

EVALUATION REPORT

Year Three

Hand in Hand: Planting Seeds for Healthy Families
Hood, Johnson, Palo Pinto, Parker, and Tarrant Counties

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EXECUTIVE SUMMARY

Introduction

Hand in Hand: Planting Seeds for Healthy Families is an \$8.3 million federally funded six-year cooperative agreement with the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. The cooperative agreement is administered by Mental Health Mental Retardation of Tarrant County in partnership with Mental Health Connection. Hand in Hand, currently beginning its third year, received its initial funding in September 2008 and will continue through September 2014. Hand in Hand is governed by Mental Health Connection, a collaboration of public and private agencies as well as mental health services consumers and their caregivers. Mental Health Connection works to revolutionize the mental health service delivery system, with a vision of creating “No Wrong Door to the Right Mental Health Resources.” The purpose of Hand in Hand is to institute system-of-care reform in Hood, Parker, Tarrant, Palo Pinto, and Johnson Counties. The project is designed to support the growth of a system that will provide seamless care for the behavioral and emotional needs of children age birth through 6. The primary goals of this initiative are to:

- ◆ Develop a system of care for children ages 0 – 6 with serious emotional disturbance (SED) and their families.
- ◆ Transform fragmented services into a high-quality sustainable system of care utilizing evidence-based practices in the target areas.
- ◆ Establish a system in target areas in which all children (0 – 6) with serious emotional disorders are identified early.
- ◆ Keep children (0 – 6) with SED in community settings with their families by improving their mental health and school readiness.
- ◆ Empower families to provide leadership in all aspects of the system.
- ◆ Provide culturally competent, evidence-based, and consumer guided services in the community.

One component aimed at improving the systems of care in Hood, Parker, Tarrant, Palo Pinto, and Johnson Counties is implementation of a wraparound model of service delivery. Wraparound, considered a promising practice in children’s mental health, is the most common method of service delivery adopted by states and communities as a way to adhere to systems

of care philosophy. In wraparound service delivery, a family team is developed based on the desires of the youth and family. Team members include both formal service providers and informal support persons such as friends, school teachers, family, coaches, or other persons important to the family. A wraparound facilitator guides the team through a process of identifying family strengths and needs and developing a wraparound plan. The wraparound plan draws on both formal and informal services and community supports aimed at improving the mental health of the child and keeping him or her in the community. The aim of this document is to report on implementation of a wraparound service delivery model during year three of the six year grant cycle (October 1, 20010 – September 30, 2011). Included in the report is data on the intake and referral process, demographics of children referred, six month outcome data, and findings of qualitative interviews conducted with caregivers of children referred into wraparound. The report will conclude with recommendations aimed at continuous quality improvement in wraparound implementation.

Referral and Intake

Referral and intake into Hand in Hand has been re-designed and decentralized over the last few months in order to streamline the process, shorten the time it takes for families to begin wraparound, and to facilitate sustainability after grant funding ends. Local agencies providing wraparound in each of the communities will now conduct their own intakes and begin the wraparound process with families.

- ◆ Eighty-two (82) children were referred into Hand in Hand during year three.
- ◆ Sixty-three (63) children received intakes to Hand in Hand during year three.
- ◆ At least 11 (13%) of children referred into Hand in Hand did not meet eligibility criteria or moved out of the service area before they could enroll.
- ◆ The average number of days from referral to intake for families was 11 (improved from 21 in year 2) with a range from -1 day to 114 days.
- ◆ 46 families (53% of referred families) went on to have contact with a wraparound facilitator.
- ◆ A total of 36 families (41%) entered into wraparound and signed a wraparound agreement by the end of September 2011.
- ◆ The average number of days from intake to entering into wraparound for non-waitlisted families was 38 days (improved from 45 in year 2), with a range from 0 days to 101 days.
- ◆ For families on a waitlist, the average number of days from intake to entering into wraparound for non-waitlisted families was 46 days, with a range from 34 days to 81 days.

Children and Families Served (n = 67)*

Once families sign their wraparound agreement, an evaluator meets with the family to describe the Hand in Hand evaluation and invite them to participate. The evaluation consists of the National Evaluation measurement instruments, local evaluation measurement instruments, and qualitative questionnaires. Families choosing to participate are evaluated across life domains at intake and every six months out to 24 months.

- ◆ Seventy-five percent (75 %) of the children admitted into Hand in Hand were male with an average age of 4.5 years old.
- ◆ The majority of children were White (72 %), 16% Hispanic, and 9% Black or African American
- ◆ The majority of primary caregivers were White (75%) females (97%) under the age of 35 (64%).
- ◆ The most common reason for referral (63.5%) was for hyperactivity and/or attention problems
- ◆ Of the referrals, 23.4% came from the mental health sector, 21.9% from a caregiver, and 9.4% from child welfare.
- ◆ Just over 60% of the children live or have lived with someone with depression.
- ◆ Forty-two percent (42%) of children in Hand in Hand live or have lived with someone with a mental illness other than depression.
- ◆ Over one third of the children (38.3%) have witnessed domestic violence.
- ◆ Seventeen percent (17%) have been victims of physical abuse.
- ◆ Nearly seven percent (6.7%) have been victims of sexual abuse.
- ◆ Fifty-seven percent (57%) of the children live below the poverty level.
- ◆ Nearly all of the children (93.4%) were reported to have an identified Primary Health Care Provider.

*Data from the National Evaluation was available through August 31, 2011 rather than through September, thus accounting for the smaller sample size being reported.

Clinical Outcomes

Shortly after enrollment in Hand in Hand, evaluation staff visited the homes of participating families and, after obtaining consent, administered a series of questionnaires to caregivers. Follow-up visits were conducted every 6 months after intake up to 24 months. Because this report is based on data from the 2nd and 3rd year of services, a large enough sample was only available for 6 and 12 month follow-ups. Paired sample t-tests were run on each scale and subscale to determine change.

- ◆ Total protective factors for child behavioral strengths increased significantly from intake to 12 months and marginally from intake to 6 months.

- ◆ Children’s level of functional impairment was significantly reduced and approached non-clinical levels from intake to 6 months and intake to 12 months.
- ◆ Children experienced significant improvements in their total behavioral and emotional strengths from both intake to 6 months and intake to 12 months.
- ◆ Children experienced a reduction in mental health symptoms (behavioral and emotional problems); however, these results were not statistically significant.
- ◆ Caregiver strain was significantly reduced both from intake to 6 months and intake to 12 months.
- ◆ A marginal decline (not statistically significant) in parenting stress was seen between intake and 12 months.

Caregiver Opinion of Cultural Competency and Service Provision

- ◆ 94.6% of caregivers feel their primary service provider, attended to their and their child's cultural needs most or all of the time (89.2% responded always).
- ◆ Over half (53.7%) of caregivers reported that it was at least moderately important the child’s beliefs and practices based on racial or ethnic group association should be included in service planning.
- ◆ Most (81.6%) caregivers agreed that their provider asks about family’s traditions, beliefs and values when planning or providing services most or all of the time.
- ◆ Over a third (37.0%) of caregivers reported that their most recent service provider was of the same racial or ethnic group as its child.
- ◆ Just over half of caregivers (52.9%) reported being satisfied with the improvements in their child’s mental health symptoms and functioning.
- ◆ Nearly 89% of caregivers reported being satisfied with the services received at 6-month follow-up.

Qualitative Study

- ◆ Emotionally violent behavior (ie, anger, tantrums, and/or fighting) formed the reason for most (61.1%) referrals, followed by defiant behaviors (27.8%)
- ◆ The majority of caregivers (89%) specifically mentioned that they felt comfortable or at ease talking to Hand in Hand staff at Intake
- ◆ Nearly all (94%) caregivers felt they understood the wraparound concept at intake
- ◆ Most families reported improvement (87.5%) at follow-up
- ◆ After being in service 6-12 months, twenty-three caregivers (96%) said that their WF was easy to talk to
- ◆ Only some families had discussed and remembered discussing the graduation process after 6 (24%) or 12 (57%) months in services
- ◆ After 6-12 months in service, a few (12.5%) families did not have a team and some (33.3%) did not have a team that met regularly
- ◆ Most teams included extended family and many had friends and community supports

- ◆ Ten caregivers (41.6%) said that they have attended other meetings such as the Community Evaluation Team and Play groups since they began wraparound. An additional six (25%) have plans to attend.
- ◆ Nearly all (87.5%) families felt the Family Guide was either helpful or a good resource to have on hand
- ◆ Several families described the Family Mentor (or Lead Family Contact) as a helpful additional resource

Flexible Funds

Flexible funding is one of the key elements of wraparound identified by SAMHSA. The purpose of flexible funding is to provide discretionary funds which allow child and family teams to devise creative, strength-based, cost-effective alternatives to traditional services. For example, flexible funding may be used to support improved family outcomes by purchasing respite, therapeutic recreation, youth camp participation, or even household items to contribute toward stabilizing the home environment. A total of \$15,126.42 in flexible funding was expended in support of plan of care goals for individual child and family teams. Activities (e.g., tickets, events, camps, classes) made up the largest part of flexible fund use (35.3%).

Multicultural Competence

An area of weakness identified by the system of care community is the provision of culturally and linguistically competent services to families. A major focus of Hand in Hand has been to provide multicultural competency training to wraparound facilitators and community partners and to develop a train-the-trainer model for the system of care. Between October 2009 and August 2011, 237 participants completed the training and of these 212 completed both the pre and post-test of the California Brief Multicultural Competence Scale (CBMCS), a self-reported measure of multicultural competence, prior to and at the completion of training.

- ◆ At pre-test the weakest areas noted by participants were ability to assess the mental health (MH) needs of gay men and of lesbians, the ability to identify the strengths and weaknesses of psychological tests for different cultures, and knowledge of acculturation models for various ethnic minority groups.
- ◆ The strongest areas at pre-test were awareness of the challenges of being born a minority, awareness of how a professional's own values might affect the client, and communication skills appropriate for clients.
- ◆ The areas showing the greatest improvement were knowledge of acculturation models for various ethnic minority groups, ability to discuss in a group differences among ethnic

groups (eg., low SES Puerto Rican vs. high SES Puerto Rican client), ability to discuss research on MH issues and culturally different populations, awareness of institutional barriers that may inhibit minorities from using MH services and awareness that being born a white person carries certain advantages.

- ◆ The areas showing the least (but still significant) improvement were communication skills appropriate for clients (which was already high at pre-test) and ability to assess the MH needs of persons with disabilities

Recommendations for Continuous Quality Improvement

- ◆ Incorporate trauma-focused assessment into the intake process and all aspects of service
- ◆ Train community partners in trauma focused assessment and treatment
- ◆ Increase presence of Hand in Hand with Child Protective Services
- ◆ Work with wraparound facilitators to identify strategies to build family teams early.
- ◆ Monitor frequency of family team meetings and seek solutions to barriers that keep teams from meeting frequently.
- ◆ Ensure that caregivers have a good understanding of wraparound from the beginning of services.
- ◆ Hand in Hand facilitators are still challenged to teach caregivers about wraparound during their stressful times of seeking services. Keeping the wraparound agreement is a necessity, with perhaps a bit more time spent on the difference between wraparound and case management.
- ◆ Make a determination as to whether case management should be considered an aspect of the Hand in Hand wraparound process as it is in some other systems of care.
- ◆ Recognize that a high proportion of families have had traumatic experiences that led to seeking services. While it appears that staff has been able to help these families, this is important to consider in system-wide service planning.
- ◆ Discuss graduation with families from the beginning of services.
- ◆ Ensure all child and family teams have well developed measurable goals and a vision of the future incorporated into the wraparound plan. Review and evaluate progress at each team meeting to guide decision making.

REFERRAL AND INTAKE INTO HAND IN HAND

From October 2010 to September 2011, 82 referrals and 63 intakes were received. Five cases had a referral in August or September of 2010, but had another point of contact later than October of 2011. These cases are included in the numbers below. While numbers were somewhat higher in year 2 (108 referrals, 65 intakes), about half (48%) of non-open referrals signed wrap-around agreements in year 3. This is an improvement over year 2 where only 42% of non-open referrals had signed agreements.

Table 1 describes the reasons families did not move on to the next stage of service. At least 12 (10%) children referred into Hand in Hand did not meet the eligibility criteria. This likely underestimates the actual number as several caregivers chose not to attempt to get a diagnosis or to have their child assessed for imminent risk by Hand in Hand staff. Open cases entered the study shortly before the end of year 3 and may have received additional contacts or services in year 4 that are not reflected in this report.

Table 1: Days between POC 10/1/10 – 9/30/11							
	N	No Response	Moved out of Svc Area	Not Eligible	Declined wraparound	Open*	Moved to Next Step
Referral	87	4	0	7	8	3	65
Intake	65	2	1	2	3	2	55
Peer to Peer Contact	45**	4	0	0	2	4	46
WF First Contact	46	3	1	0	3	3	36

* Some may have been contacted after 9/30/11; **10 Caregivers met with the WF without having spoken directly with Peer to Peer.

Due to the high demand in some counties, 17 families were put on a wait list between May and September 2011. Five of these families did sign wrap agreements, but an additional 4 declined or did not respond to calls once they were taken off the wait list. One waitlisted client moved and the remaining 7 are still open cases.

Table 2 explains the reasons that families declined or were ruled ineligible for service at Referral or Intake. When appropriate, families were always given referrals to other resources (e.g., parenting classes, play therapy) that might better suit their needs. Passive refusals (e.g.,

caregiver said they were probably not interested but would talk it over with their spouse and call back) were included under caregiver not interested. In some cases, a caregiver decided that another service or type of counseling would meet their needs better than wraparound.

