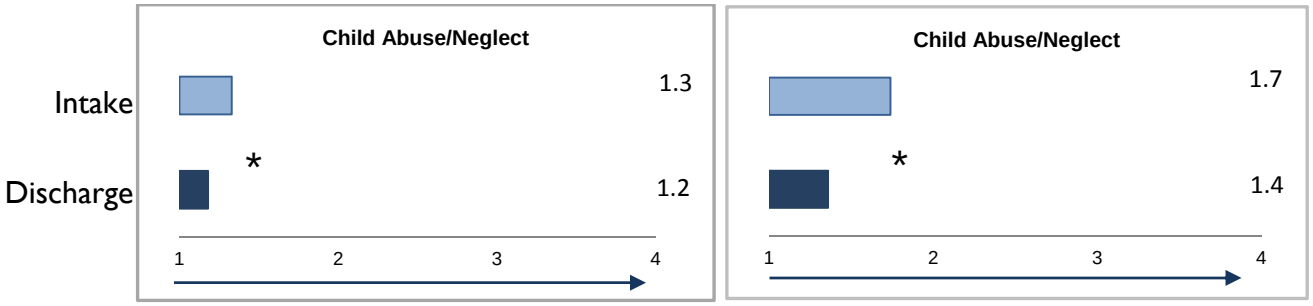
For the **Child Abuse / Neglect** subscale, 4 indicates "Serious and substantiated abuse". At intake, the average score among children receiving only Clinical Services was 1.3, indicating that some problems exist in this area; for those receiving Wraparound services, more severe problems in this area were noted. For all families, there was **a statistically significant decline in problems with Child Abuse/ Neglect** (meaning that this decline is not likely to be just an artifact of statistics, but a real decline). For those receiving Wraparound services, the decline in problems with Child Abuse / Neglect was substantial.

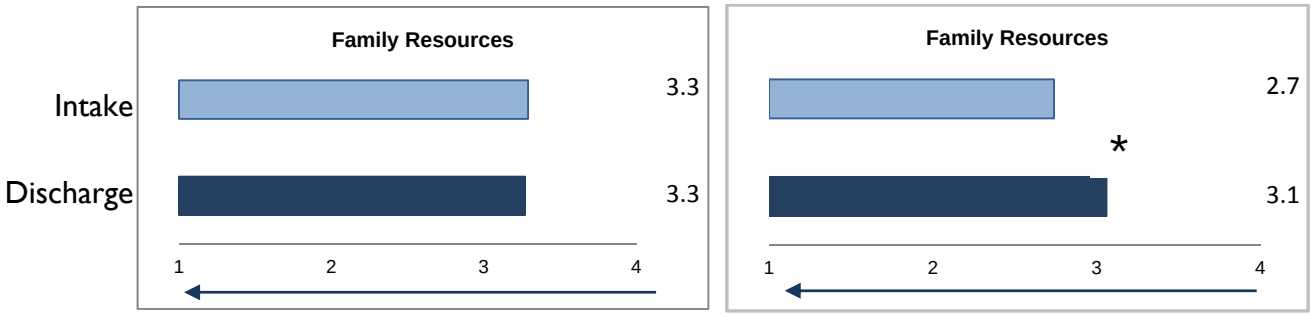
Finding: The families receiving ***Wraparound*** services experienced a significant ***improvement in family resources***. The risk of ***child abuse or neglect declined*** for families receiving Clinical Services and/or Wraparound services.

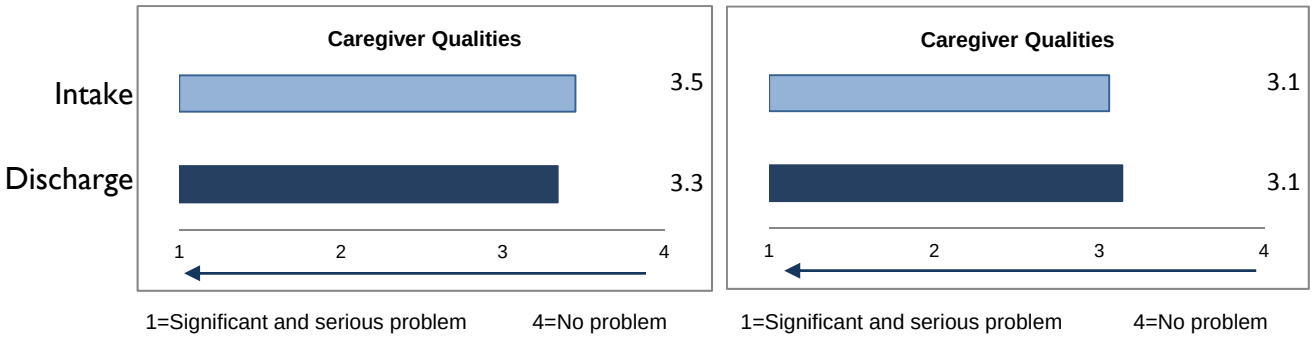
Exhibit 8: Family Situations at Intake and Exit

