Evaluation Report
Year Two

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 two of the six year grant cycle (October 1, 2009 – September 30, 2010). 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

In most cases, families enter Hand in Hand through the following sequence: Referral, Intake with Clinical Director, Peer to Peer Contact with a Family Mentor, Wraparound Facilitator Contact, and Wrap Agreement Signed. If a family is not eligible for services, does not need services, or chooses not to continue into services, they will not move to the next point of contact. Following are the key findings of the intake and referral process into Hand in Hand.

- One hundred-eight (108) children were referred into Hand in Hand during year two.
- Seventy-eight (78) children received intakes to Hand in Hand during year two.
- At least 17 (16%) 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 21 with a range from -6 days to 104 days.
- Of the 78 children with an intake, 30% were referred from the mental health system.
- Twenty-three percent (23%) of those with an intake were referred by a child's caregiver.
- Twenty percent (20%) of those with an intake were referred through Early Childhood Intervention
- Six point seven percent (6.7%) of referrals receiving an intake were made through Child Protective Services.
- Of the 78 children receiving an intake, over 46 percent of the children had received mental health services prior to Hand in Hand
- Twenty-six percent (26%) of the 78 families had come in contact with Child Protective Services prior to referral into Hand in Hand.
- The most prevalently reported presenting problem was disruptive behavior, which was identified in 93.1 percent of the children.
- 48 families (44% of referred families) went on to have contact with a wraparound facilitator.
- A total of 40 families (50%) entered into wraparound and signed a wraparound agreement by the end of September 2010.
- The average number of days from intake to entering into wraparound for families was 45 days, with a range from 0 days to 120 days.
- Families who did not sign wraparound agreements were significantly more likely to have longer amounts of time between Intake and first Wraparound Facilitator contact.

National Evaluation

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 and Local Evaluation Measurement Instruments and qualitative questionnaires. Of the 39 families, 37 have been enrolled in evaluation. One family was not invited to participate due to entering wraparound prior to the national evaluation

protocol being finalized (thus making them ineligible) and one family chose not to participate. Caregivers and children choosing to participate are evaluated across life domains at intake and every six months out to 24 months.

Key Findings from National Evaluation Quantitative Measures (n = 30)*

- Seventy-three point one percent (73.1 %) of the children are male.
- Average age of the children is 3.8 years old.
- Eighty percent (80 %) of the children are white.
- Seventy-three point one percent (73.1%) of the children live or have lived with someone with depression.
- Fifty percent (50%) have lived with someone with a mental illness other than depression.
- Twenty-three point one percent (23.1%) have witnessed domestic violence.
- Eight percent (8%) have been victims of physical abuse.
- Eight percent (8%) have been victims of sexual abuse.
- Fifty-eight point three percent (53.3%) live below the poverty level.
- Caregivers were experiencing a significant level of stress due to their child's mental health problems.

*Data from the National Evaluation was available through August 31, 2010 rather than through September, thus accounting for the smaller sample size being reported.

First Six Month Follow-up (n = 12)

Of the 37 families in the evaluation, 12 reached their first six month follow-up interview by September 2010. Due to the small number of families with 6-month data, the findings must be viewed with caution. Key findings of the first six month follow up are as follows:

- One hundred percent (100%) of caregivers either "agreed" or "strongly agreed" that the services they are receiving are the right services for their family.
- Fifty-eight percent (58%) either "agreed" or "strongly agreed" they are getting the help they wanted.
- None of the 12 caregivers reported positive levels of their child's functioning at baseline; however, 8 reported positive levels after 6 months of service.
- Most families (81%) reported they were socially connected at baseline.
- No utilization of psychiatric hospital beds was reported at either baseline or follow-up.
- Overall, caregivers reported that they were satisfied with the services they have received thus far.
- Caregivers feel their primary service provider, usually their Wraparound Facilitator, provides services in a culturally competent manner.

Qualitative Questionnaires

The Community Evaluation Team (CET), an advisory committee within the System of Care which is comprised of caregivers, youth, and the Hand In Hand Evaluators developed three qualitative questionnaires administered at different time points. The first questionnaire (intake questionnaire) is conducted after intake into wraparound. The second interview is conducted

every six months while in Hand in Hand. The third survey is conducted at time of exiting Hand in Hand. The purpose of the questionnaires is to allow caregivers the ability to express their experiences in Wraparound in their own words. Following are key findings from the intake and the six month follow-up questionnaires.

The Intake Questionnaire (n=37)

- Caregivers reported they were seeking help due to the behaviors of their children which included both verbal and physical violence and harm to self.
- Fifty-one percent (51%) identified home as the location where the problems occur.
- School was the second most common response (37%) of where the problems occur.
- Eighty percent (80%) of caregivers reported they were comfortable talking to their Wraparound Facilitator about their families' problems.
- Caregivers reported feeling overwhelmed or not knowing what to do prior to Hand in Hand.
- Eighty-percent (80%) of caregivers reported that their Wraparound Facilitator and/or Family Mentor described the wraparound process and the family team in a manner they understood.

The Follow-up Qualitative Questionnaire (n = 12)

- Eighty percent (80%) of caregivers reported experiencing improvement or great improvement in their family situation since beginning wraparound.
- Twenty percent (20%) reported that they have not seen any improvement.
- Seven caregivers (58%) reported having a family team in place, of which, six (50%) families reported that their team met regularly.
- Of the families with wraparound teams, most teams have between three to five members who include their Facilitator, either the biological mother or grandmother, and either the father or grandfather.
- Forty-two percent (42%) reported that their facilitator had explained the graduation process.
- The majority of caregivers reported that they have come to count on their Wraparound Facilitator.

Recommendations for Continuous Quality Improvement

- Identify ways to reduce the amount of time between referral and intake for families.
- Review the process between referral to the time a family signs their Wraparound Agreement and look for ways to reduce the amount of time between the two points.
- Increase presence of Hand in Hand with Child Protective Services
- Work with Wraparound Facilitators to identify strategies to building family teams early.*
- Monitor frequency of family team meetings and seek solutions to barriers that keep teams from meeting frequently.*
- Meet with community partners such as Pecan Valley MHMR to ensure staff are knowledgeable of eligibility criteria and services that can be provided through Hand in Hand.

*The Evaluation team is completing a fidelity study of the wraparound process

The Children and Families Served by Hand in Hand
Year Two of Grant Cycle (2009-2010)

Catchment Area and Population of Focus

The population of focus for Hand in Hand is children aged birth through six. To be eligible, the child must reside in one of five counties to include Tarrant (excluding the city of Fort Worth), Johnson, Hood, Parker, or Palo Pinto. To be eligible for services, the child must have a mental health diagnosis or be at "imminent risk" based on the child's score on the Ages and Stages Questionnaire (ASQ)-SE.

Tarrant County is primarily an urban and suburban area with a population of 1.8 million that includes the city of Arlington, located between Fort Worth and Dallas. Tarrant County is the most diverse of the counties served—over one quarter (26%) of the population is Hispanic, and 14 percent is African-American. There is also a growing Pacific Islander (Tongan) population in Tarrant County. Population statistics are found in Table 1. The other counties have a lower proportion of Hispanic and African-American residents. Johnson and Hood counties, which lie south and southwest of Fort Worth, are more rural, and Palo Pinto and Parker Counties, to the west of Fort Worth, are rural counties.

Table 1: Hand in Hand Demographic Statistics

	Hood	Johnson	Palo Pinto	Parker	Tarrant
Population	50,000	154,000	27,000	112,000	1.8 million
Hispanic	10%	17%	17%	10%	26%
African American	1%	4%	3%	3%	14%
Under 5	6%	7%	7%	6%	9%
Primary language other than English	8%	12%	11%	7%	22%

Source: Hand in Hand

Referral and Intake into Hand in Hand

Tables 2 and 3 describe the reasons families did not move on to the next stage of service. At least 12 (11%) of 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 2 and may have received additional contacts or services in year 3 that are not reflected in this report.

Table 2. Days between POC 10/1/09 – 9/30/10

	N	No Response	Moved out of Svc Area	Not Eligible	Declined	Open*	Moved to Next Step
Referral	108	2	0	9	15	4	78
Intake	78	5	3	2	5	4	59
Peer to Peer Meeting	59	2	2	1	4	3	48**
WF Meeting	48	2	0	0	5	1	40

* Some may have been contacted after 9/30/10; ** 1 Caregiver met with the WF without having met with Peer to Peer.

Table 3 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 that might better suit their needs. Passive refusals (eg., 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 3. Reasons for Declined/Not Eligible Service 10/1/09 – 9/30/10		
	After Referral	**After Intake**
Declined		
Caregiver not interested	6	4
Caregiver not interested/ Found other services	5	0
Caregiver not interested/ Lack of time	2	0
Referred to PVMHMR for assessment	1	0
Unknown	1	1
Not Eligible for Services		
Older than age range served	4	0
Out of areas served	4	0
Autism diagnosis	1	1
Did not meet criteria for imminent risk or diag.	0	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. However, in some cases the WF contacted the family before the Peer/Mentor; and in two cases a family had no peer to peer contact but did meet with a wrap facilitator. In one case the Intake occurred before the Referral. Families who did not need services, were ineligible for services, or chose to decline services did not move to the next point of contact. Seventy-five percent of families met with their WF within 60 days of Referral and 89.6 percent met within 76 days. However 10.4 percent of families (5 families) did not meet their WF for 120 days or more. These results are shown in Table 4.

Table 4. Days between POC 10/1/09 – 9/30/10*						
	N	**Mean Days**	**Median Days**	**Range of Days**	**25% Cases ≤**	**75% Cases ≤**
Referral to Intake	78	21	13	-6 to 104	3	28
Intake to Peer to Peer	59	13	9	-2 to 49	2	20
Peer to Peer to WF Meeting	46	22	17	-4 to 133	10	27
WF Meeting to WA Signed	40	12	6	0 to 68	0	9
Referral to WF Meeting	48	54	46	4 to 194	30	63
Intake to WF Meeting	48	36	32	0 to 148	21	46
Intake to Wrap Agreement Signed	40	45	35	0 to 120	24	55

* Some may have been contacted after 9/30/10. Note that some points of contact may have occurred in slightly out of order for some clients.

A t-test comparison was used to compare families who had signed wraparound agreements (N = 40) with those who were referred before July 2010 who had never signed a wraparound

agreement (N = 7). Families who did not sign wraparound agreements were significantly more likely to have longer amounts of time between Intake and first WF meeting (average 21 days or longer, $P < .05$) and between Peer contact and first WF contact (average 22 days longer, $p < .01$). This suggests that if there is a long period of time between the peer and the WF first contact, the family is less likely to become enrolled in wraparound. These results of those who signed wraparound agreements are shown in Table 5.

Table 5. Days between POC 10/1/09 – 9/30/10 for Families who Signed the WA						
	N	**Mean Days**	**Median Days**	**Range of Days**	**25% Cases ≤**	**75% Cases ≤**
Referral to Intake	40	19	12	-6 to 104	3	20
Intake to Peer to Peer	38	14	9	-2 to 49	3	21
Peer to Peer to WF Meeting	38	19	15	-4 to 64	9	23
WF Meeting to WA Signed	40	12	6	0 to 68	0	9
Referral to WF Meeting	40	51	45	4 to 180	29	60
Intake to WF Meeting	40	33	32	0 to 95	19	43
Intake to Wrap Agreement Signed	40	45	35	2 to 120	24	55

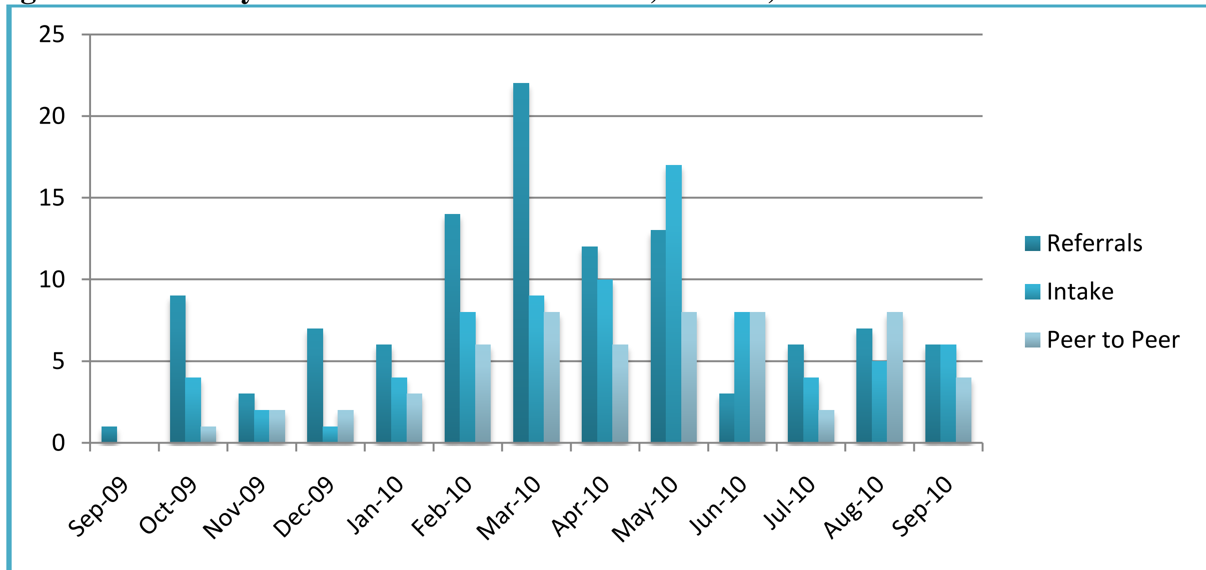
* Some may have been contacted after 9/30/10. Note that some points of contact may have occurred in slightly out of order for some clients.