Table 2. Reasons for Declined/Not Eligible Service 10/1/09 – 9/30/10		
	After Referral	After Intake
Declined		
Caregiver not interested	1	2
Caregiver not interested/ Wanted other services (Case Mgmt, Assessment, or Medication Mgmt)	3	2
Caregiver not interested/ Found other resources	0	3
Caregiver not interested/ Lack of time	1	1
Caregiver not interested/Did not like idea of team	1	0
CPS referral, Caregiver did not want services	1	0
Waitlisted client improved on own	1	0
Not Eligible for Services		
Out of area served	2	0
Autism diagnosis	2	0
Did not meet criteria for imminent risk or diag.	2	0
Caregiver’s MR or severe MH status would inhibit Wraparound	1	1

In most cases, families enter Hand in Hand through the following sequence: referral, intake, peer to peer contact, wrap facilitator (WF) contact, and wrap agreement (WA) Signed. Contact refers to a face-to-face meeting or a phone call with the caregiver. Attempted contacts are not included, though it should be noted for many of these the Peer or WF had made several phone call (or visit) attempts prior to speaking with the caregiver. In 10 cases the Peer was not able to contact the family directly and in 3 cases the WF contacted the family first. For these cases, Peer developed materials were provided either through mail or by the WF. These 13 cases are not included in the calculations for “Peer to Peer to WF Contact” and the 10 without Peer direct contact were not included in “Intake to Peer Contact”. Families who did not need services, were ineligible for services, or chose to decline services did not move to the next point of contact. Eighty-two percent of families spoke to their WF within 45 days of Referral and 64 percent met within 30 days. Only 3 percent of families (2 families) did not speak to their WF for 90 days or more after referral (compared to 10% taking more than 120 days in year 2). Results for families who were not put on a waitlist are shown in Table 3.

Table 3. Days between POC 10/1/10 – 9/30/11 (excluding waitlisted families)*						
	N	Average # of Days	Range of Days	25% Cases ≤	50% Cases ≤	75% Cases ≤
Referral to Intake	50	11	-1 to 114	1	4	7
Intake to Peer to Peer	32	14	0 to 65	6	9	16
Peer to Peer to WF Contact	25	11	0 to 31	3	10	19
WF Contact to WA Signed	31	14	0 to 44	5	9	20
WA Signed to 1 st Wrap Meeting	15	71	14 to 152	42	65	87
Referral to WF Contact	39	33	1 to 148	14	24	34
Intake to WF Contact	39	23	2 to 81	13	21	32
Intake to Wrap Agreement Signed	31	37	6 to 101	17	33	57

* Some may have been contacted after 9/30/11. Note that some points of contact may have occurred slightly out of order for some clients.

Seventeen families were placed on a waitlist in year 3 and 15 of these received intakes. Because this may have had an effect on the number of days, these families were analyzed separately. Generally they were placed on a waitlist between Intake and assignment to a WF. Forty-three percent of families spoke to their WF within 45 days of Referral. However, all but 2 spoke to their WF within 60 days of referral and only 1 family did not speak to their WF for 90 days or more after referral. Table 4 shows the results for families who were put on a waitlist.

Table 4. Days between POC 10/1/10 – 9/30/11 for Waitlisted Families*						
	N	Average # of Days	Range of Days	25% Cases ≤	50% Cases ≤	75% Cases ≤
Referral to Intake	15	6	0 to 38	0	6	17
Intake to Peer to Peer	13	9	3 to 44	8	9	14
Peer to Peer to WF Contact	7	36	1 to 53	21	36	43
WF Contact to WA Signed	5	4	0 to 49	2	4	38
WA Signed to 1st Wrap Meeting	2	14	13 to 15	-	-	-
Referral to WF Contact	7	52	20 to 97	36	50	66
Intake to WF Contact	7	46	14 to 97	32	45	52
Intake to Wrap Agreement Signed	5	52	34 to 81	38	49	68

* Some may have been contacted after 9/30/11. Note that some points of contact may have occurred slightly out of order for some clients.

Results of those who signed wraparound agreements are shown in Table 5.

Table 5. Days between POC 10/1/10 – 9/30/11 for Non-waitlisted Families who Signed the WA						
	N	Average # of Days	Range of Days	25% Cases ≤	50% Cases ≤	75% Cases ≤
Referral to Intake	31	10	-1 to 114	0	3	7
Intake to Peer to Peer	23	16	0 to 65	6	11	19
Peer to Peer to WF Contact	20	11	0 to 31	3	10	17
WF Contact to WA Signed	31	14	0 to 44	5	9	20
WA Signed to 1 st Wrap Meeting	15	71	14 to 152	42	65	87
Referral to WF Contact	31	33	1 to 148	14	24	36
Intake to WF Contact	31	24	2 to 81	12	21	32
Intake to Wrap Agreement Signed	31	38	6 to 101	17	33	57

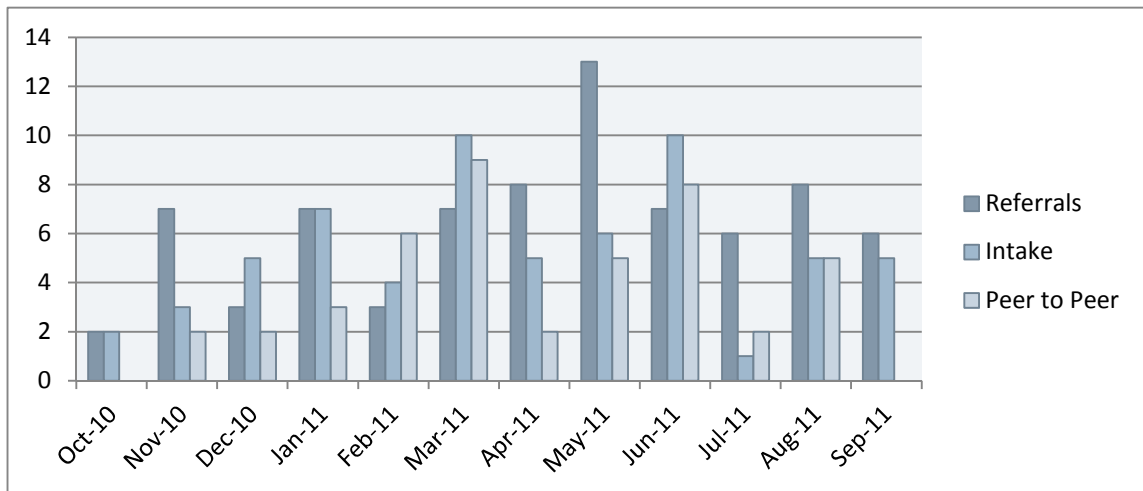
* Some may have been contacted after 9/30/11. Note that some points of contact may have occurred in slightly out of order for some clients.

Excluding cases that are still open (12) and that are definitely ineligible (11), 34 out of 64 (56.3%) referrals went on to sign wraparound agreements in year 3. This compares to 47.6% in year 2.

Enrollment Rates

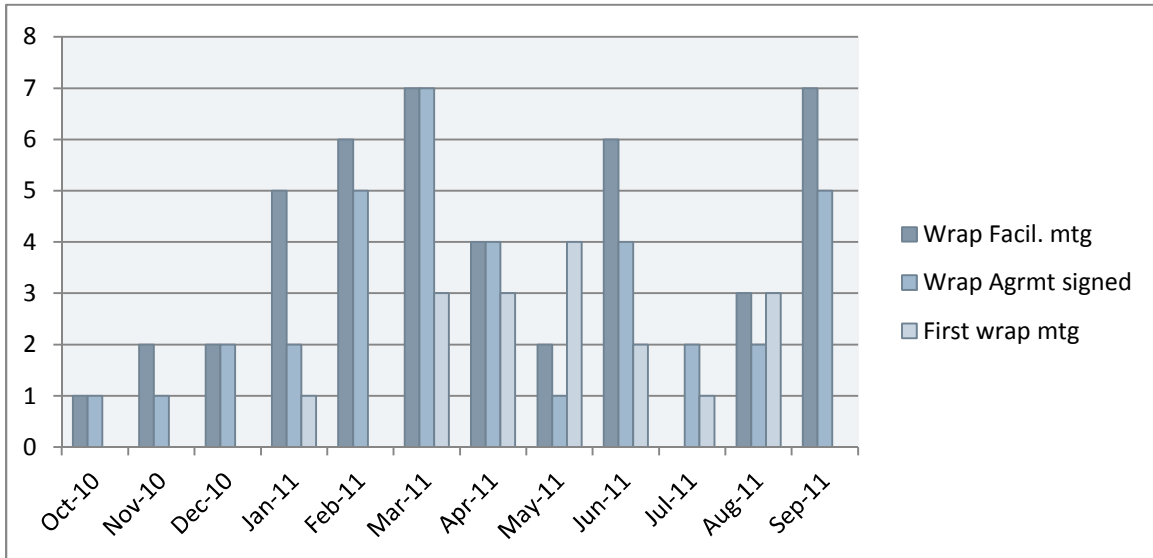
On average in year 3, Hand in Hand received 6.4 referrals, 5.3 Intakes, and 3.7 Initial Peer to Peer Contacts a month. The amount of referrals in a given month varied from 13 (May) to 2 (October), as shown in Figure 1.

Figure 1. Month by Month Number of Referrals, Intakes, and Initial Peer to Peer Contacts



On average in year 3, Hand in Hand families had 3.8 first meetings with the WF, 3 wraparound agreements signed, and 1.4 families first Wraparound Meetings per month (shown in Figure 2).

Figure 2. Month by Month Number Receiving Each Form of Contact for the 1st Time



CHILDREN AND FAMILIES SERVED THROUGH HAND IN HAND

Demographics

A total of 67 children were referred to Hand in Hand and completed the Enrollment and Demographic Information Form (EDIF) between October 1, 2009 (FY 2010) and August 31, 2011 (FY 2011).* The yearly target for Hand in Hand is 50 for a target enrollment of 100 through September 30, 2011. Of the 67 children enrolled into Hand in Hand, 30 (60% of target) were referred during FY 2010 and 37 (74% of target) were referred during FY 2011

The average age of the children at time of referral was 4.5 years old and the majority were male (74.6%) and White (71.6%) (Table 1). The identified caregiver for children enrolled were largely females (96.7%) under the age of 35 (63.9%). Over half (66%) of the caregivers had a high school diploma or some college. Fewer than 10% had a college degree (Table 2).

Table 1: Demographics of Children and Caregivers

Demographics of Children		Demographics of Caregivers	
Gender		Gender	
Female	25.4%	Female	96.7%
Male	74.6%	Male	3.3%
Average Age		Average Age	
Birth to 3	41.8%	Less than 35 years	63.9%
4 to 6	58.2%	35 - 49 years	24.6%
		50 and above	11.5%
Race/Ethnicity		Race/Ethnicity	
Amer. Indian or Alaska Native	3.0%	Amer. Indian or Alaska Native	3.3%
Black or African American	9.0%	Black or African American	6.6%
White	71.6%	White	75.4%
Hispanic/Latino	16.4%	Hispanic/Latino	14.8%

Table 2: Educational Attainment of Caregivers

Educational Attainment	
Below High School	24.6%
High School Diploma or GED	32.8%
Associate Degree/Some College	32.8%
College Degree (BA, MA, PhD, ...)	9.8%

Referral and Agency Involvement

Of the 67 children with a completed EDIF, 23.4% (n=16) were referred by a mental health provider. Caregivers made 21.9% (n = 15) of the total referrals. Nearly 30% of the children had child welfare involvement; however, child welfare made just under 10% of the referrals. Prior to referral into Hand in Hand, over 44.8% of the children had received mental health services and 26% of families had come in contact with Child Protective Services. Forty-seven percent of the children with CPS contact were placed outside of the home either in foster care or kinship care (Figures 1, 2 & 3).

Figure 1: Referring Agency

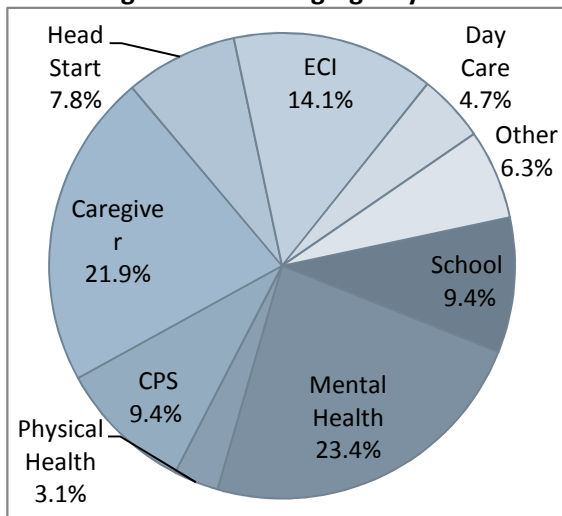


Figure 2: Prior Agency Involvement

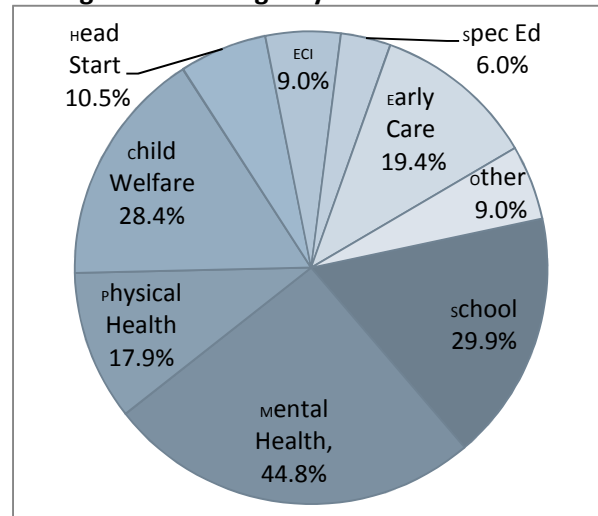
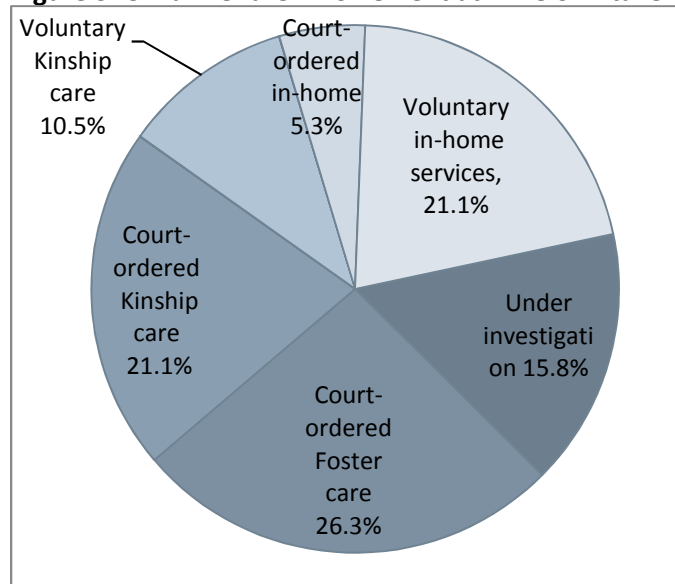