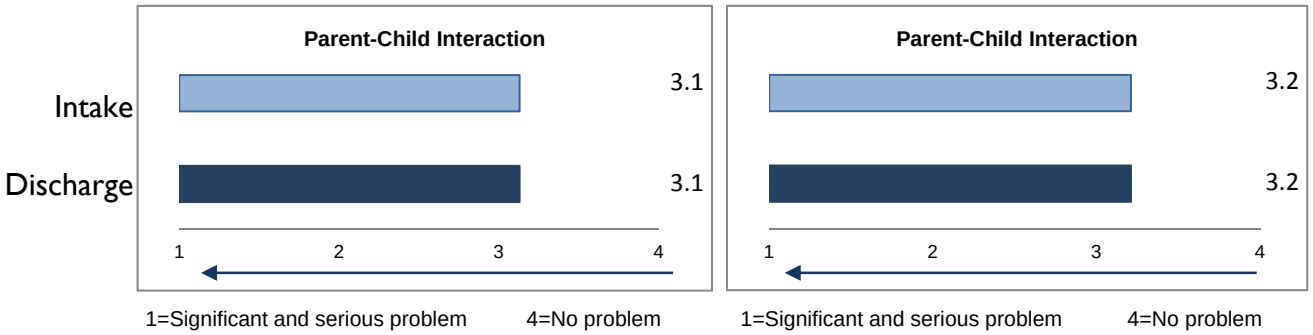
(The arrow points in the direction of more severity. An asterisk indicates statistically significant change.)

Mental Health Clinical Services only	Wraparound (with our without Clinical Services)









All responses are based on voluntary completion of the First 5 Family Situations form between FYs 2009-2011.
Only participants who completed surveys at Intake and Discharge were included. For Clinical Services: n=40.
For Wraparound Services: n=34, including 13 participants who received both Wraparound and Clinical services.

IS THERE A STATISTICAL CONNECTION BETWEEN IMPROVEMENT IN FAMILY SITUATION AND ABATEMENT OF CHILDREN'S PROBLEMS?

For 23 children, both Family Situations and CBCL assessments were available at baseline and annual/exit. As shown in the previous section, statistically significant changes were not found for the Qualities of Caregiver and Parent-child Interactions scales. Since there was no change between intake and annual/exit, these scales do not statistically affect changes in CBCL percentiles. Two scales did indicate significant improvement in family functioning over time: Risk of Child Abuse/neglect scale and (for Wrap Around families only) Family Resources scale. However, these two scales also did not correlate with changes in CBCL percentiles. Only one item on any of these scales was associated with abatement in children's problems: Conflict in the Home (one item on the Family Resources scale).

Does this mean that improvement in family functioning has nothing to do with children getting better? Not necessarily. The number of cases for analysis was too small to explain with certainty the connection between changes in the family situation and problem abatement. Perhaps there is no connection, or perhaps these tools cannot accurately measure such a connection. In the next year, a group of clinicians and evaluators will assemble to look more closely at these tools.

What did parents have to say about the services they received?

WHAT SUGGESTIONS FOR IMPROVEMENT DID PARENTS PROVIDE?

Fourteen of the 15 parents who provided information through lengthy interviews were satisfied with the services. Most could not think of a way to improve the services. The comments of two parents indicate that some clients do not understand what to expect from the service delivery process. These clients may have gotten more from the service if their clinicians helped them understand what to expect about the service delivery process. Two examples of parents unclear about the services are quoted below.