Excluding cases that are still open (12) and that are definitely ineligible (12), 40 out of 84 (47.6%) referrals went on to sign wrap around agreements.

Enrollment Rates

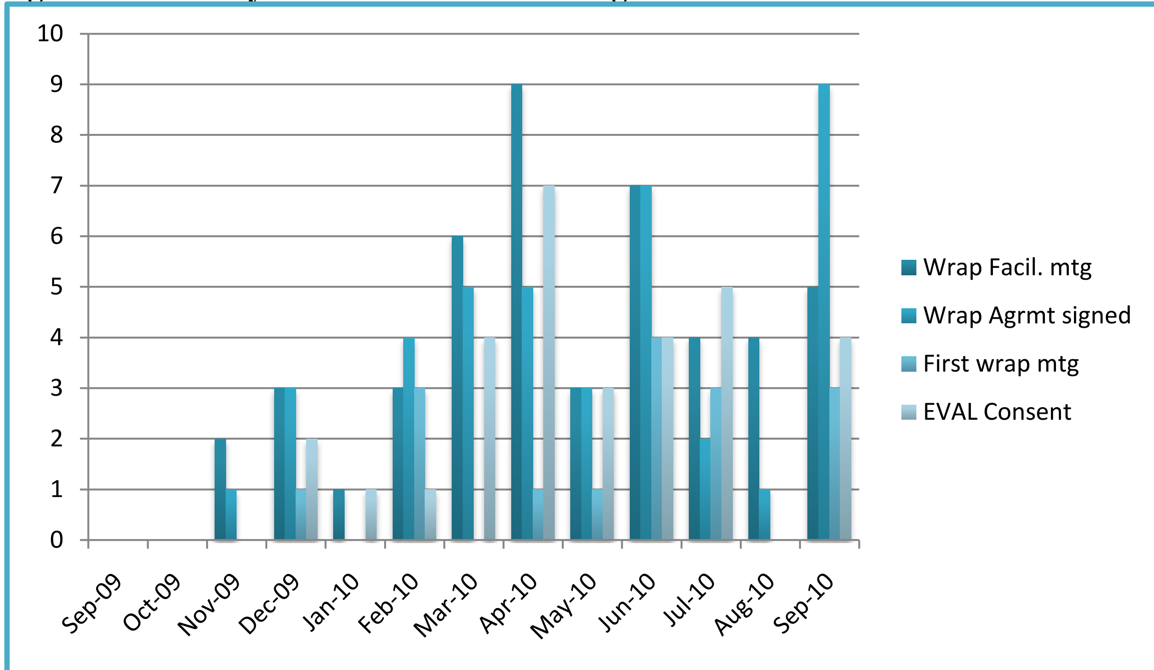
Hand in Hand wraparound services began in November 2009 after all facilitators had been hired and trained. The national evaluation protocol was not available until late December 2009. On average from November 2009 to September 2010, Hand in Hand received 9 referrals, 6.5 Intakes, and 4.8 Initial Peer to Peer Contacts a month. The amount of referrals in a given month varied widely with one month seeing as many as 22 and others as few as 3 referrals, as shown in Figure 1.

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



On average, from November 2009 through September 2010, Hand in Hand had 4.3 first meetings with the WF and 3.6 Wraparound Agreements signed per month. From December 2009 through September 2010, an average of 1.6 families had their first Wraparound Meetings and 3.1 families per month were enrolled in evaluation (and completed a baseline), as shown in Figure 2.

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



Children Enrolled October 1, 2010 – August 31, 2010

A total of 30 children were referred to Hand in Hand and completed the Enrollment and Demographic Information Form (EDIF) between October 1, 2010 and August 31, 2010.* Of those, the average age at time of referral was 3.8 years and the majority were male (73.3%) and White (80%). (Table 6)

Table 6: Demographics (n = 30) *	
Characteristic	**Percent**
Gender	
Male	73.3%
Female	26.7%
Average Age at Intake	
Average Age	3.8 years
Age Group	
Birth to 3 years	40.0%
4 to 6 years	60.0%
Race/Ethnicity	
American Indian or Alaska Native	3.3%
Asian	0.0%
Black or African American	10.0%
Native Hawaiian or Other Pacific Islander	0.0%
White	80.0%
Hispanic/Latino	6.7%
Multi-Racial	0.0%

*September data was not available at time of report.

Enrollment and Demographic Information form (EDIF). This report is based on data collected by Hand in Hand from October 1, 2009 through August 31, 2010.

Intake Referral Information [a] and Agency Involvement [b,c]

The majority of children were referred to Hand in Hand through the Mental Health Sector (30 %). Twenty-three percent (23%) of the children were referred by their caregiver; and 20 percent were referred through Early Child Intervention. Prior to referral into Hand in Hand, over 46 percent of the children had received mental health services. Twenty-six percent of families had come in contact with Child Protective Services. (Figures 3 and 4)

Figure 3: Referral Source (n = 30)

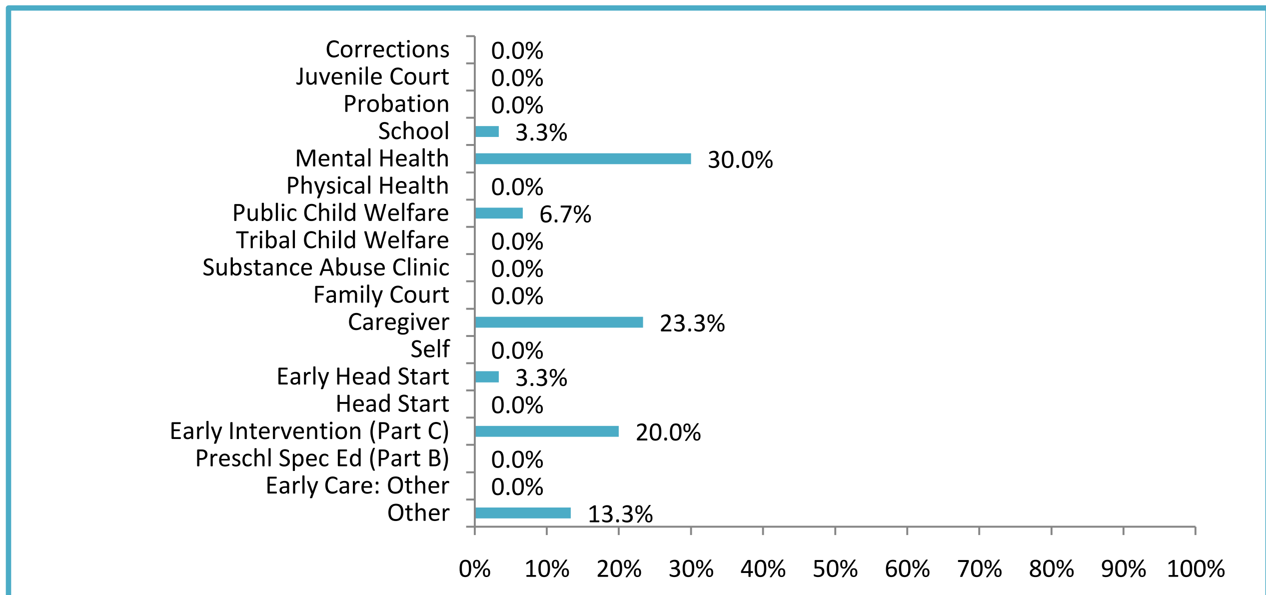
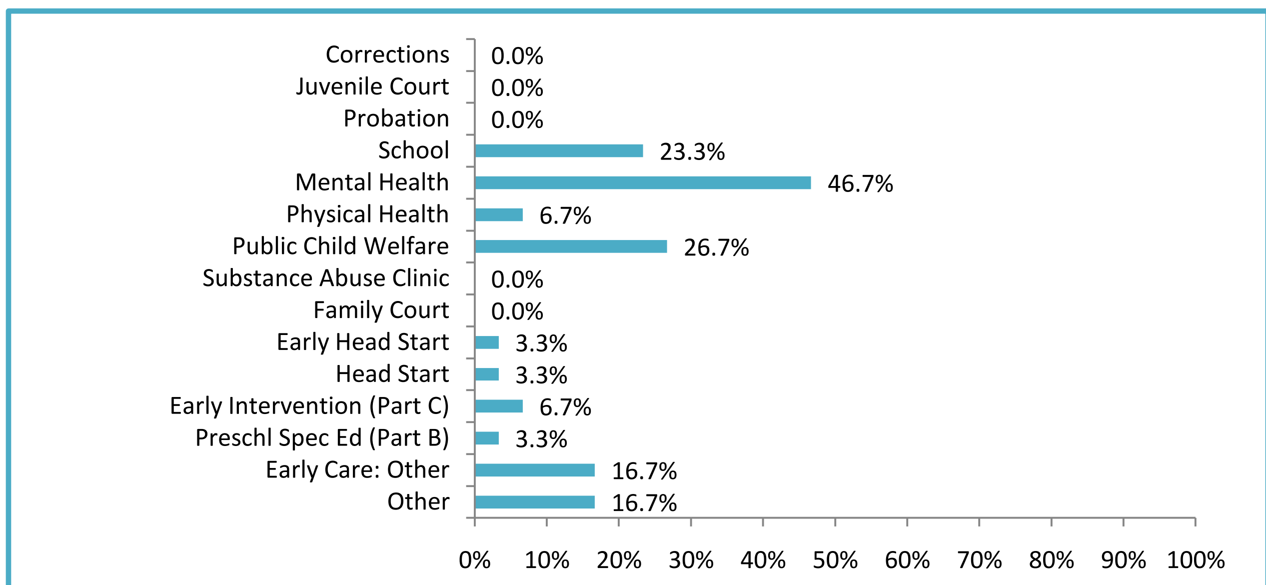


Figure 4: Agency Involvement at Intake (n = 30)



[a] Data reported were collected using the Enrollment and Demographic Information Form (EDIF).
[b] Because individuals may report involvement in more than one agency, percentages sum to more than 100%.

Diagnoses at Intake

Fourteen of the children entering Hand in Hand (47%) had a mental health diagnosis or diagnoses prior to referral (Table 7). Of the 14 children, the most common mental health diagnoses were externalizing disorders, with Attention Deficit Hyperactivity Disorder (ADHD) being the most prevalent (57.1%). The majority of children had more than one diagnosis prior to referral to Hand in Hand. These results are shown in Table 7.