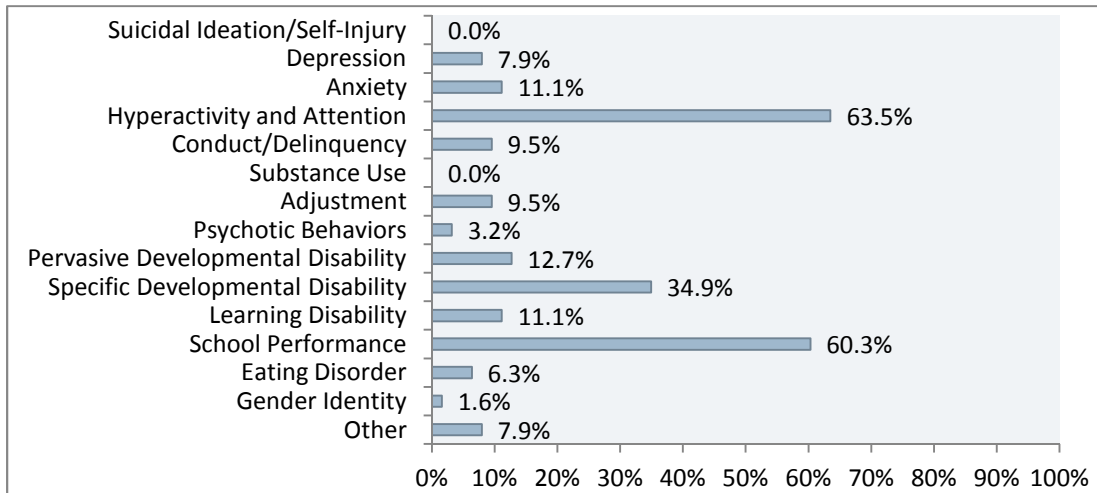
Figure 3: Child Welfare Involvement at Time of Intake



Presenting Problems

The most prevalently reported presenting problems were externalizing issues with hyperactivity and inattention being the most prevalent complaint (63.5%) followed by problems with school performance (60.3%). Nearly half (48%) of the children had a pervasive or specific developmental disability.

Figure 4: Presenting Problem at Intake



Mental Health Diagnoses Prior to Hand in Hand

Thirty-three (49%) of the children entering Hand in Hand had a mental health diagnosis or diagnoses prior to referral (Table 5). The most common mental health diagnoses were externalizing disorders, with Attention Deficit Hyperactivity Disorder (ADHD) being the most prevalent (63.3%). While nearly 40% of the children were reported to have witnessed domestic violence, 16.7% were victims of physical abuse, and 6.7% were victims of sexual abuse; those with a diagnosis prior to intake into Hand in Hand of Post Traumatic Stress Disorder was 3%.

Table 3: Mental Health Diagnosis Prior to Intake

Diagnosis * (n = 33)	49 %
Attention-Deficit/Hyperactivity Disorders	63.6%
Disruptive Behavior Disorder	24.2%
Mood Disorders	18.2%
Oppositional Defiant Disorder	15.2%
Other	15.2%
Learning, Motor Skills, Communication Disorders	6.1%
Impulse Control Disorders	6.1%
Adjustment Disorders	6.1%
Pervasive Developmental Disorders	6.1%
PTSD and Acute Stress Disorder	3.0%
Mental Retardation	3.0%
Anxiety Disorders	0.0%
Substance Use Disorders[c]	0.0%
Schizophrenia and Other Psychotic Disorders	0.0%

* Data reported were collected using the Enrollment and Demographic Information Form (EDIF). Because youth may have more than one diagnosis, percentages for diagnoses may sum to more than 100%.

Family and Child History

Caregivers were asked to complete the Caregiver Information Questionnaire (CIQ-I) at intake into Hand in Hand. The CIQ-I asks caregivers about risk factors their child had experienced. Twenty-five of the children (41.7%) were reported as having lived with someone with a mental illness besides depression. Nearly half (46.7%) reported that their child had lived with someone who had a substance abuse problem. Witnessing domestic violence (38.3%) and living with people convicted of a crime (26.2%) were also experienced by many of the children (Table 4).

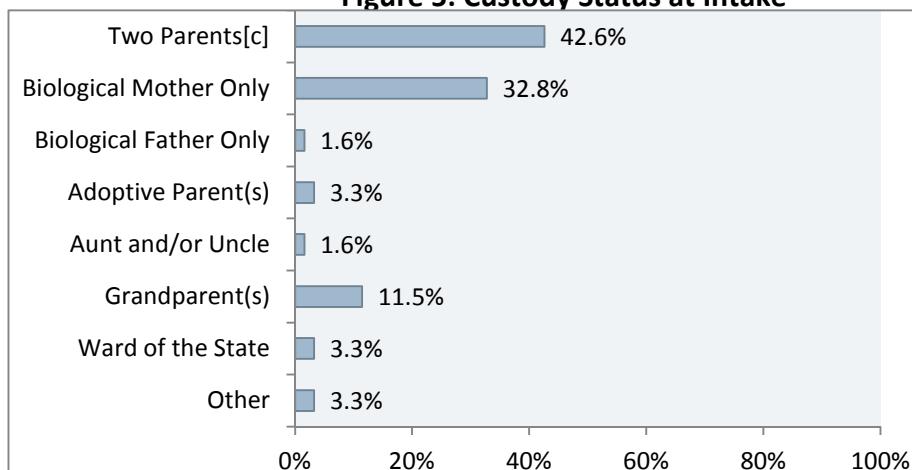
Table 4: Risk Factors

Has the child ever . . .	
Witnessed domestic violence? (n = 60)	38.3%
Lived with someone who was depressed? (n = 61)	67.2%
Lived with someone who had a mental illness, other than depression? (n = 60)	41.7%
Lived with someone who was convicted of a crime? (n = 61)	26.2%
Lived with someone who had a substance abuse problem? (n = 60)	46.7%
Experienced physical assault? (n = 60)	16.7%
Experienced sexual assault? (n = 60)	6.7%
Run away? (n = 61)	16.4%
Had substance abuse problems? (n = 61)	0.0%
Attempted suicide? (n = 61)	0.0%

Custody Status and Living Situation at Intake

At time of intake, just under half of the children (42.6%) were in joint custody of two parents, with 32.8% in custody of their biological mother only. One child was in the sole custody of the biological father. The remaining children were under the custody of a friend, relative, or child welfare (Figure 5). Over 80% of the children were living with a biological family member.

Figure 5: Custody Status at Intake



Physical Health Care

The majority of caregivers (93.4%) reported that their child had a primary care doctor, 77.2% of which were pediatricians. The average number of visits to a primary care health provider was 2.7. Allergies and asthma were commonly reported physical health problems. Table 6 shows the types of recurring health problems reported by caregivers.

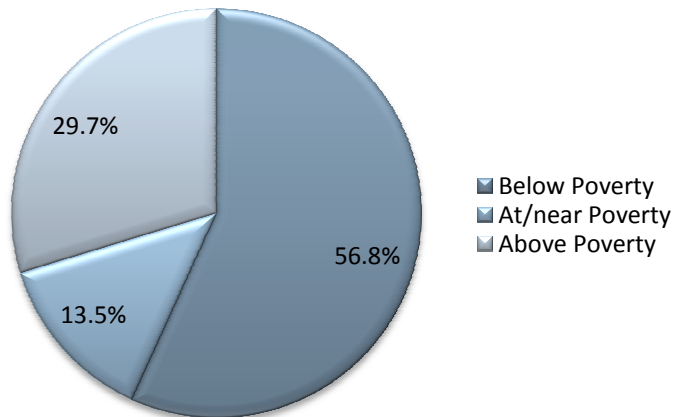
Table 6. Type of recurring or chronic physical health problems [b] (n=61)	%
Allergies	45.9%
Asthma	24.6%
Cerebral palsy	1.6%
Epilepsy	1.6%
Heart condition	1.6%
Other	21.3%
In the past 6 months percentage of ... (n=39)	
Children who took medication because of physical health problems	69.2%
Children whose regular activities (such as school, social activities, etc.) have been disrupted because of recurring or chronic physical health problems	30.8%

Economic and Employment Status at Intake*

Employment and Economic status was collected from caregivers using the CIQ-I. Over half of the families (56.8%) reported an annual household income of less than \$20,000, putting them below the poverty line. Approximately 13.8% have a household income above \$50,000, with nearly 7% reporting an annual income above \$100,000 (Table 7 & Figure 6).

Income Range	Percentage
Less Than \$5,000	22.4%
\$5,000–\$9,999	3.4%
\$10,000–\$14,999	19.0%
\$15,000–\$19,999	13.8%
\$20,000–\$24,999	8.6%
\$25,000–\$34,999	12.1%
\$35,000–\$49,999	6.9%
\$50,000–\$74,999	5.2%
\$75,000–\$99,999	1.7%
\$100,000 and Over	6.9%

Figure 6. Family Income



* Family income is reported from the family with whom the child has lived with the most in the 6 months prior to data collection.

Poverty categories are based on the U.S. Department of Health and Human Services poverty guidelines, which are available for the 50 States. The categories take into account calendar year, State, family income, and household size. Specifically, if family income is less than the relevant poverty threshold, they are "below poverty", if income is 1 to 1.5 times the threshold, they are "at/near poverty", and if income is more than 1.5 times the threshold, they are "above poverty". In 2009, the poverty threshold for a family of four residing in the 48 contiguous States was \$22,050.

Educational Placements

Data on the child’s educational placement and whether or not the child had an Individualized Education Plan (IEP) in place at intake to Hand in Hand was collected using the Education Questionnaire-Revision 2 (EQ-R2) (Table 8). A total of 43 out of 67 children (64% of total Hand in Hand population) were in some type of educational placement within the 6 months prior to intake into Hand in Hand. Of those, 69.8% were in regular public or private school. Forty-two out of the 43 had an Individual Education Plan (IEP) in place. Of those with an IEP, 35.3% were for behavioral or emotional problems. Twenty-one percent of the youths in an educational setting experienced being expelled or suspended (Table 9).

Table 8. Individualized Educational Plans (IEP)	
Percent with IEP (n = 42)	
Individual Education Plan	40.5%
Main Reasons for IEP[e] (n = 17)	
Behavioral/Emotional Problems	35.3%
Learning Disability	17.6%
Developmental Disability or Mental Retardation	17.6%
Vision or Hearing Impairment	0.0%
Speech Impairment	23.5%
Physical Disability	0.0%
Other	5.9%

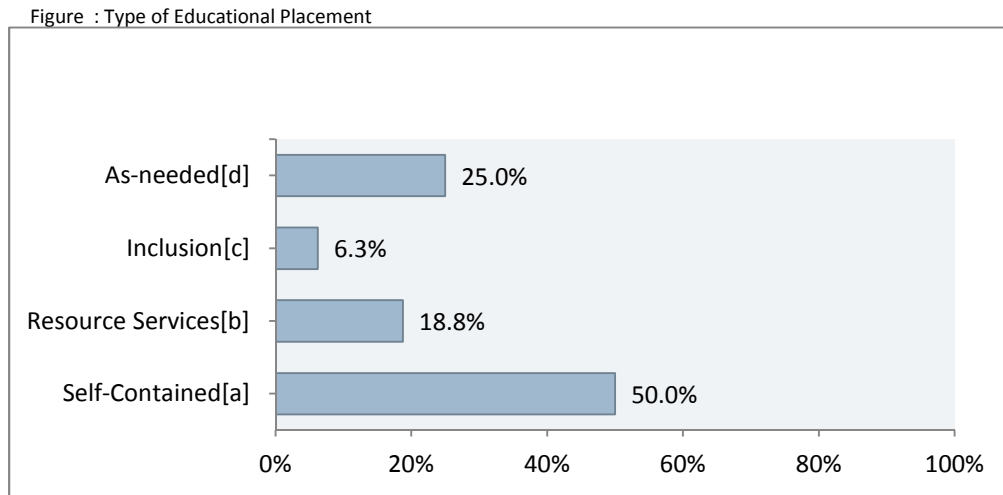
* Because individuals may have more than one educational placement, educational placements may sum to more than 100%.

Table 9. Educational Placements in the 6 Months Prior to Intake (n = 43)*	
Regular Public Day School	65.1%
Regular Private Day/Boarding School	4.7%
Preschool	25.6%
Head Start	9.3%
Other	11.6%

* Because individuals may have more than one reason for having an IEP, the reasons for having an IEP may sum to more than 100%.

Data reported on educational setting were also collected using the Education Questionnaire–Revision 2 (EQ–R2). Fifty percent of the children in an educational setting were reported to be in a self-contained, special education setting. The other 50% received some educational support through special education, but experienced some level of integration in general education classes (Figure 7).

Figure 7. Educational Setting



* Because children may have received more than one type of placement over the past 6 months, percentages may sum to more than 100%.
 [a] special education classes all or most of the day.[b] education classes in which all the children leave their general education class to receive special education instruction in specific subjects for a portion of the day.[c] Inclusion refers to special education provided in the general education class in which some children receive special education and others do not.[d] Children do not receive support on a regular basis.

School Attendance at Intake *

As shown in Table 10, for the children enrolled in school, attendance is not identified as a problem. Most students either have perfect attendance (16.7%) or miss less than one day a month (45.2%). No families reported children missing a day a week or more.

Perfect Attendance	16.7%
Less Than 1 Day Per Month	45.2%
About 1 Day a Month	16.7%
About 1 Day Every 2 Weeks	21.4%
About 1 Day a Week	0.0%
2 Days Per Week	0.0%
3 or More Days Per Week	0.0%

* Data reported were collected using the Education Questionnaire–Revision 2 (EQ–R2). This instrument collects data on the status of the child/family in the 6 months prior to the interview.

CLINICAL OUTCOMES

Shortly after enrollment in Hand in Hand, evaluation staff visited the homes of participating families and, after obtaining consent, administered a series of questionnaires to caregivers. Follow-up visits were conducted every 6 months after intake up to 24 months. Because this report is based on data from the 2nd and 3rd year of services, a large enough sample was only available for 6 and 12 month follow-ups. Paired sample t-tests were run on each scale and subscale to determine change. Results were excluded for sample sizes of less than 3.