This comment reflected a difference between expected and actual services provided:

> *"I guess they should be up front about explaining the process. I just had an idea, someone is gonna come into my home and try to talk to my [child] and all she did was sit here on the couch with me and you know, she didn't make the effort to make [child's name] sit with her and talk with her. So I don't know, so maybe that [is] how things work… Even when I tried calling [child's name], she was like 'why are you calling her?' I was like, 'well, aren't you supposed to be talking to her?' You know, she didn't do anything."*

This parent recognized that communication between her/him and service providers could have been improved. The result was an under-utilization of resources and perhaps undue stress for this parent:

> *"… I felt very lost because if I asked for help they would tell me at school to ask for help or to take him to the doctor because he probably had a mental disorder or maybe he had autism; maybe it wasn't something mental but probably something in his health, that probably he was not healthy and all that made me feel like there was nothing I could do to ask for help. I kept asking for help and several times.*
>
> *The psychologist did help me and advised me to talk to the hospital to help me with tests for my boy but nothing was done and I wanted something else to be done, because I see they have a lot of well-trained staff for that kind of help. And maybe I did not know how to express myself or how to ask for help, but I believe that they can give more, they could have done more than what I received."*

How satisfied were parents with the services their children received?

Overall, parents reported high satisfaction with the services they received.

The benefits they talked about receiving were:

- Personal validation and empowerment
- Social support
- Knowledge on how to help their children
- Supportive, caring, and trustworthy staff

> *"[The staff] were always there for me, I never felt like there was anything they couldn't help me with."*

> *"For me it would have been very hard to deal with this by myself. [T]hanks to the programs that exist, I feel these services have been very helpful."*

Another parent voiced how the services she received taught her valuable skills.

> *"Since [child's name] was born I had a nurse because [child's name] was a premature baby. The nurse was constantly asking me if I needed any help, she could refer me to someone and I said no. But when my other [baby] was born, the same nurse came. … I told her that I needed help because I couldn't handle the situation. I felt desperate, and I did not know what to do and that is when she put me in contact with [MHTS], and yes I feel that moment was when I understood several things. My husband understood, too, because I explained to him what I had been told."*

Many parents cannot afford private children's mental health services; others appreciate the coordination of services in the home and at the preschool. This parent spoke of both the cost and the coordination.

> *"[MHTS] were the only people that would take us when I got turned away from everywhere else, and … when you can't afford a hundred dollars an hour for a behaviorist to come see you once a week, for them to be able to give that to you and then have one at the school to work with them, and them being able to interact with each other is just wonderful."*

These quotes express the appreciation that parents felt about the services.

Summary

The findings presented in this report come from analysis of 15 in-depth interviews with parents (all but one of whom successfully exited the program), 72 Family Surveys with demographic information, 72 Family Situations Forms at two points in time, and 96 Child Behavior Check List (CBCL) scores at two points in time. Together these provide evidence of the impact of the Mental Health Therapeutic Services Program funded by First 5 Contra Costa.

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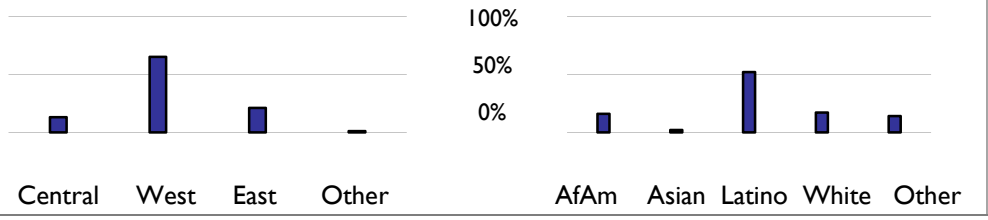
Summary of Findings

1. When their child began receiving services, parents reported being at their breaking point; feeling overwhelmed with their circumstances and not having the knowledge of where to go or what to do.
2. Children's problems were severe at intake. Parental statements and the CBCL assessments confirm this. Both Internalizing Syndromes (over-control or inappropriate efforts to control how one thinks, feels or acts) and Externalizing Syndromes (under-control or poor regulation of actions and feelings) were in the clinical range at intake.
3. Between intake and most recent assessment, children's percentile rank on the CBCL moved below the clinical cutoff on five scales including Internalizing, Externalizing, and Total Syndromes.
4. On average, children who received services for more than three months improved. Generally, those with more severe problems at intake received services for a longer period of time.
5. Parents who reported gaining communication and parenting skills as a result of services also reported significant decreases in children's problem behavior.
6. Families receiving Wraparound services experienced a significant improvement in family resources regarding residence and relationship stability, transportation, household conflict, financial resources, utilization of community resources and socio-cultural-spiritual resources.
7. The risk of child abuse or neglect declined for families receiving Clinical Services and/or Wraparound services.
8. Families found the services very helpful, and moved many from desperation to calm confidence in raising their children.