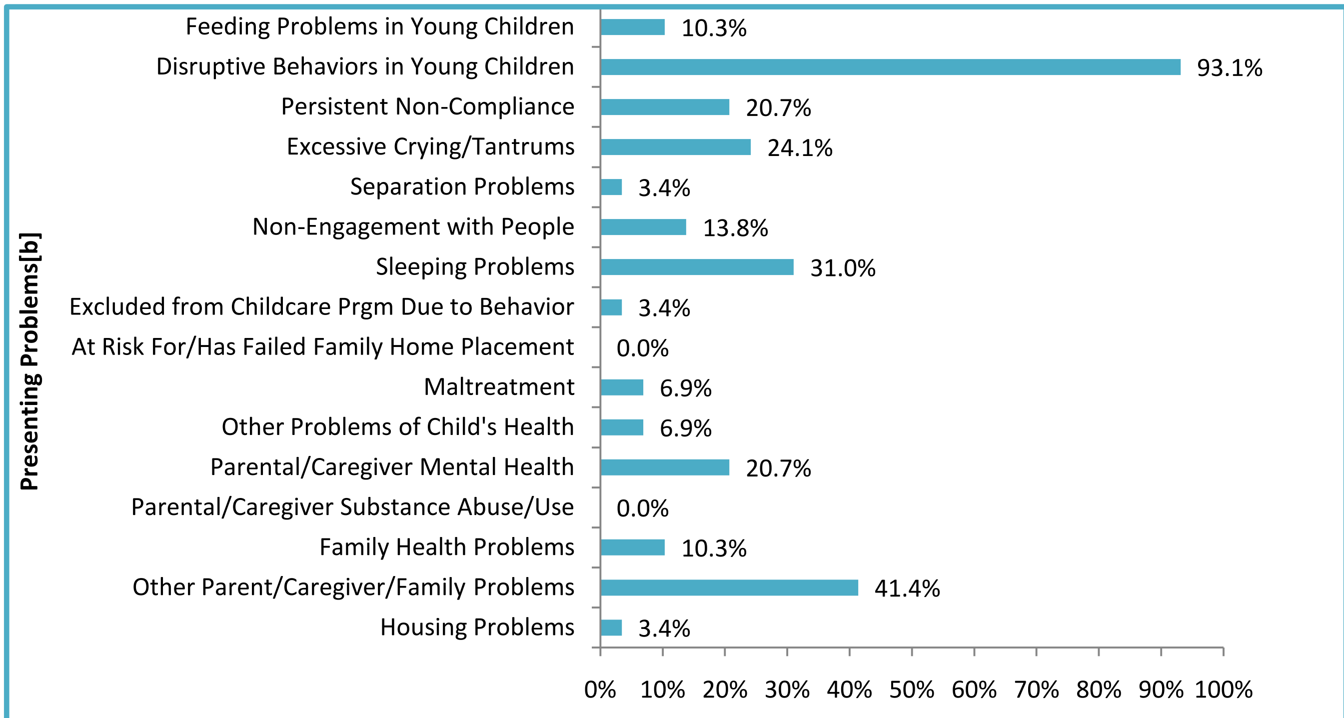
Table 7: Diagnosis of Children at Intake (n=14)	
Diagnosis[b]	**%**
Attention-Deficit/Hyperactivity Disorders	57.1%
Mood Disorders	21.4%
Disruptive Behavior Disorder	21.4%
Other	21.4%
Oppositional Defiant Disorder	21.4%
Mental Retardation	7.1%
Learning, Motor Skills, and Communication Disorders	7.1%
Adjustment Disorders	7.1%
PTSD and Acute Stress Disorder	7.1%
Impulse Control Disorders	0.0%
Personality Disorders	0.0%
Pervasive Developmental Disorders	0.0%
Anxiety Disorders	0.0%
Substance Use Disorders[c]	0.0%
Schizophrenia and Other Psychotic Disorders	0.0%
Conduct Disorders	0.0%
V code[d]	0.0%
Substance Induced Disorders	0.0%

[a] Data reported were collected using the Enrollment and Demographic Information Form (EDIF).
[b] Because youth may have more than one diagnosis, percentages for diagnoses may sum to more than 100%.
[c] Substance Use Disorders include caffeine intoxication.
[d] V Code refers to Relational Problems, Problems Related to Abuse or Neglect, and additional conditions. Percentage excludes V71.09 (No Axis I or II diagnosis).

Presenting Problems Reported [a]

The most prevalently reported presenting problem was disruptive behavior, which was identified in 93.1 percent of the children. Forty percent (40%) reported School Performance difficulties. Forty-one point four percent (41.4%) were experiencing family problems and 6.9 percent of the children were reported to have experienced child maltreatment. The percent of children with a parent or caregiver who had a mental health issues was 20.7 percent. A small percentage (3.4%) reported their child had been excluded from preschool or daycare due to behavior problems. These results are shown in Figure 5 on the next page.

Figure 5: Presenting Problems at Intake (n = 30)



[a] Data reported were collected using the Enrollment and Demographic Information Form (EDIF).
[b] Because youth may present with more than one problem, percentages may sum to more than 100%.

Family and Child History[a]

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 experienced. About three-fourths of the caregivers (73.1%) reported a family history of depression. Half of the caregivers (50%) reported their child had lived with someone with a mental illness besides depression; and, a little over half (53.8%) reported having lived with someone that has a substance abuse problem. Witnessing domestic violence (23.15%) and living with people convicted of a crime (19.2%) were also experienced by these children. (Table 8)

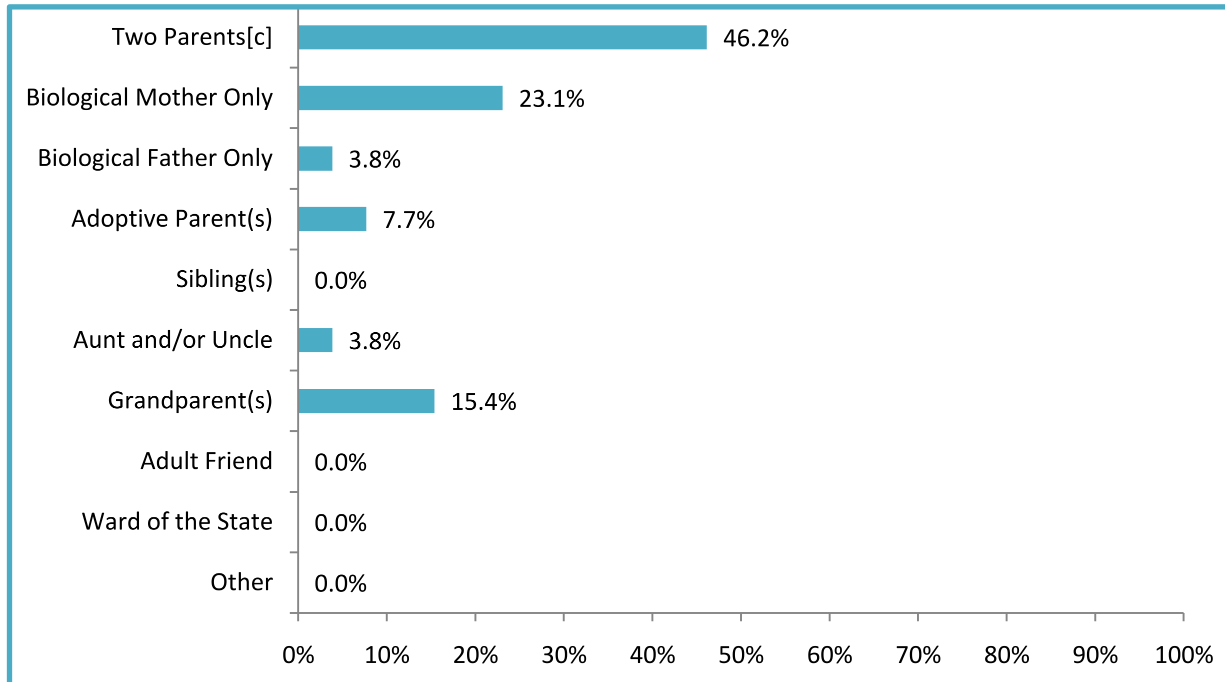
Table 8: Care Giver Information Questionnaire	
Has the child ever . . .	
Witnessed domestic violence? (n = 26)	23.1%
Lived with someone who was depressed? (n = 26)	73.1%
Lived with someone who had a mental illness, other than depression? (n = 26)	50.0%
Lived with someone who was convicted of a crime? (n = 26)	19.2%
Lived with someone who had a substance abuse problem? (n = 26)	53.8%
Experienced physical assault? (n = 25)	8.0%
Experienced sexual assault? (n = 25)	8.0%
Run away? (n = 26)	7.7%
Had substance abuse problems? (n = 26)	0.0%
Attempted suicide? (n = 26)	0.0%

[a] Data reported were collected using the Caregiver Information Questionnaire–Intake (CIQ–I).

Custody Status at Intake [a,b]

At time of intake, roughly half of the children (46.2%) were in joint custody of two parents, with about a quarter of the children (23.1%) with the biological mother alone having custody. Grandparent(s) account for custody of 15.4 percent of the children in Hand in Hand. (Figure 6)

Figure 6: Custody Status at Intake (n=26)



[a] Data reported were collected using the Caregiver Information Questionnaire–Intake (CIQ–I).
[b] Custody Status is collected on the CIQ and refers to legal custody. This may not reflect living arrangement, which is collected on the LSQ.
[c] Includes two biological parents, or one biological parent and a step or adoptive parent.

Living Situations[a] at Intake

Over three quarters (76.9%) of the children were living with their biological family at intake while about one quarter (23.1%) were living with a non-parent relative. Fewer than ten percent (7.7%) lived with an adoptive family.

Table 9: Living Situation at Intake (n = 26)

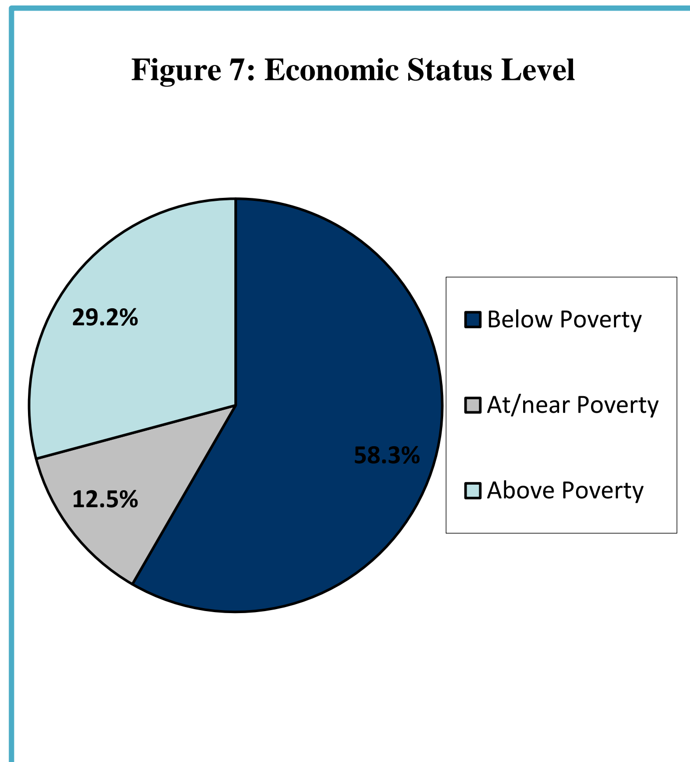
Biological Family	Adoptive Family	Non-Parent Relative	Non-Relative	Independent Living
76.9%	7.7%	23.1%	0.0%	0.0%

[a] Data reported were collected using the Living Situations Questionnaire (LSQ). The LSQ reflects living situations during the 6 months prior to data collection.
[b] Since a child may have lived with more than one individual at intake, percentages may sum to more than 100%.

Economic and Employment Status[a] at Intake

Employment and Economic status was also collected from caregivers using the CIQ-I. Over half of the families (54.2%) reported an annual household income of less than $20,000. Approximately 8 percent have a household income above $50,000, with just over 4 percent reporting an annual income above $100,000 (Table 10). The majority of the families (70.8%) fall below or near the poverty line. (Figure 7)

Table 10: Household Annual Income[b] (n = 26)	
Less Than $5,000	20.8%
$5,000–$9,999	0.0%
$10,000–$14,999	16.7%
$15,000–$19,999	16.7%
$20,000–$24,999	8.3%
$25,000–$34,999	16.7%
$35,000–$49,999	12.5%
$50,000–$74,999	4.2%
$75,000–$99,999	0.0%
$100,000 and Over	4.2%



[a] Data reported were collected using the Caregiver Information Questionnaire–Intake (CIQ–I).
[b] Family income is reported from the family with whom the child has lived with the most in the 6 months prior to data collection.

Educational Placements and Individualized Educational Plans (IEP)[a] at Intake

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). A total of 14 children were attending either regular public school (86% of 14) or pre-school (14% of 14). Forty-six point two percent (46%) reported that their child had an IEP in place, but none reported their child was in a special education setting, as shown in Table 11.

Table 11: Educational Placements in the 6 Months Prior to Intake[b] (n = 14)	
Regular Public Day School	86%
Regular Private Day/Boarding School	0.0%
Home Schooling	0.0%
Home based instruction	0.0%
Alternative/Special Day School	0.0%
School in 24-Hour psychiatric, justice, or residential Setting	0.0%
Preschool	14%
Head Start	0.0%
Other	0.0%
Percent with IEP (n = 13)	
Individualized Education Plan	46%

[a] Data reported were collected on the status of the child/family in the 6 months prior to the interview using the Education Questionnaire–Revision 2 (EQ–R2).
[b] Because individuals may have more than one educational placement, educational placements may sum to more than 100%.

School Attendance at Intake [a]

As shown in Table 12, for the children enrolled in school, attendance is not identified as a problem. Most students either have perfect attendance (15%) or miss less than one day a month (50%). No families reported children missing a day a week or more.

Table 12: School attendance and performance (n = 14)	
Average Number of Excused and Unexcused Absences in the Past 6 Months	
Perfect Attendance	15%
Less Than 1 Day Per Month	50%
About 1 Day a Month	21%
About 1 Day Every 2 Weeks	14%
About 1 Day a Week	0%
2 Days Per Week	0%
3 or More Days Per Week	0%

[a] 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.