Devereaux Early Childhood Assessment (DECA-C): The DECA-C measures both a child's strengths and behavioral concerns in children ages 2 through 5 years. It provides a balanced description of the child's behavior and allows for strength-based planning and strategy implementation. The DECA-C is designed to promote resiliency in children ages 2 through 5 years. It contains three protective factor scales: Initiative, Self-Control, and Attachment. The Total Protective Factors Scale is a composite of the above three scales.¹ Significant improvement from intake to 6 month follow-up and intake to 12 month follow-up was seen on the Self-Control subscale. Total protective factors also increased significantly from intake to 12 months and marginally from intake to 6 months. (Table 1)

Table 1: Behavior Protective Factors (DECA-C)		
Average Score		
Initiative (n=22)	Intake	6-month
	37.64	38.86
Initiative (n=12)	Intake	12-month
	36.25	39.83
Self control (n=24)	Intake	6-month
	32.46	35.83**
Self control (n=13)	Intake	12-month
	30.67	35.25**
Attachment Scale (n=24)	Intake	6-month
	39.88	42.17
Attachment Scale (n=12)	Intake	12-month
	39.92	42.58
Behavioral Concerns (n=24)	Intake	6-month
	69.17	69.58
Behavioral Concerns (n=12)	Intake	12-month
	71.25	70.08
Total Protective Factors (n=24)	Intake	6-month
	33.29	36.08+
Total Protective Factors (n=12)	Intake	12-month
	32.08	37.00**

Note: +p<.10, *p<.05, **p<.01, *p<.001**

Functional Impairment: Caregivers in the national evaluation rated their children's level of functional impairment – the extent to which they are impaired in their daily life as a result of their behavioral and emotional problems – using the Columbia Impairment Scale (CIS). Scores range from 0 to 52, with higher scores indicating greater levels of impairment; thus lower scores indicate greater functionality. A score of 15 or higher is considered to be in the clinical range. At intake, average scores were well above the threshold for clinical impairment. However, from intake to 6 month and intake to 12 month, impairment was significantly reduced and approached non-clinical levels. (Table 2)

Table 2: Functional Impairment (CIS)		
Average Score		
CIS Total Score (n = 36)	Intake	6-month
	21.14	17.61*
CIS Total Score (n = 21)	Intake	12-month
	24.81	17.29***

Note: +p<.10, *p<.05, **p<.01, ***p<.001

Behavioral and Emotional Rating Scale–Second Edition, Parent Rating Scale (BERS–2C): The BERS–2C was administered to caregivers. It measures children’s emotional and behavioral strengths in six different areas: interpersonal strength, family involvement, intrapersonal strength, school functioning, affective strength, and career strength. Scaled scores on the strength subscales range from 1 to 16, with an average score between 8 and 12. Higher scores indicate greater strengths.

A strength index can be calculated and is based on the sum of the subscale scores, excluding career strength. The strength index ranges from 38 to 161, with an average index in the 90–110 range. A higher index indicates greater overall strengths.¹

Significant improvements were seen in total strengths from both intake to 6 months and intake to 12 months. Intrapersonal strength also improved significantly from intake to 6 months. (Table 3)

Table 3: Behavioral and Emotional Strengths (BERS-2C)		
Average Score		
Family Involvement (n=13)	Intake	6-month
	8.23	8.85
Family Involvement (n = 8)	Intake	12-month
	8.50	9.75
Intrapersonal Strength (n=12)	Intake	6-month
	9.17	10.08
Intrapersonal Strength (n=7)	Intake	12-month
	8.14	11.43*
School Functioning (n=9)	Intake	6-month
	8.22	9.11
School Functioning (n=6)	Intake	12-month
	7.33	8.50+
Affective Strength (n=13)	Intake	6-month
	9.69	10.38
Affective Strength (n=8)	Intake	12-month
	8.88	9.63
Career Strength (n=4)	Intake	6-month
	8.25	9.50
BERS Strengths Index (n=9)	Intake	6-month
	89.89	97.56**
BERS Strengths Index (n = 6)	Intake	12-month
	87.17	97.00*

Note: +p<.10, *p<.05, **p<.01, *p<.001**

Behavioral and Emotional Problems: Caregivers reported on their children’s problem behaviors using the Child Behavior Checklist (CBCL). The table below provides data on the severity of problem behaviors across a number of domains. Problem scores are based on normative comparison to other children of the same age and gender across the nation and are expressed as T-scores, with a population average of 50 and a standard deviation of 10. Lower scores indicate greater functionality. Two broad-band scales are also shown – Internalizing

Problems (i.e., Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints) and Externalizing Problems (i.e., Rule-Breaking Behavior and Aggressive Behavior). Finally, a total composite Problem Score is given which also includes Social Problems, Thought Problems, and Attention Problems for a total of 8 subscales. Because the types of problem behaviors vary by age, two measures were used: The CBCL for ages 6-18 and the CBCL for ages 1 ½ to 5. Although all scales and subscales showed a reduction in symptoms, these results were not significant. A marginally significant reduction from intake to 6 months was seen for total problems for 1 ½ to 5 year olds. (Tables 4 and 5)

Table 4: Behavioral and Emotional Problems (CBCL 6-18)		
Average Score		
<i>Internalizing Scale (n=4)</i>	<i>Intake</i>	<i>6-month</i>
	63.50	62.75
<i>Externalizing Scale (n=4)</i>	<i>Intake</i>	<i>6-month</i>
	71.00	70.50
<i>Total Problem Scale (n=4)</i>	<i>Intake</i>	<i>6-month</i>
	70.00	69.25
Note: +p<.10, *p<.05, **p<.01, ***p<.001		

Table 5: Behavioral and Emotional Problems (CBCL 1.5-5)		
Average Score		
<i>Internalizing Scale (n=32)</i>	<i>Intake</i>	<i>6-month</i>
	65.47	63.63
<i>Internalizing Scale (n=15)</i>	<i>Intake</i>	<i>12-month</i>
	67.13	66.27
<i>Externalizing Scale (n=32)</i>	<i>Intake</i>	<i>6-month</i>
	73.91	70.97
<i>Externalizing Scale (n=32)</i>	<i>Intake</i>	<i>12-month</i>
	77.33	73.20
<i>Total Problem Scale (n=32)</i>	<i>Intake</i>	<i>6-month</i>
	70.81	67.84+
<i>Total Problem Scale (n=15)</i>	<i>Intake</i>	<i>12-month</i>
	73.53	70.93
Note: +p<.10, *p<.05, **p<.01, ***p<.001		

Caregiver Strain Questionnaire (CGSQ): The CGSQ assesses the extent to which caregivers are affected by the special demands associated with caring for a child with emotional and behavioral problems. The CGSQ is comprised of three subscales which range in severity from 0 to 5. Objective Strain refers to observable disruptions in family and community life (e.g., interruption of personal time, lost work time, financial strain). Subjective Externalized Strain refers to negative feelings about the child such as anger, resentment, or embarrassment. Subjective Internalized Strain refers to the negative feelings that the caregiver experiences such as worry, guilt, or fatigue. Higher scores on each of these scales indicate greater strain. A Global Strain score is calculated by summing the three subscales (i.e., Objective Strain, Subjective Externalized Strain, and Subjective Internalized Strain) to provide an indication of the total impact of the special demands on the family. Global Strain scores range from 0 to 15. As with the individual subscales, higher scores indicate greater strain.ⁱ Caregiver strain was significantly reduced both from intake to 6 months and intake to 12 months. (Table 6)

Table 6: Caregiver Strain (CGSQ)		
	<i>Average Score</i>	
<i>Global Strain (n=41)</i>	<i>Intake</i>	<i>6-month</i>
	60.20	52.15***
<i>Global Strain (n = 24)</i>	<i>Intake</i>	<i>12-month</i>
	64.58	54.00*

Note: +p<.10, *p<.05, **p<.01, ***p<.001

Parenting Stress Index-Short Form (PSI/SF): The PSI is designed to measure the source of parenting distress, parent-child dysfunctional interaction, and the difficult behavioral characteristics of the child. The PSI/SF is composed of five subscales: Parental Distress, Parent–Child Dysfunctional Interaction, and Difficult Child, and Total Stress, and Defensive Responding used to determine whether the respondent's answers shall be considered valid or not. A high Total Stress score (in the clinical significant range) indicate the parent is experiencing a high level of parenting stress. A marginal decline in parenting stress was seen between intake and 12 months.

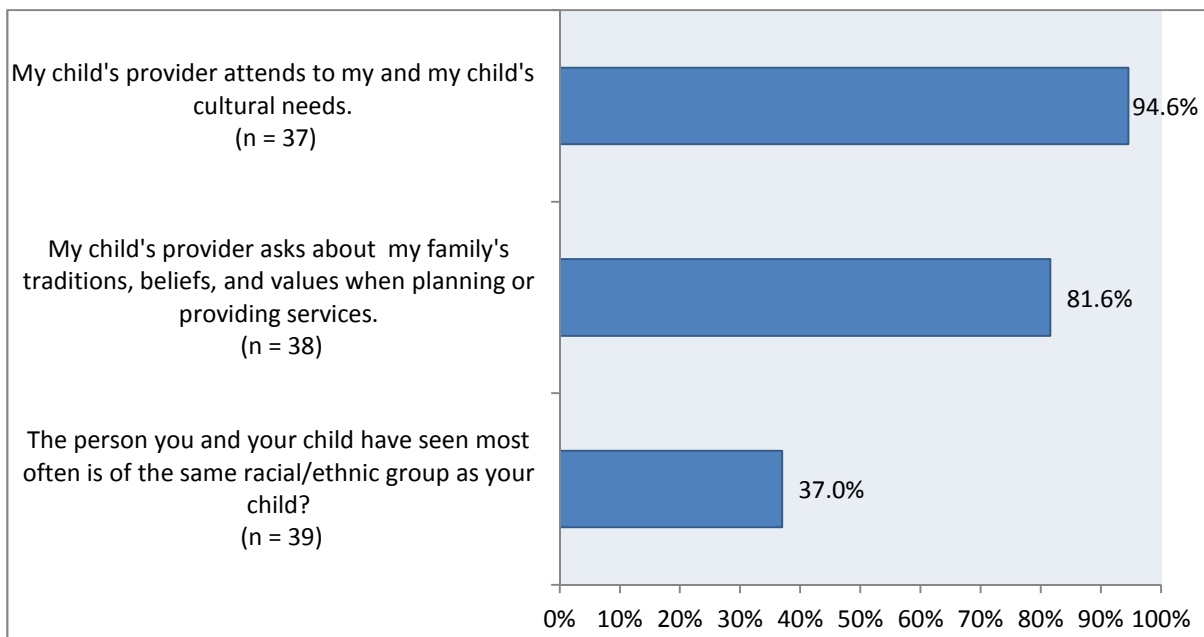
Table 7: Total Parenting Stress(PSI)		
<i>Average Score</i>		
Total Stress (n=26)	<i>Intake</i>	<i>6-month</i>
	104.62	103.00
Total Stress (n = 16)	<i>Intake</i>	<i>12-month</i>
	112.19	106.19+

Note: +p<.10, *p<.05, **p<.01, *p<.001**

CAREGIVER OPINION OF CULTURAL COMPETENCE AND SERVICE PROVISION

Caregivers were given the Cultural Competence and Service Provision Questionnaire (CCSP), which contains 13 items. These include the measure of the importance of cultural factors to the caregiver and how well a service provider addressed cultural issues while providing its respective service to the caregiver and its child. Thirty-nine caregivers answered the questionnaire, most (94.6%) reporting that the service provider attended to their and their child's cultural needs most or all of the time (89.2% said always). Most (81.6%) caregivers agreed that their provider asks about family's traditions, beliefs and values when planning or providing services most or all of the time. Over a third (43.6%) of caregivers reported that their most recent service provider was of the same racial or ethnic group as its child. Over half (53.7%) of caregivers reported that it was at least moderately important that the child's beliefs and practices based on racial or ethnic group association should be included in service planning. (Figure 1)

Figure 1: Caregiver Opinions



The Youth Service Survey for Families (YSS–F) was used to assess the caregiver’s perception of his/her system of care service experiences. The measure assesses perceptions of service across the following seven domains: 1) access, 2) participation in treatment, 3) cultural sensitivity, 4) satisfaction, 5) outcomes, 6) functioning, and 7) social connectedness. Scores on each domain range from 1 to 5. Higher scores indicate a positive service experience in that domain. (Table1)

Table 1: Caregiver Perspective on Services at 6 Months

Perspectives on Services	Caregiver: % Reporting Positively
Access to Services	94.1%(n=34)
Participation in Treatment	97.1%(n=34)
Cultural Sensitivity	97.1%(n=34)
Satisfaction with Service	88.2%(n=34)
Outcome	52.9%(n=34)
Functioning	52.9%(n=34)
Social Connectedness	91.2%(n=34)

FLEXIBLE FUND SPENDING

Flexible funding is one of the key elements of wraparound identified by SAMHSA. The purpose of flexible funding is to provide discretionary funds which allow child and family teams to devise creative, strength-based, cost-effective alternatives to traditional services. For example, flexible funding may be used to support improved family outcomes by purchasing respite, therapeutic recreation, youth camp participation, or even household items to contribute toward stabilizing the home environment.

Data presented here were gathered from electronic forms of flexible funding requests. Facilitators submitted funding requests on behalf of individual families and wraparound teams. Facilitators explored local resources for funds before submitting flex funds requests. Funds were categorized according to areas specified by the National Evaluation Team using the Flex Funds Tool. Both the dollar and percentage of overall flex funds are presented below.