First 5 Contra Costa Early Intervention Initiative
Mental Health Therapeutic Services
Appendix A: Data Summary 2010-2011



Number of Family Surveys Completed: 163

OVERVIEW OF SERVICES

In 2010-11, a total of 254 children received Mental Health Therapeutic Services, of which 139 were new to the program and 115 were continuing cases. Of the new cases, 70% were enrolled for Mental Health Clinical Services only, 20% for Wraparound Services only, and 10% for both services.

On average, families (including children) received 62 hours of mental health clinical services, 12 Wrap-around sessions, and 64 other wraparound activities. Between intake and discharge, families were served an average of 10.5 months.

On average, children's CBCL rankings indicate 'medium to high clinical risk' (above the 65th percentile) at both pre and post measurements. However, participation in the program was associated with a decline in rank on every scale except Somatic Complaints, indicating movement towards more normative behavior (defined as percentile rank below 65).

FAMILY SURVEY

	Response[2]	2005-10	2010-11
Parent/Guardian Ethnicity	Asian/Pacific Islander	4%	1%
	African-American	15%	18%
	Hispanic/Latino	47%	49%
	White	28%	17%
	Other/More Than 1	7%	13%
Children's Ethnicity	Asian/Pacific Islander	2%	2%
	African-American	15%	16%
	Hispanic/Latino	46%	52%
	White	24%	17%
	Other/More Than 1	14%	14%
Primary Language Spoken at Home	English	57%	45%
	Spanish	36%	31%
	English and Spanish	5%	18%
	English and Other	1%	5%
	Other	1%	0%
Children's Age	Birth through 3 years	54%	49%
	4 and 5 year olds	45%	51%

[2] For 2005-10: The number of adults = 201, the number of children = 201. For 2010-11: The number of adults = 163, the number of children = 188. +All response rates are at least 95% unless reported otherwise

	Response[2]	2005-10	2010-11
Children's Gender	Male	59%	58%
	Female	41%	42%
Region of County	Central	27%	13%
	West	44%	65%
	East	27%	21%
	South	1%	0%
	Other	1%	1%
Mother First Received Prenatal Care +	1st trimester	*Question not asked in 2005–10*	79%
	2nd trimester		11%
	3rd trimester		2%
	Had not yet received prenatal care		2%
Children's Health Insurance Coverage	Private	18%	6%
	Medi-Cal	57%	85%
	Healthy Families/CHIP	7%	3%
	Other	6%	4%
	None	8%	0%
Children's Tobacco Exposure	Yes, inside the house	3%	1%
	Yes, outside of the house	23%	29%
	No	56%	67%
Children Have Well Child Care	Yes	85%	94%
Parent Is Concerned About Children's Development+	Yes	*Question not asked in 2005–10*	31%
Children Are Identified with a Disability	Yes	25%	25%
Of Children 6 Months and Older, Number of Times They Ate Vegetables in Past 5 Days	0 times	*Question not asked in 2005–10*	5%
	1-4 times		41%
	5-9 times		40%
	10-14 times		11%
	15-19 times		1%
	20 or more times		3%
			(n=150)
Of Children Age 2-5, Percent Enrolled in Preschool	Enrolled	*Question not asked in 2005–10*	56%
			(n=133)
Reason Children Are Not Enrolled in Preschool	On a wait list	*Question not asked in 2005–10*	37%
	Will start later		7%
	Not yet decided		13%
	Do not intend to enroll		44%
			(n=46)
Number of Times Children were Read to in Past Week+	7 or more times	*Question not asked in 2005–10*	34%
	3-6 times		37%
	1-2 times		18%
	None		11%

	Response[2]	2005-10	2010-11
Average Number of Minutes Children Were Read to at Each Sitting[+]	Average number of minutes	*Question not asked in 2005–10*	16.4
Level of Maternal Education	Less than high school	28%	30%
	High school degree or GED	30%	38%
	2-year college or vocational school	15%	20%
	Bachelor's degree	5%	9%
	Master's degree or higher	4%	1%
Parent/Guardian has been to a First 5 Center[3]	Yes	32%	30%
Relationship to Children[4]	Mother	77%	74%
	Father	7%	6%
	Mother and Father	4%	NA
	Foster parent/guardian	4%	7%
	Grandparent or other relative	3%	7%
	Other	4%	3%
	Multiple responses checked	2%	5%
Total Number of People in Household	1	3%	8%
	2	8%	9%
	3	13%	16%
	4	11%	21%
	5	11%	20%
Of these persons:	6 or more	54%	26%
Number of Children (0-5) in Household	0 (pregnant)	7%	4%
	1	41%	48%
	2	31%	34%
	3	10%	11%
	4	2%	3%
	5 or more	10%	1%
Family Income[5]	Less than $15,000	47%	42%
	$15,001 to $30,000	22%	25%
	$30,001 to $45,000	12%	7%
	$45,001 to $60,000		3%
	$60,001 to $75,000	2%	1%
	$75,001 and over	3%	3%