Child Competence and Behavioral and Emotional Problems[a] at Intake

Emotional and behavior problems were measured using the Child Behavior Checklist 1 ½ - 5 (CBCL 1 ½ - 5) and are displayed in Table 13. Problem scores are based on normative comparisons 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 more normal emotional and behavioral characteristics. Sleep problems, Withdrawn, Anxious/Depressed, and Somatic Complaints Scales did not reach the clinical range for Hand in Hand children; however, Aggressive and Emotionally Reactive were problems where scores did average above the clinical range (scores >=70.0). Hand in Hand children scored above the clinical range (>=.63) for Externalizing, Internalizing, and Total Problems Scales.

Table 13: Behavioral and Emotional Problems at Intake		
Measure	**CBCL 1½–5 Average Score[b]**	**Clinical Range**
Emotionally Reactive	70.6 (n = 21)	>=70.0
Sleep Problems	67.1 (n = 21)	>=70.0
Withdrawn	66.2 (n = 21)	>=70.0
Somatic Complaints	57.4 (n = 21)	>=70.0
Anxious/Depressed	68.2 (n = 20)	>=70.0
Attention Problems	67.2 (n = 21)	>=70.0
Aggressive Problems	79.4 (n = 21)	>=70.0
Internalizing Problems	67.6 (n = 20)	>63.0
Externalizing Problems	76.1 (n = 21)	>63.0
Total Problems	72.7 (n = 18)	>63.0

[a] The Child Behavior Checklist (CBCL) collects data on the status of the child/family in the 6 months prior to the interview.
[b] The CBCL 1 ½ - 5 is for children ages 1 ½ through 5 years old. Therefore, youth who were 6 years old are not included in this data.

Caregiver Strain at Intake

Caregivers were assessed for their level of strain at intake using the Caregiver Strain Questionnaire (CGSQ). The purpose of the CGSQ is to assess the level to which caregivers are affected by the special demands of caring for a child experiencing mental health problems. The instrument consists of 21 items that assess the caregivers objective strain (observable disruptions of family life), subjective internalizing strain (feelings such as worry, guilt, or fatigue), and externalized strain (feelings of anger, resentment, or embarrassment about their child). The highest assessed level of stress for caregivers responding to the survey was for the Subjective Internalized Strain which would include feelings of worry and guilt from the care-giving situation.

Table 14: Caregiver Strain	
Caregiver Strain Questionnaire Subscales [a]	**Average Score**
Objective Strain (n = 26)	2.9
Subjective Externalized Strain (n = 26)	2.3
Subjective Internalized Strain (n = 25)	3.8
Global Strain (n = 25)	*9.0*

[a] Data reported were collected using the Caregiver Strain Questionnaire (CGSQ). The range in scores for each subscale is 0 to 5; the range in scores for the Global Strain scale is 0 to 15. Higher scores indicate greater strain. This instrument collects data on the status of the caregiver in the 6 months prior to the interview.

Caregiver Report on Parenting Stress at Intake

Stress was further assessed using the Parenting Stress Index Short Form (PSI-SF) which measures the magnitude of stress in the parent-child system. A total stress score over 90 indicates a clinically significant level of stress. Almost all caregivers (95.2%) exceeded the high range for Total Stress and stress related to a Difficult Child (91.7%). A majority of parents also scored high the other two categories, Parental Distress (61.95%) and Parent-Child Dysfunctional Interaction (62.5%), as shown in Table 15.

Table 15: Caregiver Stress from Parenting Stress Index Short Form (PSI-SF)

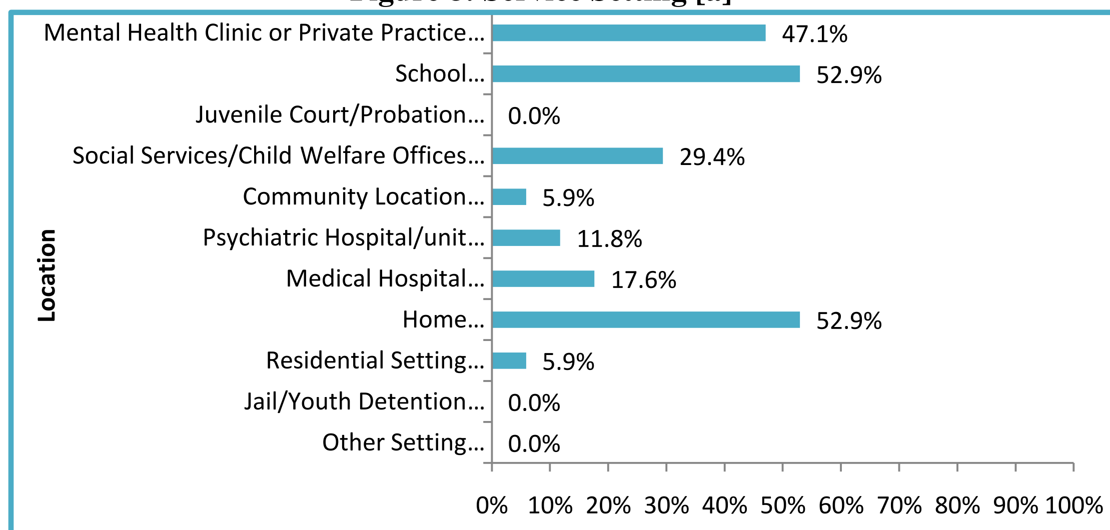
Measures	Parental Distress (n=21)	Parent-Child Dysfunctional (n=24)	Difficult Child (n=24)	Total Stress (n=21)
At or Below Normal Range	38.1%	37.5%	8.3%	4.8%
High **[a]**	61.9%	62.5%	91.7%	95.2%
Mean Score	36.0	36.0	42.0	110.0

[a] Indicates a clinical significant range: Parental Distress: appears to be highly distressed by her/his functioning in parental role. Parent-Child Dysfunctional Interaction: parent is highly distressed by the quality of her/his parent-child interaction. Difficult Child: parent perceives her/his child possesses many disruptive behavioral characteristics. Total Stress: parent is experiencing a high level of parenting stress.

Service Setting/Location[a] at Intake

The Multi-Sector Service Contacts–Revised questionnaire (MSSC–R) was used to collect data on the services received by the child/family in the 6 months prior to intake into Hand in Hand. Over half of the families were receiving services at school (52.9%) and/or at their home (52.9%). Mental Health Clinics/Private Practice (47.1%) and Social Services/ Child Welfare Office (29.4%) were also common places for families to get services. (Figure 8)

Figure 8: Service Setting [a]



[a] Because participants can have received services in multiple settings, percentages may sum to more than 100%.

Child and Family Service Use[a] at Intake

Over one-third of children in Hand in Hand report receiving School Based services (35.3%), Afterschool Programs (35.3), and Informal Support (35.3%). The other service that many children receive is Case Management (29.4%). Assessment or Evaluation (52.9%) and Individual Therapy (41.7%) are the most received Clinical Services received. Medication and medication monitoring (35.3%) was also common.

Figure 9: Support Services (n=17)

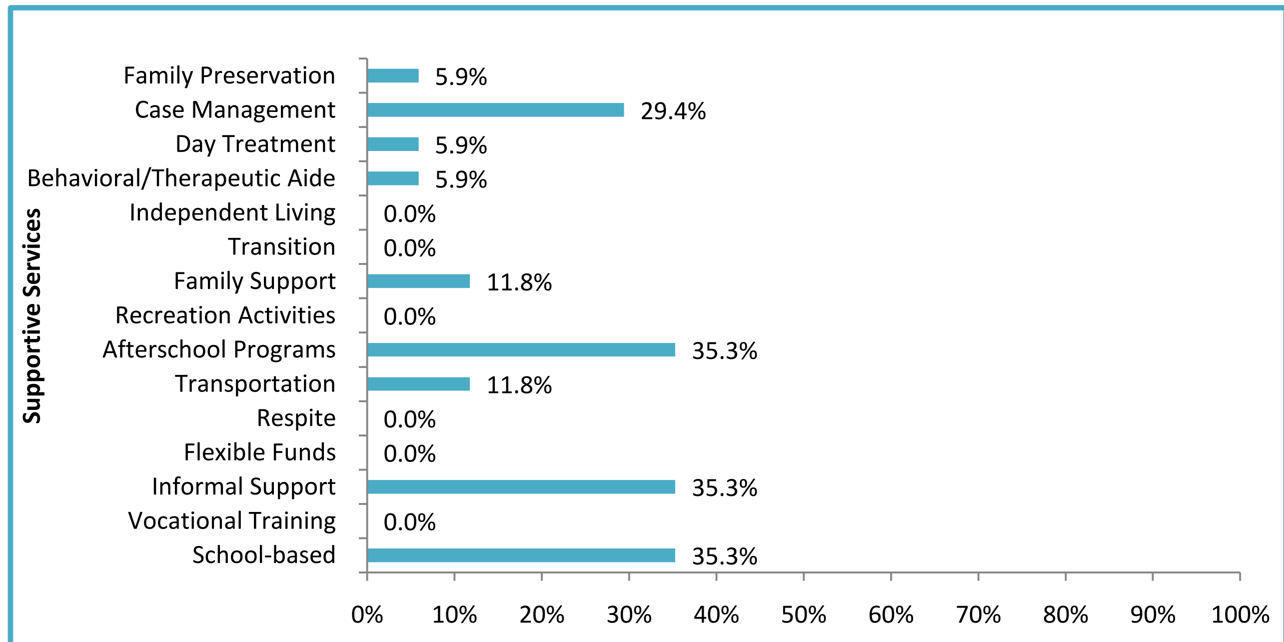
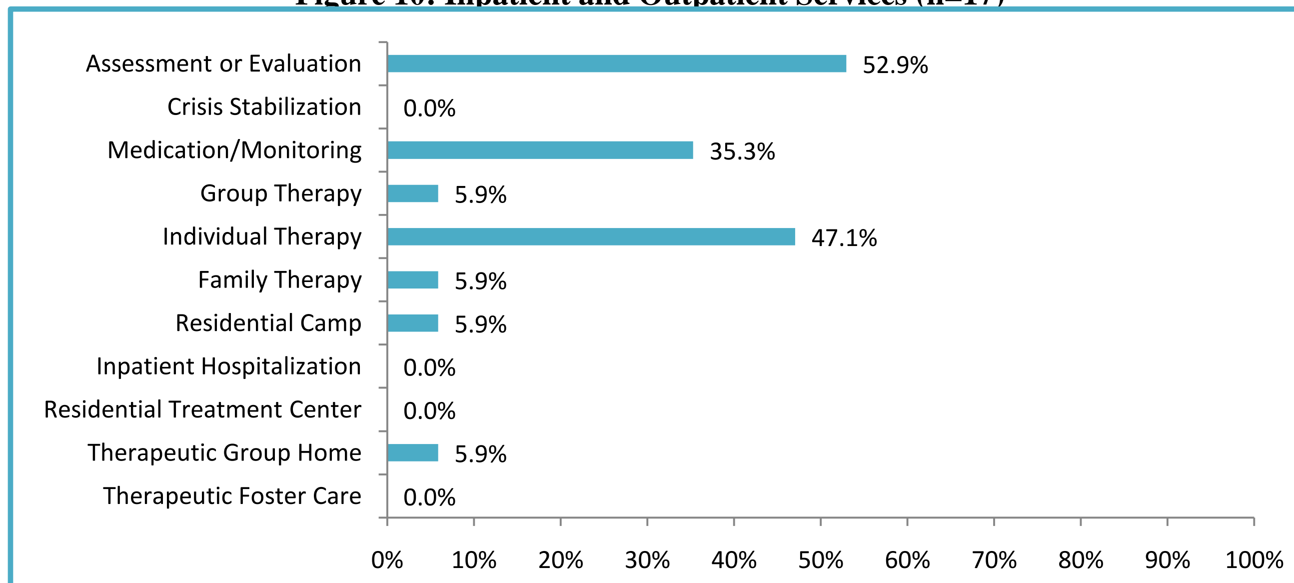


Figure 10: Inpatient and Outpatient Services (n=17)



[a] Data reported were collected using the Multi-Sector Service Contacts–Revised (MSSC–R) questionnaire. This instrument collects data on the services received by the child/family in the 6 months prior to the interview.

Quantitative Outcome Measures

This section will report six-month outcome data on children who were enrolled in Hand in Hand and the National Evaluation through September 2010. A limited number of children (12) had completed their six-month follow-up interviews by September, 2010 due to time of enrollment in Hand in Hand. The majority of children reaching their first six-month follow-up were White males. Thirty-five percent (35%) of the children were Hispanic or Latino. Due to the small sample size, any results noted in this section should be viewed with caution.