Flexible Expenditures by Category		
<i>Flex Fund Expenditure Categories</i>	<i>Amount</i>	<i>Percent</i>
Housing	\$1,013.90	6.70%
Utilities	\$828.48	5.48%
Environmental Modification	\$14.00	0.09%
Furnishings/Appliances	\$659.70	4.36%
Supplies	\$278.75	1.84%
Food/Groceries	\$3.00	0.02%
Clothing	\$331.24	2.19%
Activities	\$5,342.84	35.32%
Educational Support	\$170.53	1.13%
Day Care and Support	\$1,401.75	9.27%
Automobile	\$1,265.50	8.37%
Transportation	\$135.00	0.89%
Incentive	\$80.00	0.53%
Legal	\$1,616.00	10.68%
Medical	\$434.00	2.87%
Mental Health Services (Child/Youth)	\$50.00	0.33%
Mental Health Services (Caregiver/Family Member)	\$100.00	0.66%
Camp	\$836.00	5.53%
Training (Caregiver/Family Member)	\$235.00	1.55%
Other	\$330.73	2.19%
TOTAL	\$15,126.42	

A total of \$15,126.42 in flexible funding was expended in support of plan of care goals for individual child and family teams. This is nearly triple the amount spent in year 2 (5,898.62). Activities (e.g., tickets, events, camps, classes) made up the largest part of flexible fund use, followed by legal expenses, housing expenses (e.g., rent, mortgage, home improvement), day care and support, and automobile. Because most of the families lived in areas with no or inadequate public transportation, having a working automobile was crucial. In year 2, Activities represented 25.4% of flex fund expenditures compared to 35.3% in year 3. The proportion of flex funds used for Housing and Utilities decreased by 3.9% and 2% respectively while legal expenditures increased from 0% to 10.7%. Figures 1 and 2 display actual funding by category and percentage of funding by category.

Figure 1: Flex Fund Spending by Category

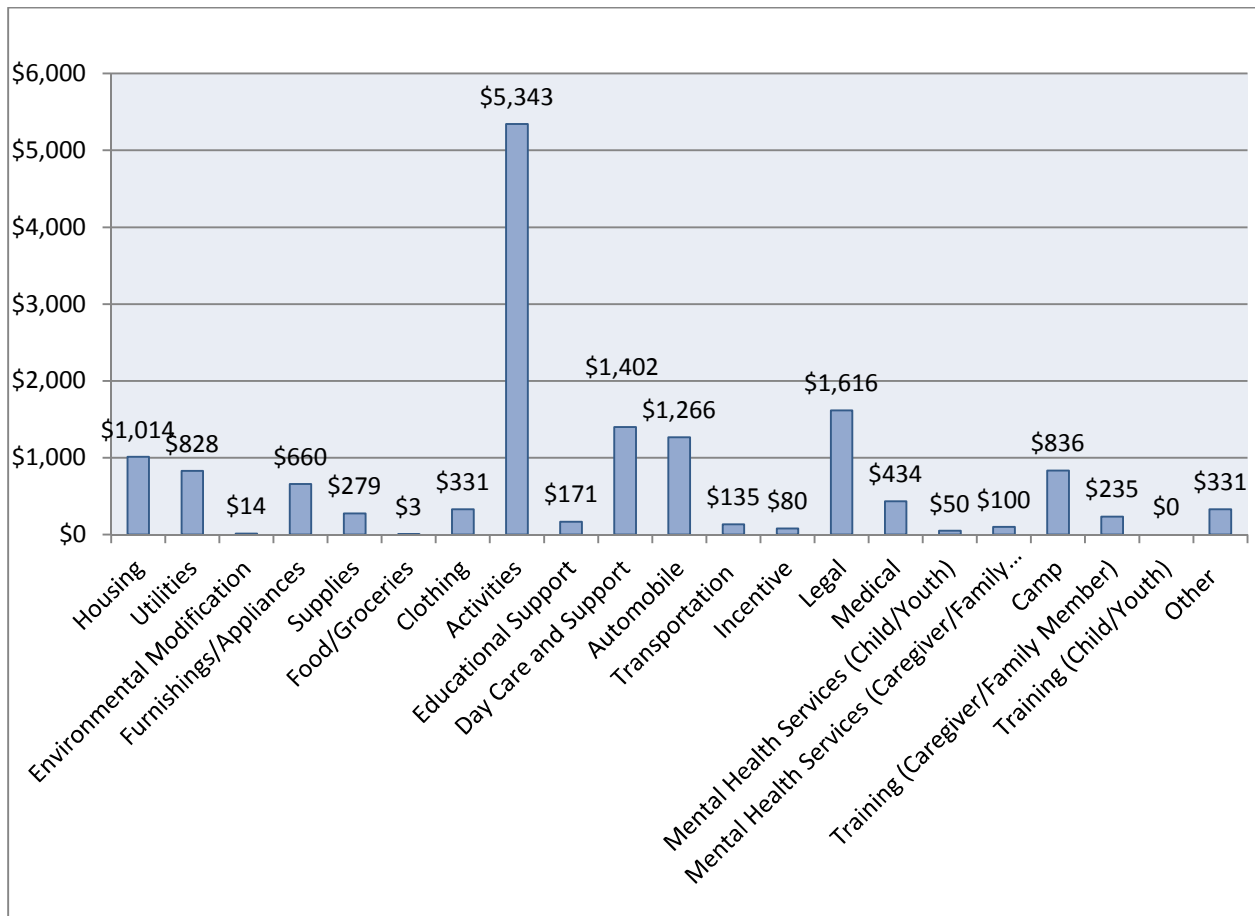
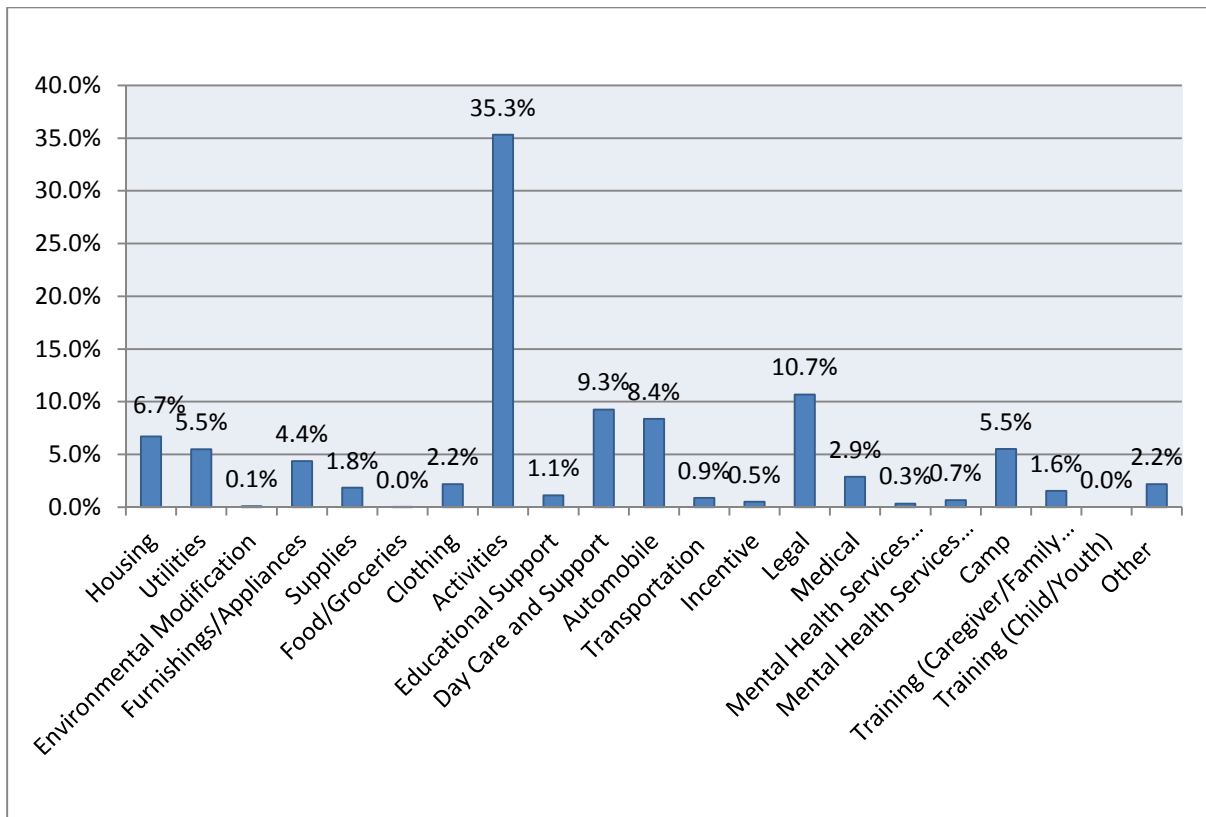


Figure 2: Percentage of Flex Fund Expenditures by Category



HAND IN HAND QUALITATIVE EVALUATION

This report is compiled from data collected using a qualitative questionnaire developed by the Community Evaluation Team (CET), a committee comprised of caregivers (parents, family members, grandparents, etc.) who have taken part in evaluation of wraparound, individual youth who have received Wraparound from the System of Care of North Central Texas, and the Hand In Hand (HIH) Evaluators from MHMRTC's Research Division. During MHMRTC's first System of Care initiative, participant caregivers in the System of Care national evaluation had expressed concern and frustration that none of the national instruments allowed for responses in their own words. This frustration led the CET to develop a separate, qualitative, family-driven local study in 2007-2008. When designing the evaluation component for HIH, CET members, already somewhat familiar with the benefits of using qualitative along with quantitative measures, strongly recommended evaluators include a qualitative measure at each data collection point and agreed to help develop the instruments.

CET members created three qualitative questionnaires. The intake questionnaire consists of three items with the flexibility to ask follow up questions if a respondent introduces a new topic. The two follow up questionnaires (one for families still in services and another for those out of services) consist of five items each and also allow for follow up questioning. All three versions of the HIH qualitative questionnaire were submitted for and received approval by the Institutional Review Board (IRB) of MHMRTC as part of the local, longitudinal evaluation of Hand in Hand.

Evaluators record responses by hand and enter them into a database. The responses are later downloaded for analysis by the evaluation team. Some of the data in this report do not directly correspond to any item on the questionnaires, yet they are significant because respondents voluntarily offered the data without being prompted. These unplanned responses reveal much about caregivers' experiences and evaluators have found that the real story of families in wraparound often lies within these unprompted responses.

Intake Questionnaire

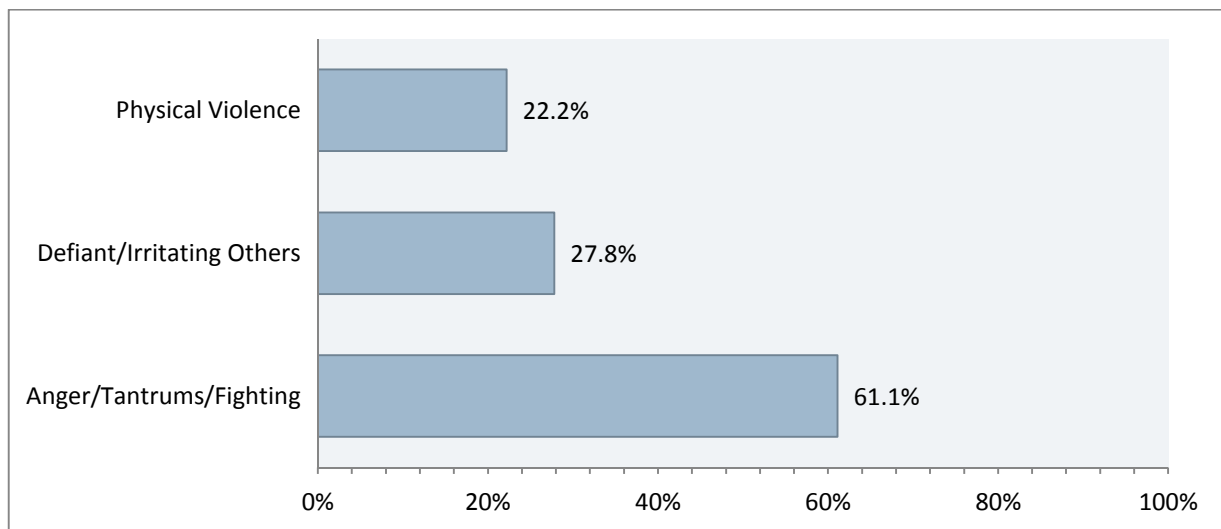
Intake Interviews were conducted with 18 families between December 2010 and April 2011. Respondents were asked about the situation that led them to seek services for their child, their experiences during the intake process, and whether or not they felt wraparound was explained in a way they could understand. Respondents reported hearing about Hand In Hand usually from an agency, school (including a John Peter Smith Hospital clinic at school), or organization. One family specifically indicated Child Protective Services (CPS) referred them to Hand In Hand.

Reason for Seeking Services:

Question 1: Please tell me about the situation with your child and family that led you to seek services with Hand In Hand.

Child's Behavior. Most of the caregivers cited their child's behavior as the motivator to seek services. Figure Q1 shows the most common types of behavior problems identified. Some caregivers identified multiple types of behavior problems. Anger, tantrums, and fighting were the most reported behavior problem, with 61.1% of the children exhibiting some form of emotional or physical violence.

Figure Q1. Most common behavior problems



Settings Where Problems Occur. Of the caregiver responses, 9 (50%) identified school as the location where the problems occur. Home was the second most common response (44.4%). Some parents said their child was having problems at home, school, and daycare.. Some

respondents emphasized that their child did not exhibit problems at home, only at school. Referring to problems at daycare, two caregivers reported the following:

"My son was kicked out of multiple daycares. School says he doesn't need special ed. Since I'm not on welfare, he either needs help or not, so daycare and school aren't helping. He's not where he needs to be. He doesn't play with other kids and gets very agitated if they get too close or touch him. Socially he's not where he's supposed to be. I think he has Asperger's syndrome."

"My son had been suspended and then expelled from daycare. He was getting mad and ugly acting to friends and the teacher and didn't want to do what he was told to do. He has always been somewhat defiant, but this got worse after 1 month into the daycare. I have moved him to a more structured daycare and that seems to be working and is what he needs. We have a family friend in <Wrap Facilitator> and she came over and told us about HIH and <Clinical Director> did the intake and it was great!"

Referring to problems at home and school, a parent reported the following.

"At home there is disobedience, a lack of emotion toward others when they're hurt, hyperactivity (kicking, biting, etc), yelling and fighting with his sisters, draws on the walls. At school he doesn't mind (listen to the teachers), he does the exact opposite of what they tell him."