Notes Regarding the Family Survey Data –

- All responses are based on voluntary completion of the First 5 Family Survey. Percents may not total to 100 due to rounding and because for some of the questions, the response options of "don't know" or "prefer not to say" are not displayed. For 2005-10 data, some questions were not asked in early years (reading to your child), some were only asked of certain individuals (entry into prenatal care), and some have low response rates (family income, child ethnicity).

[3] Not asked of First 5 Center participants

[4] For 2005-10; the data for "*Grandparent or other relative*" reflects respondents choosing "*Other relative*" only. The response option was updated in 2010-2011 to include Grandparent.

[5] The data for response options *$30,001 to $45,000* and *$45,001 to $60,000* were merged for 2005-10.

FAMILY SITUATIONS SURVEY

Family Resources

	Response	Clinical Intake %	Clinical Discharge %	Wraparound Intake %	Wraparound Discharge %
Over past 3 months, stability of child's residence	Stable	87%	90%	53%	65%
	Moved or will move in next 3 months	10%	10%	35%	32%
	Consistently unstable	3%	0%	12%	3%
	Had periods of homelessness	0%	0%	0%	0%
Problems with transportation	None	85%	70%	29%	32%
	Occasional	10%	23%	24%	38%
	Significant	5%	5%	26%	24%
	Serious	0%	3%	21%	6%
Number of stable family, friend and community relationships	Many	38%	53%	18%	15%
	Some	35%	18%	47%	65%
	At least one stable with some unstable	28%	30%	35%	21%
	None	0%	0%	0%	0%
Amount of household conflict	None	33%	15%	21%	33%
	Mild to moderate	38%	56%	18%	42%
	Significant with verbal aggression	21%	23%	33%	15%
	Profound with physical aggression	8%	5%	27%	9%

Additional Family Resources

	Response	Clinical Intake %	Clinical Discharge %	Wraparound Intake %	Wraparound Discharge %
Financial resources	Sufficient	33%	38%	12%	15%
	Enough to address basic needs	38%	33%	21%	53%
	Limited with stress associated with providing basic needs	20%	23%	59%	29%
	Severely limited and unable to provide basic needs	10%	8%	9%	3%
Utilization of community resources	Utilizing needed resources	43%	40%	21%	32%
	Limited knowledge , but fully able to use known resources	38%	35%	47%	44%
	Absent or inconsistent use	18%	25%	29%	21%
	Unable or unwilling to use	3%	0%	3%	3%
Social, cultural, and spiritual resources	Abundant	23%	20%	18%	24%
	Adequate	51%	55%	44%	62%
	Limited	21%	23%	35%	12%
	Severely limited or absent	5%	3%	3%	3%

Qualities of the Caregiver

	Response	Clinical Intake %	Clinical Discharge %	Wraparound Intake %	Wraparound Discharge %
Organizational skills	Efficient	53%	35%	35%	32%
	Some problems	35%	50%	29%	50%
	Significant problems	10%	13%	29%	15%
	Poor	3%	3%	6%	3%
Current substance abuse	No difficulties	97%	97%	70%	76%
	Mild problem including occasional intoxication	0%	0%	17%	12%
	Moderate problem requiring treatment	0%	0%	10%	9%
	Significant problem disrupting child care	3%	3%	3%	3%
Current mental health	No significant issues	35%	31%	24%	24%
	Mild symptoms	35%	28%	18%	27%
	Moderate symptom and adjustment difficulties	25%	36%	39%	36%
	Significant symptoms and adjustment difficulties that interfere with child care	5%	5%	18%	12%