Table 16: Demographics of Youth with 6-Month Follow-Up (N=12)		
Demographic	**Number**	**Percent**
Race/Ethnicity		
White, non-Hispanic	8	*67%*
African American	1	*8%*
Hispanic or Latino	3	*35%*
Gender		
Female	4	*33%*
Male	8	*67%*

Education

The Education Questionnaire (EQR-2) was completed at baseline and follow-up. The EQR-2 evaluates frequency of school absences, whether a child had an Individualized Educational Plan (IEP) in place, if the child had a favorite teacher, and overall functioning at school. Many of the children were not in any form of school at baseline (42%). By the 6-month follow-up, the number of children not in any form of school dropped from 42 percent to 25 percent. These results should be interpreted with caution due to the low number of children in school and the potential for maturation effects as many of these children are just beginning school (some began while they were in the program). As can be seen in Table 17, for the small number of children in school or preschool, absenteeism does not appear to be a significant problem at either baseline or 6 month follow-up for the majority of children. At baseline, seven children were reported to be enrolled in school or pre-school. Of those, two children missed a day of school approximately every other week. At 6 month follow-up, nine children were enrolled in school. Of those, one child was noted to miss school three or more days a week. The other eight were reported to be missing no days of school or less than one day per month.

Table 17: Frequency of Absences from School (or Preschool) (N = 12)		
Absences	**Baseline**	**6 month**
Not Applicable	5	3
Did not miss in past 6 mo.	1	2
Less than 1 day per month	2	6
About 1 day per month	2	0
About 1 day every 2 weeks	2	0
3 or more days a week	0	1

Of the seven children in school at baseline, two children had Individual Education Plans (IEP) in place. One caregiver was unsure if their child had an IEP. At six-month follow-up, three children were reported to have an IEP in place. It should be noted than none of the caregivers reported that their child was in special or alternative education. (Table 18)

Table 18: Did your child have an IEP in the past 6 months? (N = 12)		
Answer	**Baseline**	**6 month**
Not Applicable	5	3
Unknown	1	0
Yes	2	3
No	4	6

*Note that only 2 of the N/As at Baseline were N/As at 6 month.

Caregivers were more likely to report that their child had a favorite teacher or adult at school after 6 month follow-up. (Table 19)

Table 19: Did your child have a favorite teacher or adult at school? (N = 12)		
Answer	**Baseline**	**6 month**
Not Applicable	5	3
Unknown	2	0
Yes	3	9
No	2	0

*Note that only 2 of the N/As at Baseline were N/As at 6 month.

Most schools that children in Hand in Hand were enrolled in did not give letter grades. Likely this was due to the young age of the children. None of the children were noted to be below average or failing at baseline. One child was noted as doing excellent in school at baseline and above average at follow-up. Two children were rated as being below average in their school work.

Table 20: In general would you describe his/her work at school as? (N = 12)		
Answer	**Baseline**	**6 month**
Not Applicable	7	5
Unknown	1	0
Failing	0	0
Below Average	0	2
Average	3	4
Above Average	0	1
Excellent	1	0

*Note that only 4 of the N/As at Baseline were N/As at 6 month.

Cultural Competence and Service Provision Questionnaire

The Cultural Competence and Service Provision Questionnaire Revised (CCSP-R) is administered at follow-up only. The first portion of this questionnaire addresses caregiver's perception of importance of the service provider's cultural competence. Caregivers are asked to rate the items on a Likert Scale from 1 (Not at all important) to 5 (Extremely Important). Seven caregivers (58%) reported that their primary service provider was not of the same racial or ethnic group as their child. However, on average, most did not feel that this was important.

Table 21: Caregiver's Perceived Importance of Provider's Cultural Competence (N = 12)	
Item	**Mean Score**
Important that service provider understands child's customs, practices, and traditions	3.25
Important that cultural heritage/traditions are included in service planning	2.75
Important that service provider is of same cultural heritage as child	1.50

The second part of the questionnaire concerned the perception of the cultural competence of the provider that the caregiver and child have seen most often in the past 6 months. Responses are on a Likert Scale from 1 (Never) to 5 (Always). Most often, the wraparound facilitator was noted as being the primary provider. Responses were very positive to all items. These finding can be seen in Table 22.

Table 22: Caregiver Ratings of Provider Cultural Competence (N = 12)	
Item	**Mean Score**
Provider understands family's beliefs about MH	4.75
Provider speaks the same language that I/child speaks	4.83
Feel comfortable discussing alternative therapies or other ways to work with child	5.00
Provider asks about family's traditions/beliefs/values when planning/providing services	4.58
I feel like other children have access to better services than my child	1.45
Materials given to me about the program/services are easy to understand	4.75
Provider attends to my and my child's cultural needs	4.83
Provider is comfortable interacting with me and my child	4.92

Functioning and Stability

Data below is taken from the caregiver interviews using the Transformation Accountability System (TRAC) measure. This measure asks caregivers to rate items related to their child's level of functioning and utilization of psychiatric hospitalization. The measure also asks caregivers to report on their perceived level of social connectedness and housing stability. None of the caregivers reported that their child was functioning positively at baseline; however 2/3 (9) reported positive levels after 6 months of service. Most families were socially connected at baseline, and all of those who were not had improved by follow-up. All but one family had stable housing at baseline (in the past 30 days) and this family had improved by 6 months follow-up.

No utilization of psychiatric hospital beds was reported at either baseline or follow-up. (Table 23)

Table 23: National Outcome Measures Report (N = 12)						
Item	**Positive at Baseline**	**Positive at 6 mo.**	**Rate of Change**	**Outcome Improved**	**Outcome Remained Positive**	**Outcome Remained Below Desired Level**
Perception of Child's Functioning	0%	66.7%	0%	66.7%	0%	33.3%
Socially Connected	81.8%	81.8%	0%	18.2%	63.6%	0%
Stable Housing	91.7%	100%	9.1%	8.3%	91.7%	0%
No Criminal Involvement	100%	100%	0%	0%	100%	0%
No Utilization of Psychiatric Hospital Beds	100%	100%	0%	0%	100%	0%

Perception of Care Outcomes

Perception of Care was assessed at 6 month follow-up. Caregivers are asked to rate the staff member providing services that they had the most contact with (generally the facilitator) on a Likert scale from 1 ("Strongly Disagree") to 5 ("Strongly Agree"). All Caregivers (100%) rated their provider at or above the national perception of care outcome criteria which is an average score greater than 3.5. Nearly all items had "agree" or "strongly agree" ratings by 100% of participants, and all caregivers either agreed (71%) or strongly agreed (29%) that they were satisfied with their services. However, less than half of caregivers (43%) felt that they got the help that they wanted for their child.

Table 24: Perception of Care at 6 Month Reassessment (N = 7)					
Item	**Strongly Disagree**	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**
Sensitive to culture	0 (0%)	0 (0%)	0 (0%)	2 (29%)	5 (71%)
Treated with respect	0 (0%)	0 (0%)	0 (0%)	1 (14%)	6 (86%)
Respected religious beliefs	0 (0%)	0 (0%)	0 (0%)	1 (14%)	5 (71%)
Spoke in way I understood	0 (0%)	0 (0%)	0 (0%)	2 (29%)	5 (71%)
I helped choose services	0 (0%)	0 (0%)	0 (0%)	1 (14%)	6 (86%)
I helped choose treatment goals	0 (0%)	0 (0%)	0 (0%)	3 (43%)	4 (57%)
I participated in child's treatment	0 (0%)	0 (0%)	0 (0%)	2 (29%)	5 (71%)
Satisfied with services	0 (0%)	0 (0%)	0 (0%)	5 (71%)	2 (29%)
People stuck with us no matter what	0 (0%)	0 (0%)	0 (0%)	3 (43%)	4 (57%)
Child had someone to talk to when troubled	0 (0%)	0 (0%)	1 (14%)	3 (43%)	2 (29%)
Received the services right for us	0 (0%)	0 (0%)	0 (0%)	4 (57%)	3 (43%)
Got the help we wanted	0 (0%)	1 (14%)	2 (29%)	2 (29%)	2 (29%)
Got as much help as we needed	0 (0%)	1 (14%)	3 (43%)	1 (14%)	2 (29%)

The following page shows charts of select Perception of Care outcomes in Figures 11-13.

Figure 11: I (my family) got the help we needed for my child.

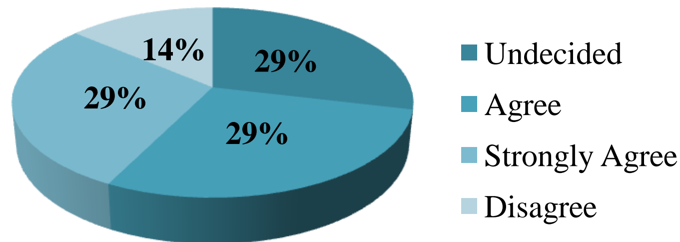


Figure 12: I (my family) got as much help as we needed for my child.

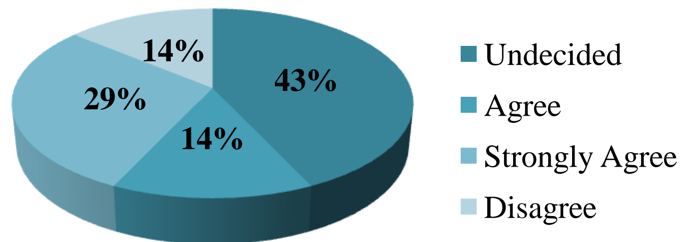
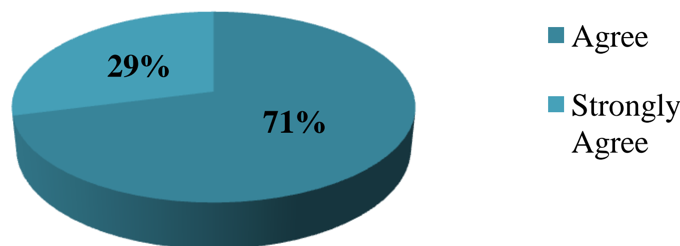


Figure 13: Overall, I am satisfied with the services my child received.



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.

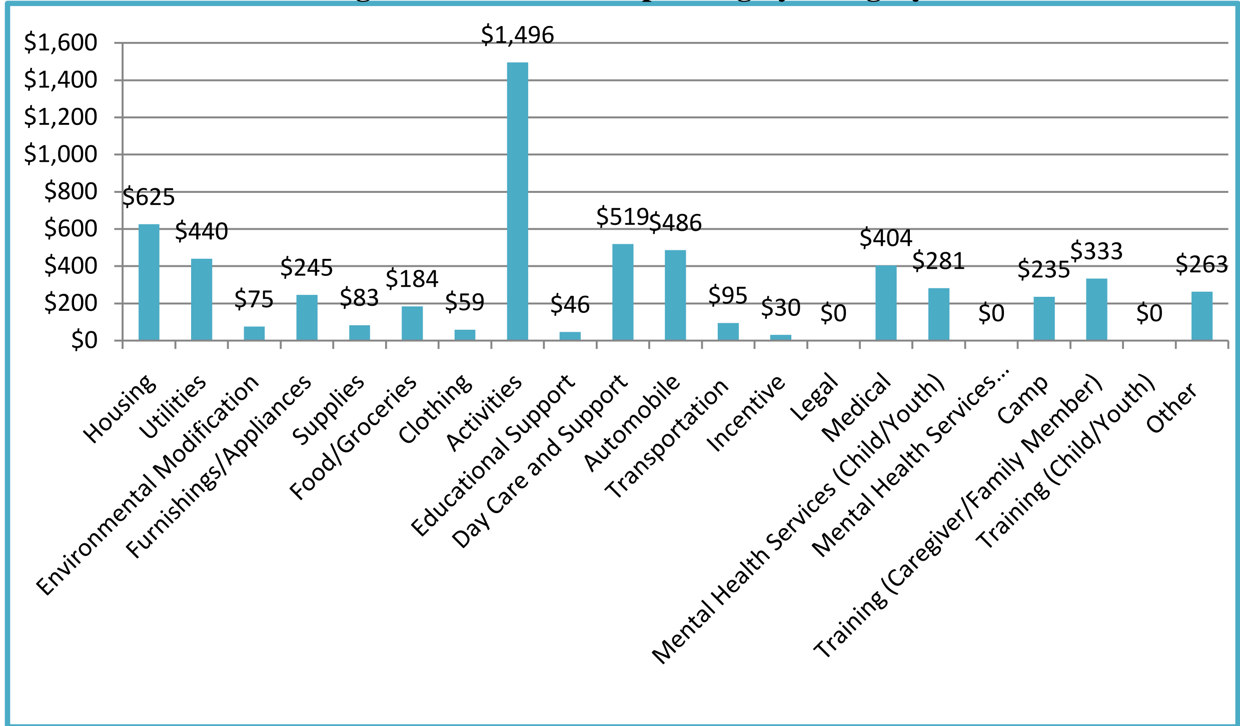
Data presented here were gathered from electronic forms of flexible funding requests provided to the evaluation team. Facilitators submitted funding requests on behalf of individual families and wraparound teams. Facilitators explored local resources for funds before submitting flex funds requests. The clinical director reviewed requests before funds were released. 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.