Trauma was mentioned by one caregiver:

"Problems at school were awful BUT problems were bad especially at HOME. We were all over it once ya'll explained it and <Family mentor> helped. He has ADHD, mood disorder, and PTSD. His dad was very verbally abusive and my son witnessed his dad's sexual advances toward his sisters and made an outcry. He's on <4 medications> and was in Cooks for emotional/behavioral meds."

One caregiver reported seeking help because they were referred by their Child Protective Services (CPS) worker. Hand in Hand has in the past several months made presentations to CPS to encourage caseworkers to refer those that might benefit from wraparound.

"The worker with CPS is great and she's been a lot of support since my son was given to us at age 3 weeks. She referred us to HIH. Her supervisor told her about it. She emailed me and it is a way to help a lot."

Intake Process:

QUESTION 2: How did the intake process work for you? (Follow-up questions: Did you feel comfortable discussing your family's personal experiences with the person who helped you enroll in Hand In Hand? If this was difficult, how could Hand In Hand make it easier for future families?)

General Ease of Process. Several families mentioned that the process was quick and easy. Although one caregiver said that she did not know how to answer the question, none expressed any difficulty or dissatisfaction with the intake process overall.

"The intake process worked pretty fast. I didn't have to wait. If anything, they had to wait on me to find time to meet with them. I felt comfortable talking to the intake coordinator. I knew I needed help."

"The intake process was easy and fast. I felt fine talking to them at intake."

Another caregiver expressed enthusiasm for the program from the very beginning.

"HIH called me...<Facilitator> and told me about it and I told her I'd already heard about HIH and I was willing to do anything to help my child and our family. I heard about Wraparound and I said, hey, I had already started that myself here in the neighborhood and at school, but I didn't know it was called "wrap". I had always thought it didn't take a village until I had my child ...Now I know with some kids, it takes a village."

Level of Comfort. Several families reported that prior to contacting Hand in Hand, they had worried about divulging so much detailed personal information about their families. However, the majority of families (89%) said they felt comfortable or at ease talking to Hand in Hand staff, especially their wraparound facilitator (WF). The other 11% (2 caregivers) did not specifically mention their level of comfort (one was unsure how to answer the question). Following are quotes from caregivers regarding their comfort level with beginning wraparound.

"Not at first-- I didn't feel comfortable talking to people about our personal problems, but <Facilitator> made all the difference and made us more comfortable."

"I felt very comfortable talking to all the staff who called me. But I feel especially comfortable with <Facilitator>. She's great."

"Oh, being able to talk and have someone listen is all too precious. It was very easy talking to the ones who called me. Excellent communication is not talking, but rather listening! Listen!"

"I got a call from the Clinical Director and it was easy to talk to her. All of HIH have been so great...just wonderful people --I'm so glad I got in with you all and I couldn't believe it was with no wait list!"

Another caregiver mentioned services provided while on a wait list for wraparound.

"My mom called HIH and talked to the Community Liaison and they called back for me. They put us on wait list and it was about one month. Gave us links and ways to find help and services until then, this was for Therapy 2000, <Local Provider>, had an appointment. Then we met the Family Mentor and the WF and then other staff came by to discuss respite. I met the Family Mentor in person once. The WF came and I felt very close to her."

Understanding of Wraparound Process

Question 3: Do you feel that your wraparound facilitator and your family mentor have given you a good understanding of the wraparound process? (Follow-up question: Has the Hand In Hand staff told you about wraparound teams?)

Wraparound requires a certain level of effort and commitment on the part of caregivers. Because of this, it is important that caregivers understand the wraparound process from the beginning. Wraparound facilitators and family mentors are asked to make sure that the family understands what Wraparound entails before the caregiver agrees to be enrolled. The majority of caregivers (94%) said that Wraparound had been explained and that they understood the concept including the wraparound team. This shows an improvement over the last report where only 80% felt that they understood the wraparound concept.

"I think the teams will be a great help. I get so overloaded and overwhelmed with stuff and overloaded b/c I'm advocate 24/7 times a day. I took family leave from school because I am it and I don't have help! If it works the way I think it will, it will be awesome. Everyone we've met so far has been of the greatest people. I don't know where ya'll find the greatest people, but you all do too! The Family Mentor came to mediation with me at the school within a week. I don't know how she did it but she did! I adore them all."

"My WF explained HIH and about wrap and teams. The other day she did some work on Strengths...I think the whole team is what we need now to make our family better. Respite is part of that team, too. I asked my mom how she did it all and she said family members and friends, so we'll do it that way, too, and have a monthly meeting."

"I know it's getting family, friends and business associates together to help. <HIH staff member>gave me the wheel to fill out but I haven't done it yet; it's a tag team process. She told me it takes a village and that's what the team does; some do therapy or counseling. It's consistency, we need that."

"I feel I have a good understanding of the team from <WF>. They've told me about teams and I feel somewhat comfortable with the idea. Basically, I already have a team of girlfriends from work (been at job for 20 years); teachers and others from school. I also have family in another city, not real close, but close enough. So that concept (of team) isn't new to me."

While a majority of caregivers responded that they understood wraparound and that Hand in Hand staff had done a good job explaining it, a couple of notable concerns emerged. One caregiver expressed difficulty getting a hold of Hand in Hand and a partner agency.

"Mother in law got a <Partner Agency> Brochure and took a long time to get a hold of anyone. He needs extra special counseling. This took a couple of months and left many messages with <Intake Staff>."

"Got phone call from representative <Intake Staff>. Never met <Family Mentor>. I had not seen our WF in two weeks so I called <Family Mentor> and she got <WF> to call me."

"WF said she'd get us zoo tickets 3 weeks ago, but she hasn't called with anything yet. I feel like she hasn't done anything for us yet."

Another caregiver expressed confusion over the process.

"We haven't started it yet. It was not really explained well. Don't know much, nothing really, don't know what it is."

Follow-up Qualitative Questionnaire

Follow up qualitative instruments were administered to 24 caregivers between December 2010 and April 2011. The follow-up questionnaire is administered every six months throughout the 24 month longitudinal evaluation. Questions in the follow-up interview focus on whether the family has experienced any improvement in the situation that brought them into Hand in Hand. Out of the 24 follow-up interviews, there were 17 caregivers answering the 6 month follow up and 7 caregivers answering the 12 month follow up questionnaire. As of April 2011, no family had hit their 18-month follow-up.

Question #1: IMPROVEMENT

Question One: How are things going with wraparound? Has there been any improvement at home, school, daycare, etc... If so, how have things improved? If not, why do you think things have not improved?

Improvement in the daily life of the child at home and school is the overall goal for wraparound families, teams and facilitators. Families seemed encouraged when that improvement was noticeable and therefore, *measurable*, by the first follow up interview at six months. It is important to point out that evaluators are measuring caregiver's perception of improvement. Evaluators asked the responding caregivers if there had been any improvement in any of the domains in which their child and family participated in the last six months. Most families reported improvement (21 of 24, 87.5%).

"We just got the team only a couple of weeks ago! I can tell my son's learning and being around other kids is helping with social skills, independence, going to the bathroom more."

"(Things are) Excellent! Things have improved. I know how to cope with my son and there are less fights with siblings."

"Things are going great. My kids have learned to communicate so much better and they've mellowed out a lot."

"Things have improved. I've learned to have patience and be a little easier. My son seems calmer."

"Things are going wonderfully well. My child is speaking some and learning to sign. He's even moved up into his age group. I've completed (two vocational) trainings and have two interviews for work coming up."

Though many respondents said that there was noticeable improvement during the last six months, this improvement was not consistent. For instance, one caregiver reported improvement at school, but not at home. The other three reported home improvement, but none at school.

"Things have been going good and bad. Slight bit better at home. School, definitely not better. I'm totally OK with helping another family in crisis. I think that would be wonderful to do. I've been frustrated there's not enough services and you put trust in services and waiting lists and then you find out they aren't interested in helping you."

"My child's behavior has been improving but he's still struggling with school work."

"Teachers kept things bad for my child," one caregiver said. "My kid's reputation (due to teacher gossip) went before my child everywhere (at school)," the caregiver explained why things were better at home.

"My child's behavior is still pretty unpredictable at school. My child has an IEP and Special education designation, but no special ed. classes are needed yet. The school really wanted to move her to "504" and out of special ed. designation, but I wouldn't let them after her counselor said, "No!" (We've had) lots of crying jags and wraparound really helps with that."

Three respondents reported there had been no improvement noticeable in the past six months while in wraparound. Of these three, two reported that some aspects of their situation had actually gotten worse, in spite of wraparound. Both of these caregivers, however, emphasized that wraparound was not to blame for this, and said wraparound itself was going well. One caregiver attributed the decline to the fact that their family situation had deteriorated, and the other reported that wraparound itself was "going good," but that the situation with their child's behavior had declined.

"Home--we're still working on. At school, the behavior problems have gotten worse. I don't know how they would improve."

"I'm very worried about my son's violent behavior and our WF said to wait for the Child Study Center assessment but that will take 6-12 months (wait list) and I cannot wait that long. The services have helped with some things...me, for instance. But I need them to help my son's behavior and they aren't helping that yet."

"When I moved my children to this daycare, I thought it would be great because it is affiliated with Hand In Hand. But after three weeks they kicked out my son and said they don't serve kids with behavior as bad as his! They said this in front of him. I was so frustrated and disappointed! I cannot believe a daycare associated w/ Hand in Hand's partner was kicking him out! The meds and CSC appointment we had before wraparound have helped him."

FACILITATOR RAPPORT/WRAPAROUND TEAMS

Question #2: Is your wraparound facilitator (WF) easy to talk to? Do you feel she/he has your best interest in mind? Has she explained the graduation process to you? Has your wraparound team been meeting regularly? Please describe the makeup of your wrap team.

WF Communication/Support

Twenty-three caregivers (96%) said that their WF was easy to talk to. Twenty-two (92%) of the 24 said that they felt their WF had their best interest in mind. One caregiver said their WF was not easy to talk to and, likewise, the same respondent said that the WF working with them had their best interest in mind "sometimes," and described her frustration reaching her WF and not getting a return phone call within what she considered a reasonable time frame. One caregiver did not respond to the question.

GRADUATION

Wraparound requirements recommend that graduation be discussed from the very beginning of enrollment and that it be addressed at each meeting. In the year 2 reports, data showed that caregivers often did not answer the question about whether their WF explained the graduation process to them. Despite increased efforts by evaluators to try to get a response, this topic is still frequently avoided or skipped by caregivers. Only 18 (75%) of the 24 respondents answered and of these 18, 12 responded to 6 month follow up and 6 responded to 12 month follow up interviews. Six respondents (5 six month and 1 12-month) did not answer this part of the question at all and two said they did not remember (1-6 mo and 1- 12 mo.).

Seven caregivers said their WF had discussed graduation from the program with them although the same amount said the WF had not discussed graduation with them at all. Only a third of caregivers stated that their WF had explained graduation. However, this proportion jumps to 57% for those who were being interviewed at 12 months (who are typically close to graduating from wraparound services). This suggests that either graduation was not discussed early on with most families, or that it was not done in a way that families understood and/or remembered.

A few caregivers made comments that they are happy with their WF, but graduation had not been clearly explained to them.

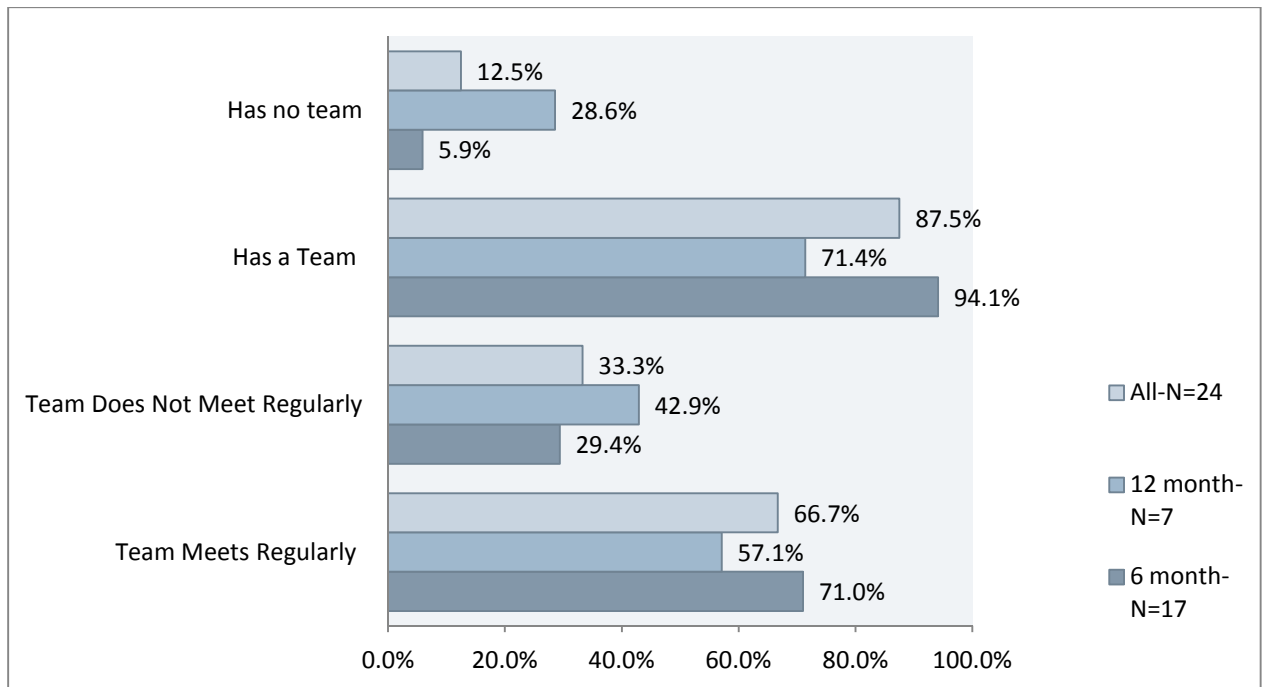
"Our WF is great and wonderful to talk to. She is always available when I need her and returns calls quickly. Graduation? She may have mentioned it and I don't remember. I don't think we have gone there yet."

"My WF is available and very easy to talk to. She always calls me right back. She hasn't explained graduation yet, but we are not ready at all!"