Presence of Child Abuse

	Response	Clinical Intake %	Clinical Discharge %	Wraparound Intake %	Wraparound Discharge %
Neglect	None noted	79%	80%	50%	70%
	Verbal accusations	10%	18%	22%	18%
	Suspected but unsubstantiated	5%	0%	28%	12%
	Repeated and notable	5%	3%	0%	0%
Emotional abuse	None noted	72%	79%	44%	70%
	Verbal accusations	13%	18%	32%	21%
	Suspected but unsubstantiated	10%	0%	21%	9%
	Repeated and notable	5%	3%	3%	0%
Domestic violence	None noted	79%	80%	35%	62%
	Verbal accusations	3%	10%	26%	15%
	Suspected but unsubstantiated	8%	8%	26%	15%
	Repeated and notable	10%	3%	12%	9%
Physical abuse	None noted	92%	95%	59%	82%
	Verbal accusations	0%	5%	24%	12%
	Suspected but unsubstantiated	5%	0%	18%	6%
	Repeated and notable	3%	0%	0%	0%
Sexual abuse	None noted	92%	95%	79%	88%
	Verbal accusations	3%	5%	15%	12%
	Suspected but unsubstantiated	5%	0%	6%	0%
	Repeated and notable	0%	0%	0%	0%

Parent-child interaction - Child

	Response	Clinical Intake %	Clinical Discharge %	Wraparound Intake %	Wraparound Discharge %
How often do the child and parent look at one another?	Frequently	31%	35%	33%	41%
	Sometimes	51%	48%	30%	44%
	Infrequently	18%	18%	21%	3%
	Do not know or NA	0%	0%	15%	12%
How enjoyable is child and parent physical contact?	Enjoyable	49%	38%	29%	35%
	Sometimes enjoyable	31%	40%	44%	44%
	One or both seem uncomfortable	13%	20%	9%	12%
	Do not know or NA	8%	3%	18%	9%
What is the range of emotions the child expresses with the parent?	Wide range of emotional expression	28%	43%	27%	36%
	Some variation in expression	59%	48%	52%	48%
	Only one emotion, positive or negative	8%	10%	6%	6%
	Do not know or NA	5%	0%	15%	9%

Parent-child interaction - Parent

	Response	Clinical Intake %	Clinical Discharge %	Wraparound Intake %	Wraparound Discharge %
How often does the parent reflect back feelings in a way that lets the child know the parent is present and attentive?	Most of the time	23%	21%	15%	26%
	Sometimes	64%	72%	59%	65%
	Rarely	10%	8%	12%	3%
	Do not know or NA	3%	0%	15%	6%
Does parent remain calm and interactive when the child is upset or agitated?	Most of the time	37%	30%	27%	26%
	Sometimes	26%	40%	27%	53%
	Parent becomes agitated and upset	18%	20%	33%	12%
	Do not know or NA	18%	10%	12%	9%
Does the parent encourage child vocalizations?	Consistently, actively and enthusiastically	33%	35%	24%	41%
	Inconsistently	50%	53%	48%	50%
	Does not encourage or praise	10%	8%	12%	0%
	Do not know or NA	8%	5%	15%	9%
Does the parent seem accurate about what the child needs?	Most of the time	40%	30%	39%	59%
	Sometimes	45%	55%	36%	29%
	Not at all	10%	13%	12%	6%
	Do not know or NA	5%	3%	12%	6%

Parent-child interaction (continued)					
	Response	**Clinical Intake %**	**Clinical Discharge %**	**Wraparound Intake %**	**Wraparound Discharge %**
Is engagement and play enjoyable for the child?	Often	43%	43%	39%	65%
	sometimes	25%	35%	33%	24%
	Child sometimes turns away or seems unhappy	28%	18%	6%	3%
	Do not know or NA	5%	5%	21%	9%
Does parent talk to and about child in a way that is affectionate and positive?	Consistently	51%	41%	41%	59%
	Makes some negative statements	38%	49%	41%	35%
	Parent is critical to child or when talking about child	10%	8%	6%	0%
	Do not know or NA	0%	3%	13%	6%
Is voice of parent warm and positive?	Consistently	43%	33%	28%	26%
	Sometimes	50%	54%	47%	65%
	Infrequently	8%	10%	13%	0%
	Do not know or NA	0%	3%	13%	9%
Does parent use effective disciplinary practices?	Most of the time	0%	5%	25%	6%
	Often	62%	41%	56%	50%
	Somewhat severe, lenient or inconsistent	31%	49%	9%	35%
	Extremely severe, lenient, or inconsistent	8%	5%	9%	9%
At separation from parent, child experiences...	Normal discomfort	44%	54%	23%	67%
	Difficulty calming down	31%	27%	52%	21%
	A total meltdown	6%	3%	10%	3%
	Indifference	19%	16%	16%	9%

For questions, please contact kim@appliedsurveyresearch.org or evaluation@firstfivecc.org