Table 23: Flexible Expenditures by Category

Flex Fund Expenditure Categories	Amount	Percent
Housing	$625.00	10.60%
Utilities	$440.00	7.46%
Environmental Modification	$75.00	1.27%
Furnishings/Appliances	$245.00	4.15%
Supplies	$83.04	1.41%
Food/Groceries	$184.29	3.12%
Clothing	$58.95	1.00%
Activities	$1,495.95	25.36%
Educational Support	$45.93	0.78%
Day Care and Support	$518.50	8.79%
Automobile	$485.95	8.24%
Transportation	$95.00	1.61%
Incentive	$30.00	0.51%
Legal	$0.00	0.00%
Medical	$404.46	6.86%
Mental Health Services (Child/Youth)	$281.00	4.76%
Mental Health Services (Caregiver/Family Member)	$0.00	0.00%
Camp	$235.00	3.98%
Training (Caregiver/Family Member)	$333.00	5.65%
Training (Child/Youth)	$0.00	0.00%
Other	$262.55	4.45%
TOTAL	**$5,898.62**	

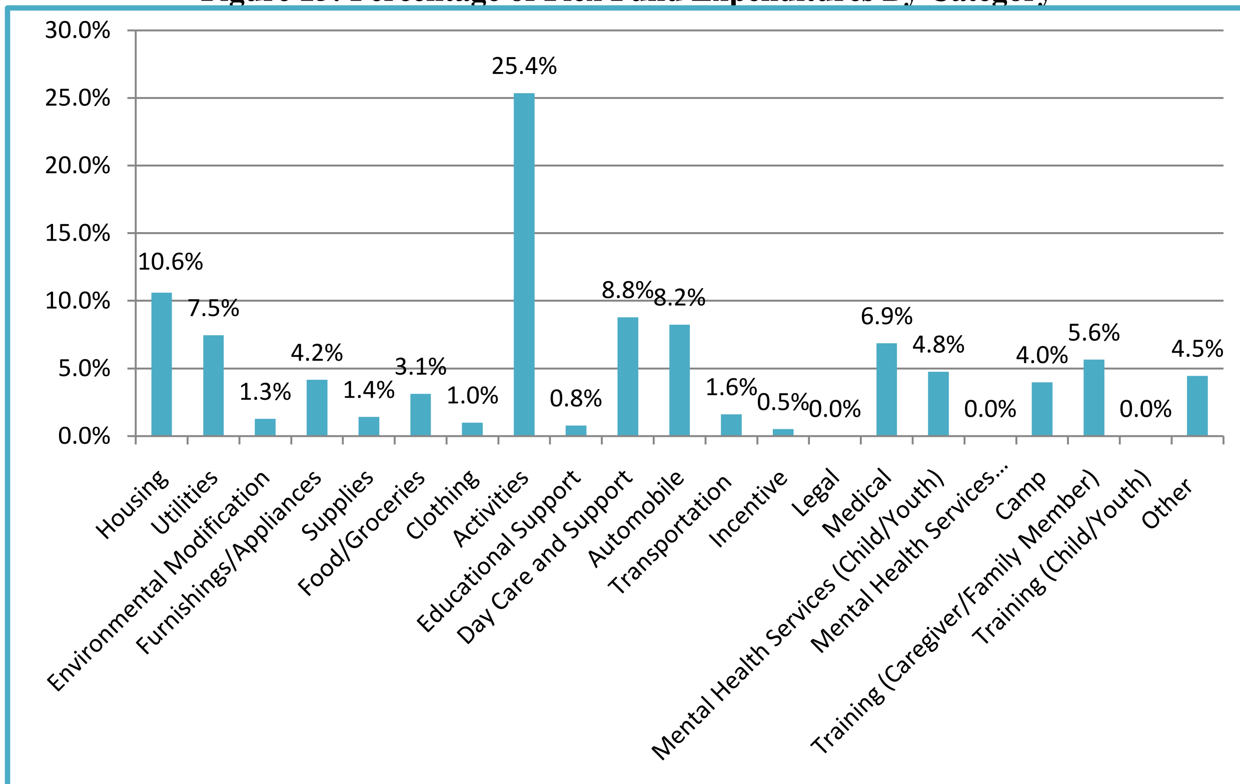
A total of $5,898.62 in flexible funding was expended in support of plan of care goals for individual child and family teams. Activities (e.g., tickets, events, camps, classes) made up the largest part of flexible fund use, followed by housing expenses (e.g., rent, mortgage, home improvement), day care and support, and automobile. Because most of the families lived in areas with no or inadequate public transportation; having a working automobile was crucial. Figures 14 and 15 display actual funding by category and percentage of funding by category.

Figure 14: Flex Fund Spending by Category



*The "other" category included car seats and laundry service.

Figure 15: Percentage of Flex Fund Expenditures By Category



Qualitative Interviews

This section of the report is compiled from data collected using instruments developed by the Community Evaluation Team (CET), an advisory committee within the System of Care. The CET is comprised of caregivers (parents, family members, grandparents); individual youth who have received Wraparound from the System of Care of North Central Texas, and the Hand In Hand Evaluators from MHMRTC's Division of Advancement and Research. CET members created three qualitative questionnaires to be administered at intake, while the client is enrolled in services, and after the client has graduated, to gather caregiver responses regarding their family's experiences in Wraparound in their own words. The questionnaires received approval from the Institutional Review Board of MHMRTC as part of the local, longitudinal evaluation of Hand in Hand Wraparound services.

The intake questionnaire consists of three questions with the flexibility to ask follow up questions if a respondent introduces a new topic. The follow up questionnaire for families who are still receiving Wraparound consists of five items, and also allows for follow up questioning. The third follow-up questionnaire for families who have graduated from Wraparound also has five items.

Respondents' answers were recorded by evaluators at each interview and entered into a database. Some of the items mentioned in this report were not questions on one of the questionnaires, yet were emphasized voluntarily by respondents. These topics are vital to analyzing qualitative data because they are the spontaneous answers (some of which may come up more than once by more than one respondent) which caregivers feel are significant to mention when discussing their Wraparound experience. These topics tell the real story of Wraparound lives, as caregivers had these themes and ideas foremost on their minds.

Intake Questionnaire

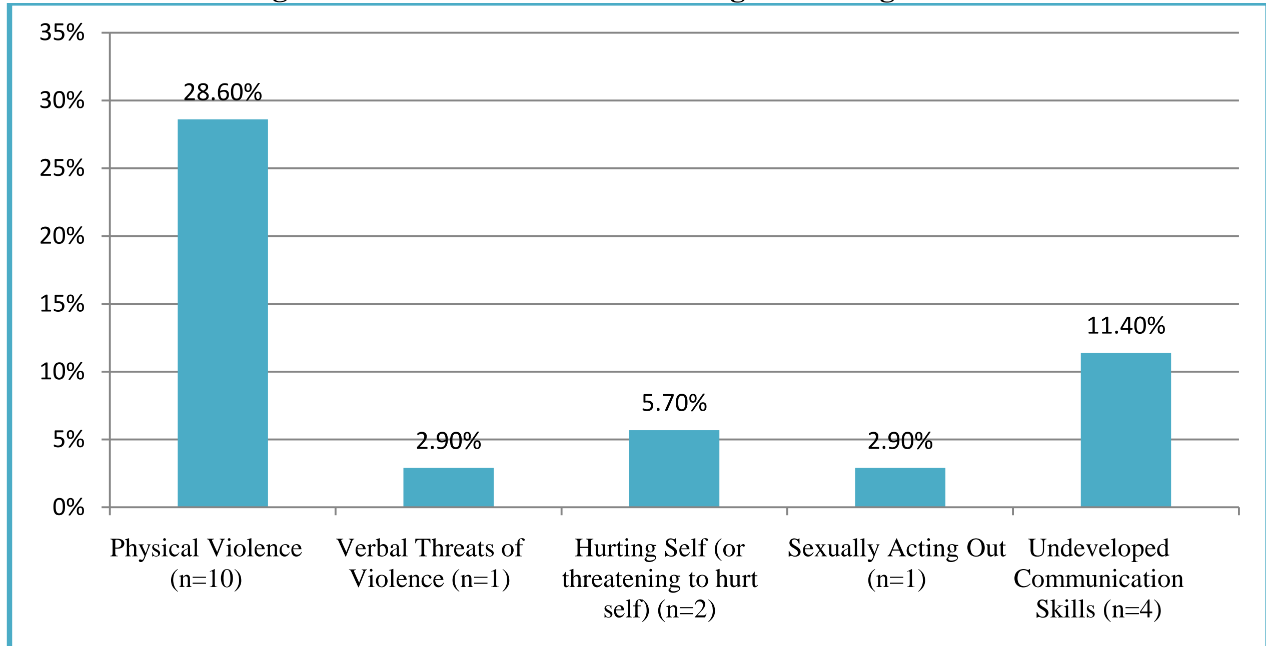
Three qualitative questions were asked at the Intake Interview of 35 families. Respondents reported hearing about Hand In Hand usually from an agency, school, or organization. Of the responses, nine families identified Early Childhood Intervention as either referring the family to Hand In Hand or telling the family about Hand In Hand (so caregiver could make their own referral); one family pointed out that the staff of the WIC offices told her about Hand In Hand; two families indicated CPS referred them to Hand In Hand; and, incidentally, one caregiver mentioned being afraid CPS would be called.

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 16 shows the types of behavior problems identified. Some caregivers identified multiple types of behavior problems. Physical violence was the most reported behavior problem, with 28 percent of the children exhibiting some form of violence. It is noteworthy to mention that 6 of 35 (17%) respondents mentioned trauma to the child such as oxygen depletion during birth, serious allergies, physical abuse, and witnessing violence (either verbal or physical)

committed by a parent as being the situation leading to referral. Four respondents (11.4%) said that undeveloped communication skills led to frustration in their child and caused them to act out with physical violence.

Figure 16: Child's Behavior Leading to Seeking Services

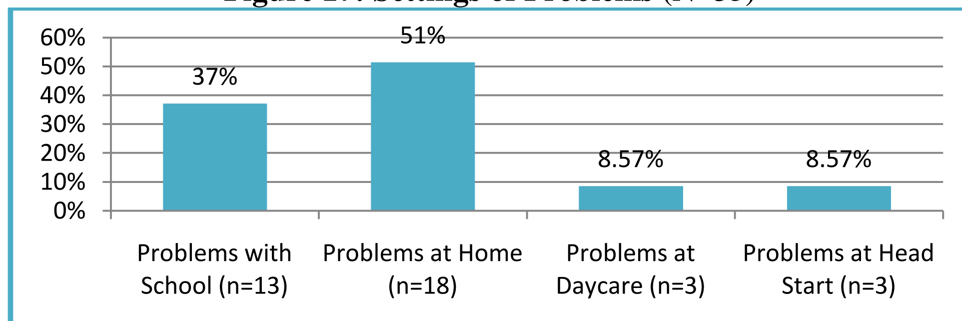


Settings Where Problems Occur. Of the caregiver responses, 18 (51%) identified home as the location where the problems occur. School was the second most common response (37%). Some parents said their child was having problems at home, school, and daycare, so all three would be counted and included in the chart below. Some respondents emphasized that their child did not exhibit problems at home, only at school. Referring to problems at school, two parents reported the following. (Figure 17)

One parent said, "He's not defiant, just frustrated and pulls people's hair to get them to play with him."

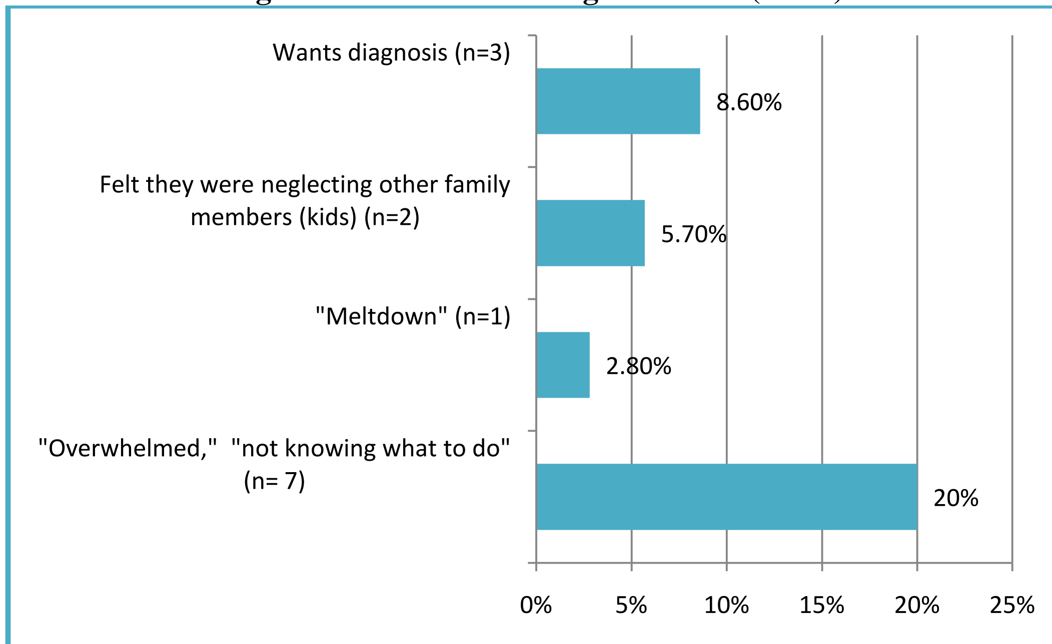
Another said, "He just really wants to play but he doesn't know how to get along with other kids."