REGULAR TEAM MEETINGS

Forming a team and meeting regularly is another key component to wraparound. Of the 24 responders, only 16 reported having regular team meetings, although two of the 16 said they just started regular meetings. Twelve of the 16 (75%) are responding to six month follow up interviews while four (25%) are responding to 12 month interviews. Of the remaining eight (33.3%) who do not meet regularly, five have met before and have established a team. One of the five said they have not met regularly because they just started meeting. The other four have not met regularly for various reasons such as health, family situation, separation, etc. Three of the eight who do not meet regularly do not yet have a wraparound team. Of those three, two are responding to 12 month interviews and one is responding to a six month interview.

Figure Q 2: Team Meetings



TEAM COMPOSITION

Considering the above data, of the 21 who have teams, 20 answered the question regarding who is on their wraparound team. (Three of 24 respondents overall do not yet have a team.) One said they have a team that offers support and is "great," but did not answer who participates on it. Of the 20 who responded, four caregivers gave non-specific answers such as "friends," "family," or "friends and family," without giving numbers. The remaining 16 caregivers reported the following: (N=20)

- Eight (40%) reported a mom and dad (either biological or step parent) on the team in addition to the caregiver being interviewed. At least one of the biological mom and dad teams are divorced but still meet for the sake of the child.
- Ten (50%) teams include friends. Caregivers reported "best friends" on 3 teams.
- Extended family (i.e. Grandparents, aunts, sisters, etc.) on teams: 11 (55%) (grandparents most popular teammates: 7 (35%) of the 11.)
- Five (25%) reported teams with school or daycare/head start personnel, which includes speech therapist, bus driver, Head Start worker, teachers, school/daycare director.
- Faith-based community supports on team: 5 (25%) (from church or other faith based entities such as Christian Women's Work Group; Stephen's Ministries, etc.)
- Community Supports (other than faith-based) include an interpreter who is also a team member, not only to provide interpretation, neighbors (3 or 15% teams have neighbors), and some have Hand In Hand staff, not counting the facilitator. The Lead Family Contact sometimes serves on teams and the former project director serves on teams still.

Two caregivers reported unsolicited that they have had a change of opinion about the value of Wraparound Teams.

"I remember at the beginning of the program, I didn't think I needed a team. Man, am I glad I have their support now!"

"I never thought the way to fix a problem like ours would be to bring in extra people for a team, but it seems to be working well for us."

FAMILIES SPEAK OUT ABOUT FACILITATORS, RAPPORT AND TEAMS

*"Our WF is so easy to talk to. She has explained things to us, but we still feel we just started."
(At six month follow up.)*

"Lately, the WF won't call or text back when I call her, so no, she's not easy to talk to. She seems hard to reach. I've had to always go to her office. And we never have gas and she has not offered to reimburse us for gas. But, she has given me gas for the party that Hand In Hand had."

"I really like our WF. I did NOT like the first one! But this one really has our interest at heart. The team gives me support. They are mainly here for support."

"The WF is invested in our family."

"I think we need to re-pick our team. It seems the parents of the bio-parents aren't as involved or committed and don't come to meetings. I have others who want to be on team--a teacher and my partner would like to help. Still my child's dad (we're divorced) and WF and I meet every week for a team meeting until I can get the others lined up."

"My team is understanding. It's very hard (to find time to schedule people for meetings). I've had to get a job since my divorce and take care of my kids while working."

"My WF is so easy to talk to. She lets me call whenever I need to talk. It makes all the difference to know that someone cares."

"Our WF provided us with some suggestions for redirecting and other techniques and stuff we wouldn't have known without her. I think she's great!"

"Our daycare director and teacher from my child's previous daycare took off their lunch hour to do wrap meetings!"

"Most of the people I thought would be on my team became unreliable."

Question #3: Local Community Meetings For Families, Care Givers

Question #3 asks about participation in other community meetings besides wraparound team meetings. As a multi-agency, multi-partner initiative, Hand In Hand offers advocacy, advisory and support groups locally, in most of the five counties, as well as mental health educational classes and webinars through SAMHSA and the Federation of Families. Likewise, training and educational seminars and classes, advocacy, support and advisory committees are available through Mental Health Connection and its partner relationships with several local universities and colleges, hospitals and legal and cultural organizations. Specific parenting classes are

offered through the Parenting Center, a HIH partner. The most common community meetings families had participated in, the CET and playgroups, are described below.

Community Evaluation Teams (CET)

The creators of the Hand In Hand (HIH) Qualitative Study, the Community Evaluation Team (CET), (which was founded during the previous System of Care initiative in 2005) began inviting HIH Evaluation participants to join the CET gradually, during the latter part of the 2nd year of the initiative. Evaluators and wraparound-savvy parents understood that the first few months of wraparound are spent learning the process and developing trust for the team. After careful consideration of their own wrap experiences, CET members recommended that evaluators wait to invite families until the six month follow up evaluation interview, so caregivers would be able to consider the CET with less stress than they had when they first began wraparound. This "gradual recruitment" has proven itself in the history and demographics of the group. CET members, including evaluators, have always been much more concerned with--and, therefore, much more successful in-- recruiting long-lasting members, rather than recruiting many members who may only visit once or twice. Throughout recruiting, evaluators focused on families drawn to the idea of learning about evaluation and helping evaluators learn about families. CET meetings provide food, childcare, stipends and a separate travel reimbursement for each family in attendance. The CET goal is to develop a family-driven evaluation that will reciprocate by providing data to families to share with their community groups based on needs and strengths, a relationship that will eventually help to transform the System of Care.

Playgroups

HIH started Family Support Groups in the various counties, without much success, until the focus changed to one that emphasized the value of play. The Playgroups are designed for parents and their children, facilitated by the youth engagement specialist of HIH, a young father, who was under contract with HIH through Strong Fathers, Strong Families. This coordinator focuses on a lesson for the children and their parents and uses various games and activities to teach the kids and parents various skills, such as using your imagination (with a shower curtain spread out on the floor to become a Magic Flying Carpet), taking turns, as well as listening. Single mothers and fathers, as well as parents of all kinds are welcome to attend these playgroups that help parents remember what too many adults have forgotten -- how to play. These groups meet in three of the five counties so far.

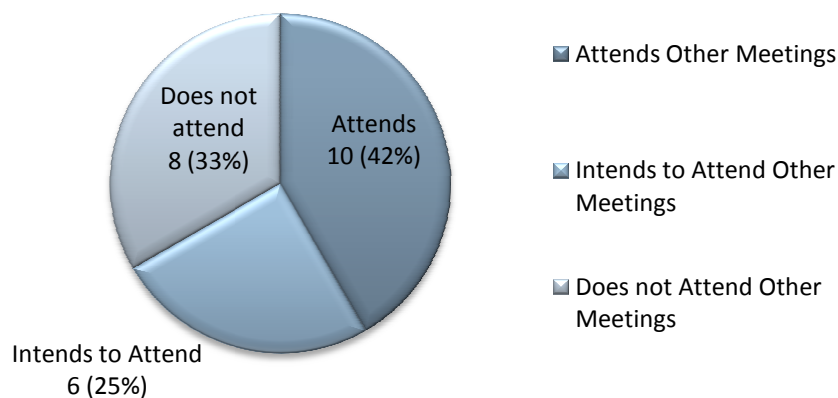
Caregiver Participation in Community Meetings

Question #3: Have you had the opportunity to participate in any other meetings (online or in person) such as support groups, advocacy groups or other meetings focusing on children’s emotional, behavioral and mental health? If yes, was the information helpful? If not, how could Hand In Hand help enable you to attend and encourage you to participate in such a meeting?

Of the 24 respondents, 10 (41.6%) said that they have attended other meetings since they began wraparound. Six (25%) said they have not yet, but fully intend to do so. And eight (33.3%) said they have not attended any other meetings and cited barriers such as transportation, childcare, job demands, time conflicts, distance, and family obligations, as reasons that they cannot attend such meetings, emphasizing that attending a meeting was not one of their current priorities. One of the latter said they just did not see how things could change so that they could attend in the future and one said they did not see a need to attend any other meetings.

The following chart illustrates the breakdown of those who have attended another community meeting, which ones have not attended and which ones said they had plans to attend. Information regarding which caregivers responding to 6 or 12 month follow ups, attended other meetings follows the chart.

Attending Additional Community Meetings (N=24)



The 10 (42%) who said they had attended other community meetings were split evenly between those responding to six month interviews (5, 21%) and those responding to 12 month interviews (5, 21%). Of the eight who do not attend meetings, seven (29%) were responding to 6 month follow up interviews, while one (4%) responded to the 12 month. Of the six caregivers who said they intended to attend a meeting soon, five (21%) were responding to 6 month follow ups and one (4%) was responding to the 12 month follow up interview. A look at CET attendance records indicates that following this data collection point, five of the six who said they intended to attend a meeting, visited the CET and four attended more than once, becoming regular members.

Strong Fathers Strong Families Playgroup was the meeting most of our caregivers attended (6). However, three caregivers attended the CET prior to the closeout for this report (as mentioned above, four more joined them after this closeout). One caregiver who attends the playgroups regularly, who is also a regular member of the CET, has attended webinar classes and presentations online and was invited to attend the Federation of Families Annual Conference as a Hand In Hand guest. Other groups attended by HIH families are the Head Start Board Meetings and Head Start Classes (1 family); a Strong Woman's support group; webinars and online classes were attended by two caregivers; one said she finds these online classes to be a good resource for her to keep her Foster Parent license up to date.

Families Speak Out about Attending Other Meetings:

"Not yet, but you'll get me to the CET if I know you! Just been too busy, so far." (to evaluator who invited caregiver numerous times.)

"I attended the Playgroup where I met other parents and exchanged numbers. This seemed geared for dads and kids more than moms. While it was good to meet others, I didn't learn anything new."

"I plan on coming to CET when I can get a car." (This caregiver visited shortly after.)

"I plan to attend CET this next meeting." (Caregiver joined CET and is regular member.)

"My WF has suggested I go to some of the other meetings, I just haven't yet. I'd like the CET --it sounds interesting. In the past with two jobs, I haven't had time. I hope I will now." (Caregiver found time for CET and is now a regular member.)

"No, honestly, I don't think we need to go."

"I've been a member of your CET and I like what I'm learning there."

"No, because of timing. I need transportation with lots of seats to haul me and my husband and all our kids."

"I've gone to Playgroups and a strong women's group from the shelter and they were helpful."

"Head Start board meetings and Parent meetings."

"No, but I want to attend the CET." (Caregiver is now regular CET Member.)

"I attend online sessions, webinars and classes on education and mental health. I also do this for my foster care license."

"We've signed up for Parenting Center classes and I'd like to try the CET."

Family Guide and Family Mentor

Question #4: Have you received the FAMILY GUIDE TO HAND IN HAND AND WRAPAROUND from your Family Mentor? (Follow up questions: Have you used it often? If yes, how has it helped you? If not, did you not find it helpful?) How often have you spoken with your Family Mentor? Has the FM provided an additional, helpful resource for you to use?

The Family Guide

The first part of Question Four asks the respondent if they have received the FAMILY GUIDE TO WRAPAROUND, how often they used it and if they found it very helpful. The Guide is one of the first resources that families in Hand In Hand receive. This Guide is a detailed guide to wraparound with research information, definitions of common terms, charts and tables and is designed to be a Wraparound 101 for the family. The Lead Family Contact adds personalized information to the Guide for each family based on her interview with them or the WF's knowledge of them and sends it out. This makes the Guide a more individualized resource for the family. For example, if a family is very interested in parenting classes, the LFC would most likely include The Parenting Center's Schedule of upcoming classes along with information regarding the type of class, instructor's experience, cost and a contact number with information on enrolling. The Guide is one of the first resources new families in Hand in Hand receive and it is usually sent within the first few days and/or weeks of a family's enrollment in wraparound, therefore, it is one of those processes set in place with a great deal of emphasis on the principles of System of Care - specifically individualized services - and an example of how Hand in Hand strives to continue these principles.

Of 24 respondents, only one (a six month respondent) reported that they did not receive a Family Guide); one said she thought she received it, but could not remember (a 12 month

respondent); while another said she didn't need it (a 12 month respondent); leaving 21 who remembered receiving the Guide. Of these 21, one said it was lost in the move, but she hadn't used it (a six month respondent), another failed to answer the question, (also a six month respondent). Then, out of the remaining 19, two six month respondents and one 12 month respondent said they never read it, leaving 16 respondents who reported that they read the Guide at some point.

Overall, four six-month respondents and two 12-month respondents (6 of 16 or 37.5%) indicated that the Guide was very helpful. Five (32.5%) six-month respondents and 1 (6.25%) 12 month respondents mentioned that the Guide was good to have on hand in case they needed to look up information or a resource. A few (one of each a six- and a 12-month (2, or 12.5%) responded less specifically that the Guide was "Somewhat Helpful." And finally, 2 (12.5%) said they rarely used the Guide.

Families speak out on Family Guide

"I had one but I think it got lost in the move."

"Yes, that orange folder right there. I don't read it much, but it is nice to have when I need to look something up."

"My Family Guide helped me build my wrap team!"

"I haven't read it but I know it is there if I need it."

"When I need to look up something about wraparound, I can use it. I don't use it much, though."

"I rarely used it."

"It's helped very much."

FAMILY MENTOR

The second part of the fourth question asks about the amount of contact with the Family Mentor, assigned to each family. Some aspects of the program have changed since these questions were written by the CET. The plan for Family Mentors originally called for multiple mentors, but due to training and other time consuming efforts, there was no team of family mentors ready to go. Therefore, the Lead Family Contact, LFC, for Hand in Hand, has doubled as the Family Mentor.

Of the 24 respondents to the question if they had a Family Mentor, 19 (79%) respondents said yes. Of the remaining five, 4 did not answer the question and one said they did not have an FM. Of the 24 respondents, 17 were six-month interviews with 12 answering that they had a

mentor and four not answering the question. Seven of the answers were 12 month interviews with 3 being yes and four not answering.

Families speak out on Family Mentors

"The FM told us about support groups and she said I could call, but I haven't called because the WF takes care of most of my needs."

"I remember talking to her at the beginning and she was very assuring and nice. I haven't called her since then, though, because my WF is the one I call."

"My mentor has helped a lot!"

"My mentor is on my team!"

"I haven't spoken to her recently, but she was very helpful."

"I know who you are talking about. She was sweet and helpful."

"Yes, I spoke to her at the beginning, but I haven't needed to call her since."

"I talked to someone at the beginning, I don't remember much."

"She's great. I've talked to her a couple of times. She's trying to find us a psychiatrist."

"To a certain extent, the FM has been an additional resource, especially early on. I haven't spoken to her lately. I haven't needed her as much as other families do."

"I talk to her about once a month. She is an additional resource for me."

Gains from Wraparound

Question #5: Have you gained anything from wraparound that has helped you while working with your child and family?

This question is less specific in order to give the respondent a chance to answer anything that may come to mind. Of the 24 respondents to the questionnaire, one did not answer the question (a 12-month respondent) and four (4) said no.

Two of the respondents (both six-month respondents) who said no indicated that they had not really started yet.

"At this point since our wraparound team is just getting started, I have gained a little from the process so far but hope to gain more in the months to come."

"Not yet. Haven't been doing wrap."

Another caregiver said they did not really get anything out of wraparound but they were just glad they had the WF to talk to, and was answering a 12-month interview.

"Not really gained anything from wrap that has helped overall, but I'm just glad I have (WF) to talk to."

The "no" response transcribed above seemed frustrated about a referral to a resource that did not pan out and was a six-month respondent.

"No...haven't gained anything really. I wish. I'm really frustrated, though. It has helped me. But not with child's behavior. I need help with my son's violence and I don't see why we have to wait 6-12 months when he's violent. WF did help us, but she hasn't helped my son yet. (Respondent had mentioned previously about a 6-12 month wait for the Child Study Center)."

Of the 19 who did feel they got something out of wraparound, there were a great variety of answers. Many respondents (10 of the 19) mentioned that wraparound has helped them change something about themselves that might have been a barrier to parenting their child.

"I learned a little more patience. I learned to be more open--not so closed off as I was. I'm much more open to suggestions than I used to be."

"Wraparound has helped me understand my son."

"I learned about time-outs, talking in short sentences--all help me get better results with my child. These help me parent better. Oh, and I learned about reading books to the kids."

"I learned about redirecting."

"Coping skills for me and obtaining resources for my son."

"Patience. Patience to try new activities to calm my child."

"I learned how to cope better with him, help him and get services for him."

Several respondents talked about **emotional support** from the WF and one or two mentioned getting it from the team. Six answered the emotional and or financial, informational support was what they gained. Others mentioned some self-growth items such as **"I learned I can be dependent on myself."** And one said they learned how to **"give opinions and take advice."**

"I can enjoy Christmas again, now, thanks to you all and HIH and especially, my WF! Ever since my mom died, I haven't been able to really be around the trees and decorations and lights without feeling horrible, because she always did all the decorations just right on Christmas for all of us. However, since my WF brought me a big bag of toys for my son and presents for me, too, (which really shocked me), and a turkey with all trimmings, and showed so much love and compassion, I can now enjoy the holiday again. I am so grateful for everything--I never expected anything like that!"

Follow Up Questions for Families out of Wraparound

Only three respondents who participated in the evaluation had either graduated or ended services with wraparound. A different set of questions was asked for these families who were no longer in services. All three were responding to 12-month interviews at this data collection point.

Question 1: Even though your wraparound facilitator no longer attends your wrap meetings, does your wraparound team still meet regularly to provide support that your family may need? 1a) Has the make-up of your team changed in the last six months? If so, how? Have you talked to your wraparound facilitator since you completed services and if so, for what purpose? 1b) If your wraparound Team is no longer meeting, what else could Hand In Hand have done to help you maintain your team? What other supports could you have used to maintain your team?

It appears that one of the three is still meeting with their team to work on their child and family's improvement. The other two never had a team in the first place when they were working with Hand In Hand. One of these families mentioned trying to talk to the WF after closing services.

"We never got a team set up so the make-up hasn't changed. At first, after WF closed us out, I tried to call her and she never called me back. This upset me a lot at first, but then I thought about it and understood."

Question 2: How often have you spoken to your Family Mentor from Hand In Hand since ending services? How often do you use the Family Guide? Which parts do you find most helpful? Can you think of anything else that should be included in the Family Guide?

To this question, all three answered in the negative.

Question 3: Have you attended any meetings such as support groups, advocacy, evaluation, or other community meetings which focus on children's emotional, behavioral and mental health? If so, how much have you participated in these meetings? Would you recommend these meetings to other families with problems similar to your family's problems?

When asked about attending community meetings, one of the three was active in the Advocates for Children of Trauma and recommended this group as a good resource. One caregiver commented that he/she had attended a support group for the college classes he/she was taking and would love to find some kind of support group for parents of challenging kids. He/she is still looking for one such group in one of the outlying counties. *"I really need one (a support group) where I can learn from other parents."*

Question 4: Do you feel that you and your family were adequately prepared and empowered to continue the wraparound meetings and coordinate services for your family after graduation from Hand In Hand? If not, in your opinion, what more could Hand in Hand have

done to offer an easier transition? If yes, please describe your transition with the close-out of services.

This last question brought forth the most detailed responses for this small group of families out of services. To this, one caregiver said that she disagreed with the idea of having to have a team to stay in services. *"I think HIH is wonderful,"* she said. *"But, I just wish they had changed that aspect of it."* Having a team is a core principle of wraparound, so most likely this caregiver needed case management or family intervention, something besides the wraparound model. The difficulty is to find this out before these families before they sign up for wraparound.

However, the same caregiver admitted some of this on his/her own in the last question. *"You know, I was just so used to doing so much on my own for myself and by myself, I just feel like I resisted the team concept because of this."*

When the question asked if families were adequately prepared, one answered, *"Not Applicable -- we never really used the team approach."* Another felt that wraparound let them down. *"No. I feel as if they closed us out to be rid of us and our problems."*

EVALUATION OF THE MULTICULTURAL (CBMCS) TRAINING

An area of weakness identified by the system of care community is the provision of culturally and linguistically competent services to families. A major focus during years two and three of Hand in Hand has been to provide multicultural competency training to wraparound facilitators and community partners and to develop a train-the-trainer model for the system of care. The purpose of the training and the development of a train-the-trainer model is to work towards meeting and sustaining the strategic plan objective to *integrate cultural and linguistic competence into SOC through community training, development, and educational activities.*

Dr. Gloria Morrow, one of the nation's leading clinical psychologists, is a Master Trainer for the CBMCS (California Brief Multicultural Competency Scale) Training Program. This program focuses on four major ethnic groups: African American, Asian/Pacific Islanders, Hispanic/Latino/Mexican American, and American Indian/Native American. Leadership of Mental Health Connection and Hand in Hand invited Dr. Morrow to provide multicultural training to executives and practitioners and to train and prepare local community trainers.

Executive and senior level managers participated in the first training provided by Dr. Morrow. The next round of training was provided to practitioners in the community. The practitioner training was four days in length. The first two days were held in October 2009 and the last two days were held a month later in November 2009. The goals of the Practitioner Training were aimed at the following:

1. Increasing Multicultural Knowledge - Issues of acculturation, racial/ethnic identity language, etc.;
2. Increasing Awareness of Cultural Barriers - Discuss challenges accessing mental health services;
3. Assisting in Sensitivity to Consumers - Review what it means to be a person of color AND a mental health consumer of services; and
4. Reviewing Socio-cultural Diversities - Review issues of gender, sexuality, aging, social class, and disability.

The next round of training was focused on developing local CLC trainers in a train-the-trainer model. Dr. Morrow returned to the community in late February 2010 to provide a week-long, intensive training on CBMCS to a select group of practitioners who had attended the practitioner training in October and November. Under the supervision and guidance of Dr.

Morrow, trained practitioners will provide the cultural competency training to others in the community. In April 2010, the newly trained CBMCS trainers provided their first community training.

Between October 2009 and August 2011, 237 participants completed the training and of these, 212 completed the California Brief Multicultural Competence Scale (CBMCS), a self-reported measure of multicultural competence, prior to and at the completion of training. The CBMCS measure is composed of 21 items utilizing a four point Likert Scale aimed at measuring multicultural knowledge, awareness of cultural barriers, sensitivity and responsiveness to consumers, and socio-cultural diversities. Participants were asked to rate responses from 1 to 4 (strongly disagree to strongly agree).

At pre-test, the weakest areas noted by participants were the ability to assess the mental health (MH) needs of gay men and of lesbians, the ability to identify the strengths and weaknesses of psychological tests for different cultures, and knowledge of acculturation models for various ethnic minority groups. The strongest areas at pre-test were awareness of the challenges of being born a minority, awareness of how a professional's own values might affect the client, and communication skills appropriate for clients. Paired item t-tests indicated that all areas showed significant improvement from pre- to post-test for the combined scores. The areas showing the greatest improvement were knowledge of acculturation models for various ethnic minority groups, ability to discuss in a group differences among ethnic groups (e.g., low SES Puerto Rican vs. high SES Puerto Rican client), ability to discuss research on MH issues and culturally different populations, awareness of institutional barriers that may inhibit minorities from using MH services, and awareness that being born a white person carries certain advantages. The areas showing the least (but still significant) improvement were communication skills appropriate for clients (which was already high at pre-test) and ability to assess the MH needs of persons with disabilities (Table 1).

**Table 1: California Brief Multicultural Competence Scale Pre-Post Test
(N = 212)**

	Pre	Post	Diff.	P Value
1. Aware of challenges of being born a minority	3.42	3.77	.35	< .001
2. Aware of how own values might affect client	3.37	3.67	.30	< .001
3. Able to assess the MH needs of persons with disabilities	2.41	2.59	.18	< .01
4. Aware of institutional barriers that affect the client	3.09	3.41	.29	< .001
5. Able to assess the MH needs of lesbians	2.04	2.46	.42	< .001
6. Able to assess the MH needs of older adults	2.28	2.52	.24	< .001
7. Able to identify strengths & weaknesses of psychological tests for different cultures	2.13	2.59	.46	< .001
8. Aware that counselors frequently impose own cultural values	2.87	3.40	.53	< .001
9. My communication skills are appropriate for my clients	3.20	3.33	.13	< .01
10. Aware that being born a white person carries certain advantages	3.18	3.75	.57	< .001
11. Aware that cultural background and experiences influenced my attitudes about psychological processes	3.18	3.61	.43	< .001
12. Able to critique multicultural research	2.21	2.67	.46	< .001
13. Able to assess the MH needs of men	2.26	2.58	.32	< .001
14. Aware of institutional barriers that may inhibit minorities from using MH services	2.89	3.46	.57	< .001
15. Can discuss w/in a group, differences among ethnic groups (eg., low vs. high SES)	2.24	2.93	.69	< .001
16. Can identify my reactions that are based on stereotypical beliefs	2.93	3.41	.48	< .001
17. Can discuss research on MH issues and culturally different populations	2.48	3.11	.63	< .001
18. Able to assess the MH needs of gay men	1.93	2.36	.43	< .001
19. Knowledgeable of acculturation models for various ethnic minority groups	2.14	3.06	.92	< .001
20. Able to assess the MH needs of women	2.50	2.84	.34	< .001
21. Able to assess the MH needs of persons from poor SES	2.46	2.80	.34	< .001
Total	2.63	3.06	.43	< .001

CONCLUSIONS

Many families who have entered into wraparound reported that they were satisfied with the process into Hand in Hand, felt respected, and felt comfortable upon meeting their wraparound facilitator. Nearly all of the families identified that they sought help because of serious problem behaviors exhibited by their child to include verbal and physical violence and self-harm behaviors.

Clinical outcomes improved significantly in many areas. Building strengths and protective factors forms a key part of wraparound and results indicate that children in the program have significantly improved in these areas. At 6 and 12 months after enrollment, children are significantly less likely to be impaired in their daily life and their caregivers feel significantly less strain than they did when they started the program. Although improvements in behavioral problems were not significant, past research from the Community Solutions Final Report (2009) and Quarterly Reports indicates that changes in this area typically happen somewhat later than improvements in strengths and continue well after 12 months. Future reports will be able to determine if a similar pattern will be seen in Hand in Hand families.

Nearly all caregivers felt that their primary service provider attended to their cultural needs and took their beliefs and traditions into account. Although most caregivers were satisfied with services after 6 months, just over half of caregivers reported being satisfied with the improvements in their child's mental health symptoms and functioning. This may relate to the clinical findings that problem behaviors were not significantly reduced. Most caregivers reported overall improvement, but this could primarily reflect building strengths and reducing their stress.

The length of time it takes a family to get from referral to intake and from intake to meeting with their wraparound facilitator can be lengthy, in one instance as long as a 114 days from referral to intake and 148 days from referral to first meeting with a wraparound facilitator. The average time it takes from referral to intake is 11 days. This time has been cut nearly in half from year 2. The average time it takes from referral to first meeting with a wraparound facilitator is 33 days. Approximately 53% of families referred to Hand in Hand dropped out before signing a wraparound agreement.

A number of families (17) have been placed on the waitlist. While it is unclear what the long-term impact of this is, qualitative results suggest that caregivers appreciated efforts by Hand in

Hand staff to refer them to resources and stay in contact with them while they waited to be assigned a Facilitator. Both waitlisted and non-waitlisted families also had access to the Family Guide and Lead Family Contact which they felt were helpful resources.

Another area of note is the difference in the number of families with Child Protective Services involvement (28.4%) and the number of CPS referrals to Hand in Hand (9.4%). In addition, the lack of CPS presence on family teams further suggests a lack of connection between CPS and Hand in Hand. However, major initiatives to increase CPS referrals were not initiated until the latter half of year 3 and thus may not have had time to substantially impact referral rates.

Caregivers seem to have a greater understanding on the wraparound process (including having a team) upon enrollment in year 3 than they did in year 2. Informal supports are important for sustaining teams after services, and most teams did include extended family and many also had friends and other community supports. However, a few areas of concern emerged about services. A few families (12.5%) did not have a wraparound team developed. Thirty-three percent of the families that did have a team did not meet regularly even after 6 or 12 months of service. In addition, graduation is often not discussed until families are nearing the end of services.

Hand in Hand has also had an impact within in the system of care community. This includes the continuation of the Cultural and Linguistic Competence training which trained 237 participants between October 2009 and August 2011. Training participants report an increased awareness of institutional barriers and other issues faced by minorities. In addition, several families in services reported that they had attended or intended to attend other meetings in the community.