Figure 17: Settings of Problems (N=35)



Caregiver Stress. While caregiver stress was not directly inquired about in the qualitative questionnaire, it is one of the answers that voluntarily arose from 7 caregivers (20%). Since the questionnaire did not specifically ask if caregivers felt stress, it is possible the percent of caregivers feeling stress is higher than the 20 percent who responded. Figure 18 displays the causes of caregivers' stress.

Figure 18: Causes of Caregiver Stress (N=20)



Caregivers reported feeling overwhelmed or not knowing what to do. In one instance, a caregiver was provided false information in that she was told her child could not receive any services from Hand in Hand due to having Medicaid. :

"I was overwhelmed with all that was going on; there wasn't enough of me to meet the demands of the boys and school and everything. "

"When my child is at home with me it is bad. Some days I have to just take her to my mom's and say, 'here, take her!' And then I leave because I cannot stand it."

"It was a constant outburst—I couldn't take it."

"The boys' counselor set it up (w/ HIH). I had a meltdown and thought I was going to crack and he gave me the (contact) info."

Three caregivers (11%) mentioned the frustration of trying to find help for their child (mental health services for early childhood) and/or not having a correct diagnosis or understanding of the problem as contributing to their stress:

"I had heard of Hand In Hand before from Pecan Valley MHMR, who said they could see him, but not really offer any services because of his Medicaid. Later, when I went to Cook Children's Hospital with him, they gave me another referral to Hand in Hand… But, by that time, it was just like…Get Me Help! I was not too proud to ask for help or embarrassed because I knew I needed help! I hope no one ever has to go through as long as it took me to get help—six months is a bunch of crap!

My son was having constant outbursts and I took him to the only place that I could find that would take him—Cook Children's Hospital. They really didn't give him a diagnosis or assessment, though. They observed him for five days. I was surprised that no one ever gave us an assessment or evaluation for him. I'd been looking for a place for six months and no place could help, either they were full or they don't take 3 year olds or his Medicaid plan wasn't eligible for anything else. I was on a wait list at Cook for 2 months and no one ever called. Finally, (that one day was so bad) I called and they agreed to take him. They gave a general diagnosis of conduct disorder, but nothing specific, and I know he has ADHD. I just know it."

"I thought that from reading about diagnoses that my son was autistic, but the ECI group doesn't agree. I'd like a diagnosis. So far, we don't have one."

A few other topics were brought up by caregivers that were not directly asked. Two caregivers reported they felt they were neglecting their other children and one caregiver identified feeling isolated.

"I know this sounds bad, but I feel I have to neglect my son as a parent because of my daughter's behavior. I have to wait until someone can help (with children before I can pay attention to my son's needs)."

"My son's sister is five and I think she feels a little left out or passed over for me dealing with him and all of his problems now."

"We're very secluded, no outreach to anything; it's just me and the kids."

Two other caregivers identified concerns with school officials.

"Essentially, they (school officials) said to put him on drugs or he's out of class…but teachers and principals aren't qualified to judge him (medically)."

"At his ARD Meeting, they (school officials) said he might not ever be able to live on his own and I should have a plan in case that happens. That was my concern (why I got involved with the program) because they said he might not be able to live on his own."

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?)

Level of Comfort. Families told evaluators that because their trust had been violated in the past, they were worried about divulging so much detailed personal information about their families. However, the majority of families (80%) said they felt comfortable talking to the staff, especially, their Wraparound Facilitator (WF). Following are quotes from caregivers regarding their comfort level with beginning wraparound.

"I felt real comfortable with my WF. And then the Family Mentor came and she was so nice with hugs and friendship. When I'm upset, however, I call my WF because she is the one I bonded with the most—she understands. When I'm upset, I call her."

"The Intake Process? It was Great. All of y'all have been great so far."

"I felt at best talking about the things that are going on. It helps to talk about it."

One described the intake process (which was an initial home visit) as *"...just like talking to friends."*

"...no difficulty with talking to others and (it was easy because of) their willingness to come to our house."

"I felt very comfortable. I would recommend it for anyone."

"I had no problem talking about our experiences as long as it is confidential and to help my son."

"I never thought I'd find someone that my child's dad accepted! He really takes our WF seriously. She can drag things out of him that I can't! In one hour we get so much accomplished! She's our mini superhero! We never felt that way about the first one."

"Yes, I felt comfortable talking to Hand in Hand people. My WF is wonderful and I was impressed with what was offered and very impressed with or facilitator."

"Everyone I've talked to has been personable and friendly. I've even had to tell them about my pending divorce and all that drama. My new WF has really listened and been especially supportive. Tomorrow my WF is going over the binder with me for Wraparound. The Family Mentor helped me get an appointment with the psychiatrist she uses for her daughter. She had to call because they were giving me the run around. We will see him next week."

"It was comfortable. I felt comfortable talking to our WF. We were very glad she wanted to help instead of just the type to nose into your business. You know people tend to project into each other's lives and now we have a united front with the kids."

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?)

The majority of caregivers (80%) said that Wraparound had been explained and that they understood the concept including the wraparound team.

"I'm just eager to see how these services will help and I want to learn about Wraparound. They (WF) explained teams a little."—from grandmother caregiver. Her daughter, the Mother of the child piped in, indicating a good understand of the wrap team concept, with: "We do that now with informal supports!"

"My WF told me about team meetings and we're trying to find some people to join it. I've told my pastor's wife and so far she seems to be a hopeful. It looks like it will help a lot and I already feel better emotionally."

"Yes I feel comfortable with the understanding that my WF and Mentor gave me. I think y'all are great."

"I have a book. It explains stuff about wraparound. It sounds like it will be good."

While a majority of caregivers responded that they understood wraparound and that Hand in Hand staff had done a good job explaining it, a few notable concerns emerged with Question #3. Four of the caregivers (11.4%) reported they felt confused about wraparound.

"Yeah, we're waiting to see how it works. It was explained, but we're waiting to see how it works out when it all gets together. Yes, I was told about wraparound teams. I was told I had to put one together."

"I know there are services, but we haven't gotten there yet. I have been told there's an interview that has to take place first."

"The WF tried to explain the team concept and informal supports, but we still have a lot to wrap our heads around. The Family Mentor seemed very nice and so does our WF, so we will understand things and benefit from them, I'm sure."

"I'm still a bit fuzzy (about Wraparound). I'm sure we need services." (Respondent wasn't sure if she'd received Family Guide yet and had not met FM).

"I didn't understand wraparound until our new WF came and explained it. The first WF didn't explain it. Our new WF helped us understand it and this is now our 4th or 5th time to meet her. We didn't meet the first WF nearly as much."

"I don't like people getting up in my business, so we'll have to see about the teams. I may not want my parents on it because I'm very independent. Can I have a team without them?"

"I somewhat feel I know about Wraparound, but I get mixed up sometimes. I have not yet met the Family Mentor and I'm not sure how everything fits together, but I know it will. I am just still learning about it." (Respondent also said she hadn't received Family Guide yet, but was "horrible about checking her email").

The Follow-up Qualitative Questionnaire

The follow-up questionnaire is administered every six months while the child and family receive wraparound services through Hand in Hand. To date, 12 families have been in wraparound at least six months. No families have made it to the 12-month follow-up. The following data includes responses from the 12 families reaching six months in Hand in Hand.

Question1. How have things been going with your Wraparound program in the last six months? (Follow-up Questions: Have things improved at home, school, daycare, Head Start, etc.? If so, how have they improved? If not, what do you think has kept things from getting better?)

Eighty percent (80%) of caregivers reported experiencing improvement or great improvement in their family situation since beginning wraparound. Twenty percent (20%) reported that they have not seen any improvement. Following are quotes from caregivers' responses to question one.

"It has been good overall, it has improved at home how I have handled things and have helped my daughter."

"Things have been slow because we haven't been able to get the team together. But, things have improved because I have my WF to call now. Things just haven't had the chance to improve a lot, yet."

"Things have been pretty good with the program. I'd say things have improved, but very little. At school, teachers kept things bad for my son as his reputation went before him everywhere. We really need to work with preschool teachers about special needs kids."

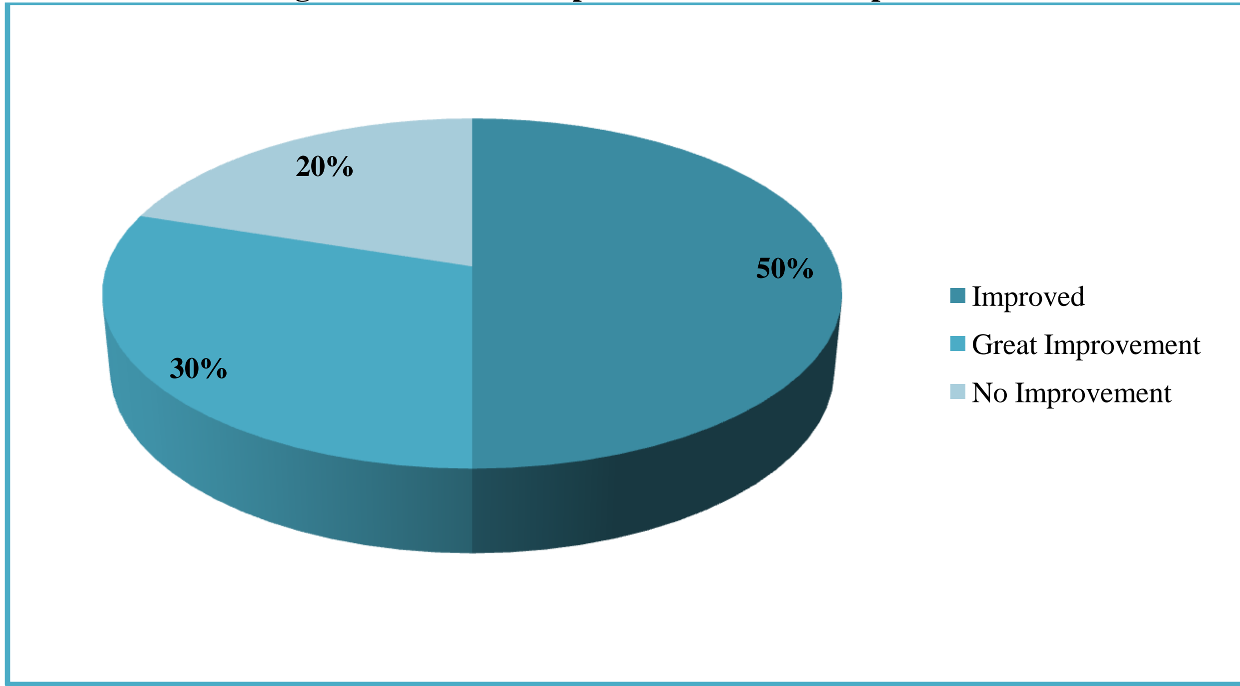
"Things have improved greatly. I understand what issues need to be taken care of and school is great."

"Things are going a lot better. Our WF has been doing a wonderful job interacting with my child."

"Excellent, as far as I'm concerned. Everyone is there when I need to talk. Very fewer temper tantrums and my son is excited about going to school."

Figure 19 on the next page breaks down by percent the level of improvement caregivers experienced since they began wraparound.

Figure 19: Level of Improvement Since Wraparound



Question 2. Is your Wraparound Facilitator easy to talk to? (Follow-up questions: Do you feel s/he has your family's best interest in mind? Has she explained the graduation process to you? Has your Wraparound Team been meeting regularly? Describe the make-up of your Wrap Team.)

One hundred percent of the families responding to the follow up questionnaire reported that their Wraparound Facilitator (WF) was easy to talk to and had their best interest in mind. Of the 12 families, 7 (58%) reported having a wraparound team. Six families (50%) reported that their team met regularly. Four caregivers reported that they did not have a team yet. One caregiver reported a team was in place but they had not had any wraparound meetings. Data was either missing or incomplete for one of the respondents. Respondents were also asked questions regarding graduation. Five (42%) of the families reported that their WF had explained the graduation process.

Of the families with wraparound teams, most teams have between three to five members who include the WF, either the biological mother or grandmother and either the father or grandfather. Other team members identified on some of the teams include friends, roommates, neighbors, occupational therapists, speech therapists, school counselors, in-laws, and non-school counselors. One team identifies having 10 members which include friends and neighbors, professionals such as therapists, as well as great grandparents and grandparents. The following quotes are from caregivers when discussing their wraparound facilitator, team meetings, and graduation from Hand in Hand.

"Our WF is great to talk to and cares a lot."

"The WF is so easy to talk to and she has explained things but we still feel that we've just started. We just got our team started meeting and such so I don't remember everything yet.

"We were evicted and she (the WF) tried to help. We were able to stay in a hotel for two nights and our WF talked to the landlord of these apartments and go us a pretty good deal."

"Our WF is great! I met the nice mentors, but I just relate to our WF and always call her first. She hasn't explained about graduation, but I get the idea."

"My facilitator is amazing."

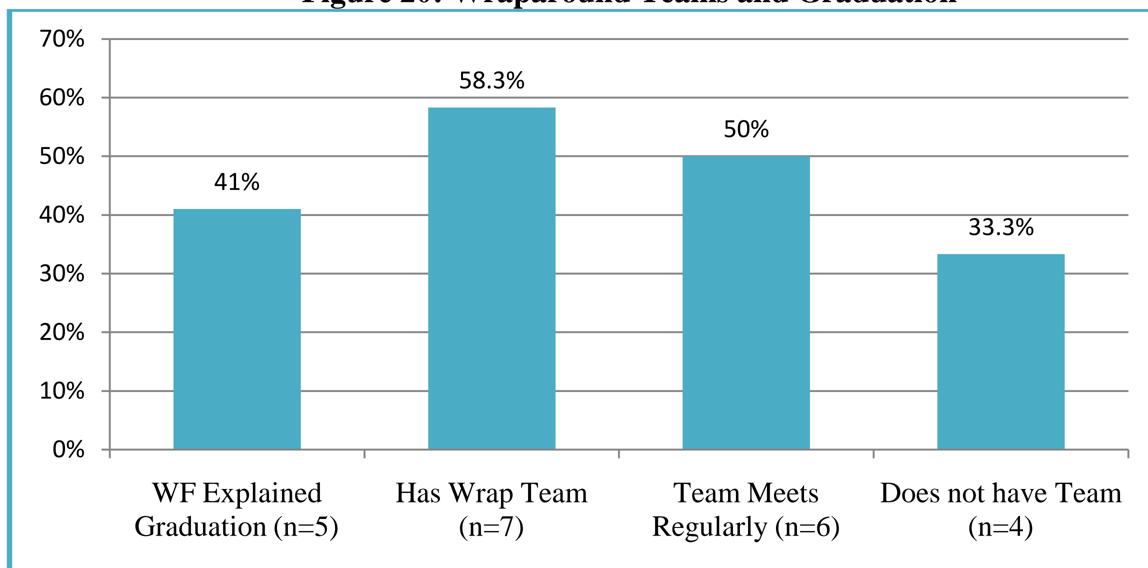
"Ours is the best facilitator ever. She is great with my family."

For those without teams, one caregiver explained why the team concept doesn't work for them and pointed out that some families are more isolated than others. Another caregiver described circumstances that have interfered with their family developing a team. See Figure 20.

"There's this assumption that people have all these supports and don't know it and you just have to pull out the wheel and put names there; not everybody has that. We have supports in case of emergency, but every day, people work and at first the team idea sounded good, but it just doesn't work for us."

"Things were going good and then it was a pain because I lost my phone and all of my contacts in it. I replaced my phone the next day, but not the contacts. For over a month, I was hoping the WF or someone from Hand in Hand would call me, but no one did. My WF is very easy to talk to and I was very surprised she didn't call me when she didn't hear from me in so long. That's why I don't have a team yet."

Figure 20: Wraparound Teams and Graduation



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 community meetings focusing on children's emotional, behavioral and mental health? (Follow-up questions: If yes, was the information you learned at the meetings helpful? If not, how could Hand In Hand help enable you to attend and encourage you to take part in such a meeting?)

Four of 12 caregivers reported attending meetings such as those listed above. One caregiver reported attending the SAMHSA site visit family dinner and two caregivers reported they have attended Strong Fathers, Strong Families. One respondent says yes to the question about attending meetings but did not identify what type of meeting.

"I liked the SAMHSA meeting because they were really trying to talk to us to find out what is actually helping and what is not helping."

"Strong Fathers, Strong Families was a very helpful meeting."

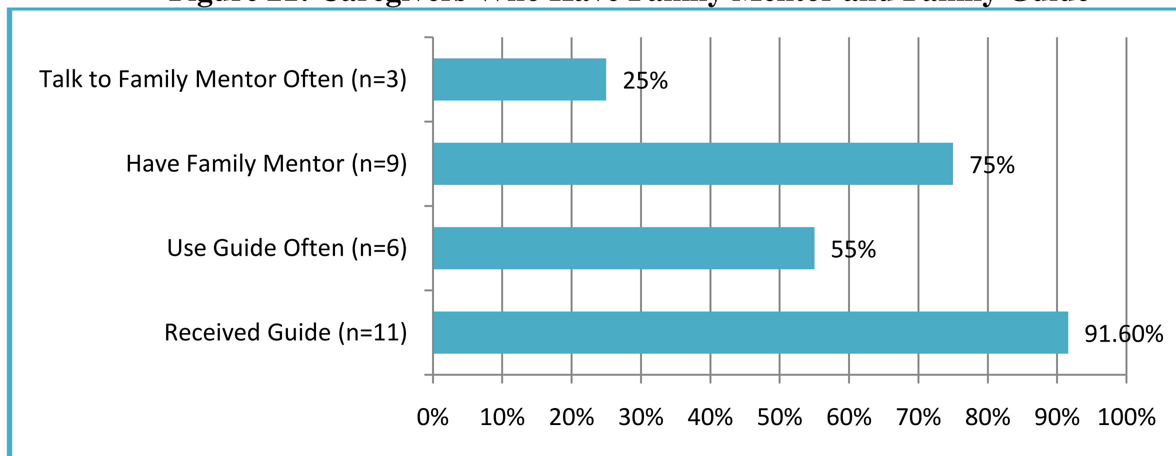
"I haven't had the chance yet, but I would like to go out and meet others in my situation…other moms with kids like mine who are working to make their lives better."

"No, I haven't gone yet, but my WF has volunteered to drive me, if I can go to one."

Question 4: Have you received A 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 Family Mentor provided an additional, helpful resource for you and your family?)

Of the 12 families interviewed, 11 reported receiving the Family Guide. (The Spanish-speaking family is the only one of the 12 families responding to the sixth month follow up evaluation interview, who has not received a Guide.) Of the 11 who received the Guide, 6 reported they read it often and were helped by the Guide. Four reported that they do not read the guide often or find it helpful. One caregiver reported that she reads it occasionally.

Figure 21: Caregivers Who Have Family Mentor and Family Guide



"I received the Family Guide and I read it from time to time. I use it to mark and see if we have moved up any milestones. "

"Yes, I've read the Guide often and it has helped me with learning activities and coping skills."

"Yes, the Guide has a lot of useful information."

"A lot of info is provided in the Guide that we already knew, so it wasn't that helpful."

"I have it, but without my team, I don't have much use for it, yet."

"I've been reading the Guide and it helps me understand the services and support that is out there for us."

"The Guide has been a big help."

Hand in Hand has two Family Mentors (FM), one of which is also the Lead Family Contact. The first six month follow-up data suggests all families report having a family mentor. Three of the 12 caregivers reported that they speak with their family member regularly. Following are quotes from those three families.

"I speak with the Family Mentor weekly. She has provided an excellent service."

"I've spoken with the FM several times."

"Yes, the mentor has provided an additional helpful resource for my family. I've spoken with her several times."

Some of the caregivers have spoken to or met their family mentor, but have not spent much time with them. They reported that they appreciate the availability of the Family Mentors, but they contact their wraparound facilitator if they need support or to talk to someone.

"I remember the Family Mentor was very nice and told us about Support Groups, but I haven't called her. I just really clicked with my Wrap Facilitator."

"I don't call the Family Mentor like I do the facilitator. My Wraparound Facilitator, she does it all!"

"I met the FM at the beginning and then again when she got us an appointment with her daughter's psychiatrist, for which I'm very grateful."

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

Ten of the 12 families (83%) reported that wraparound has been helpful to their family and child. The other two caregivers reported that they have not received the help they need through wraparound. (Figure 22) The following are quotes from the caregivers regarding their overall view of the helpfulness of wraparound.

"Wraparound has helped me a lot and to get some things that we couldn't get on our own in the form of services."

"Wrap has helped me understand my son."

"It really helps to have our WF. I feel I can ask her anything and I feel now that the problems are a shared burden with our WF."

"Our WF keeps telling me I'm doing good. I was second guessing myself and she's helping me reason. I'm better now with her to call, although I do have a lot of friends I can talk to, as well."

"Yes, wraparound has helped me learn to put my child in different activities to make him focus and work with others. I've also learned different ways to discipline him."

"Yes, hope and confidence that I am handling this problem correctly. The WF and FM have provided me continuous support."

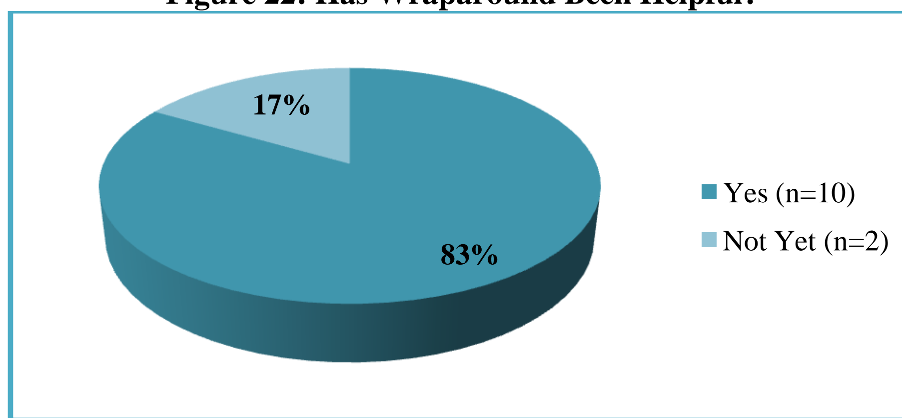
"I've learned a lot of knowledge and support."

"Yes, I've learned patience with my children."

"Yes, better routines make things run smoother."

"Yes, they've helped me with strategies, counseling and ways to try more things with my daughter.

Figure 22: Has Wraparound Been Helpful?



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. All families who have reached their six-month follow-up evaluation (12) have reported that they feel their facilitator is acting in the best interest of their family and responds to the family in a culturally competent manner even though 58 percent have a facilitator of a different ethnicity from them. The majority also reported that they have come to count on their facilitator. Eight of the 12 families reported their children have experienced improvement in their behaviors at six-month follow-up. While many positives are occurring through Hand in Hand, a few areas of concern.

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 quite lengthy, in one instance as long as a 104 days from referral to intake and 194 days from referral to first meeting with a wraparound facilitator. The average time it takes from referral to intake is 21 days. The average time it takes from referral to first meeting with a wraparound facilitator is 36 days. Though the sample size was small, statistical analysis suggests the longer it takes a family to get through the process from intake to signing a wraparound agreement, the more likely the family will drop out of Hand in Hand. Approximately 50 percent of families referred to Hand in Hand dropped out before signing a wraparound agreement. Of the 12 families who have been in Hand in Hand for 6 months, nearly 50 percent reported that they did not have a family team in place. In addition, of the caregivers that reported having a family team, many identified their team as consisting of themselves, their facilitator, and one other family member. Some families also reported not meeting with their team often. Developing a family team in the first few weeks of wraparound consisting of both formal and informal supports and having regular team meetings are key components of the wraparound.

Another area of note is the difference in the number of families with Child Protective Services involvement (26%) and the number of CPS referrals to Hand in Hand (6.7%). In addition, the lack of CPS presence on family teams further suggests a lack of connection between CPS and Hand in Hand. Finally, though this was mentioned by only a few caregivers, it appears that some families are being given misinformation regarding Hand in Hand thus delaying services. Based on these areas of concern, the following are recommendations for quality improvement.

Recommendations for Continuous Quality Improvement

- Identify ways to reduce the amount of time between referral and intake for families.
- Review the process between referral to the time a family signs their Wraparound Agreement and look for ways to reduce the amount of time between the two points.
- Increase presence of Hand in Hand with Child Protective Services
- Work with Wraparound Facilitators to identify strategies to building family teams early.*
- Monitor frequency of family team meetings and seek solutions to barriers that keep teams from meeting frequently.*

- Meet with community partners such as Pecan Valley MHMR to ensure staff are knowledgeable of eligibility criteria and services that can be provided through Hand in Hand.

  *The Evaluation team is completing a fidelity study of the wraparound process