State Incentive Grant Enhancement for Early Childhood Prevention (SIG-E)

Final Evaluation Report

Submitted to:

Karen Wheeler, M.A.
Addictions Policy and Program Development Manager
Department of Human Services
Addictions and Mental Health Division (AMH)
500 Summer Street NE
Salem, OR 97301-1118

Submitted by:

NPC Research
Portland, Oregon

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NPC RESEARCH
4380 SW Macadam Ave., Suite 530
Portland, OR 97239
(503) 243-2436
www.npcresearch.com

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Juliette R. Mackin, Ph.D., Project Director

Judy M. Weller, B.S., Project Coordinator

For questions about this report or project, please contact Juliette Mackin at (503) 243-2436 x 114 or mackin@npcresearch.com.

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EXECUTIVE SUMMARY

In 2003, the Center for Substance Abuse Prevention (CSAP) awarded Oregon a State Incentive Grant Enhancement for Early Childhood Prevention (SIG-E). This project was intended to help continue Oregon's efforts to provide comprehensive services and supports to children ages 0 to 6 and their families, particularly focused on preventing caregivers' substance use and mental health issues, and promoting children's healthy physical, emotional, and social development.

The goals of the SIG-E were to 1) institutionalize data systems that collect information about the status of Oregon's prevention system and its ability to meet the needs of youth ages 0 to 6; and 2) implement and evaluate Starting Early, Starting Smart prevention demonstration projects to build a knowledge base for successful implementation of integrated substance abuse prevention services throughout the state.

This project included statewide early childhood systems development and data infrastructure work, as well as community-level service system development (early childhood and behavioral health) and direct service components.

Summary of Results

RESEARCH QUESTIONS

1. Are the state early childhood system partners and behavioral health system partners increasing their collaboration over time?

Yes. Key stakeholder interviews illustrated positive development of collaborations both within the early childhood system and between early childhood and behavioral health. Significant cross-system sharing, training, and communication occurred.

2. What are the factors influencing success in building collaborative systems?

- Leadership.
- Time and energy.
- Engagement in and commitment to the system development process.
- Communication and training within and across all levels and systems.
- Training and technical assistance, preferably on site.

3. Are the statewide data systems for prevention and intervention services for families with young children becoming more integrated at the client level?

No, during this project, data infrastructure efforts moved away from cross-system data integration and toward expansion and development of within-agency database management. However, behavioral health and public health strengthened a connection through the inclusion of behavioral health and child development information being added to electronic data gathering forms for Maternity Case Management in Maternal Child Health.

4. To what extent are the pilot sites successful at implementing SESS (Starting Early Starting Smart) components?

Based on local key stakeholder interviews, site visits, conference calls, and analysis of pilot site quarterly reports, pilot sites made significant progress toward understanding the SESS principles and creating locally specific ways to implement them.

STATE LEVEL

System Development

The SIG-E project obtained results on the state early childhood system developed in

three main areas: collaboration, policy and funding, and programming.

Collaboration

This project contributed to increased collaboration between state early childhood system partners and behavioral health system partners[1]. As a result, several key outcomes were achieved.

- Substance abuse treatment and mental health providers learned about issues related to early childhood development and parenting (including early screening and identification), and early childhood providers learned about the impact of parental mental health and substance abuse issues on child development and on parenting/family functioning.
- Increased recognition of the steps that are involved in system change and the amount of time and effort it takes for that to occur
- Development of multiple projects and efforts in many communities and across a variety of agencies that cumulatively are moving the system in the desired direction
- Expansion of public-private partnerships to support early childhood efforts
- Reorganization of the inter-agency collaborative work group focused on early childhood system issues to include management staff (decision-makers), now called Oregon's Early Childhood Council; development of priorities toward family member inclusion, public-private partnerships, and setting priorities for early childhood system development activities

Several activities, projects, and events represent significant maturation of the state-level early childhood system development efforts.

Policy & Funding

State leaders, including the Governor, initiated several efforts that have policy implications for the early childhood system.

- Governor's Executive Order No. 07-04 creating the Statewide Children's Wraparound Project, to ensure coordination of services for children across agencies, and requiring coordination of funding across state agencies to facilitate services to children
- Additional state funding allocated for early childhood programs such as Head Start
- Early childhood mental health diagnostic codes and treatment guidelines, to allow billing for early intervention services

Programming

- The Early Childhood Comprehensive Systems Plan incorporates input from multiple stakeholders across the state and outlines strategies for achieving a statewide coordinated set of services across agencies and disciplines for young children
- The SIG-E project funded four pilot sites to implement and test the Starting Early, Starting Smart model and to operationalize best practice principles into local services

Data Infrastructure

The SIG-E project forwarded discussions regarding the complicated nature of client-level data sharing, confidentiality of sensitive data, and workload management for direct service providers. During the course of the project, efforts moved away from cross-system, cross-agency data integration and toward expansion and development of within-agency database management.

[1] As reported by key stakeholders at both the state and local levels.

The project facilitated:

- The inclusion of behavioral health information in early childhood electronic data gathering forms in the new ORCHIDS[2] data system for Maternity Case Management in Maternal Child Health.
- The development of a Systems Indicator Work Group to develop a plan to measure indicators of early childhood systems development.

Lessons learned will be incorporated in early childhood systems development and in the continuum of services for the Statewide Children's Wraparound Project.

LOCAL LEVEL

System Development

Many collaboration, policy, and programming outcomes also occurred through development of the local level early childhood systems.

- Resolution of conflict at local sites through increased understanding, negotiation, coordination, and communication
- Increased interaction between cultural groups and increased cultural responsiveness in direct services
- Local service enhancements (both increased service availability and increased quality of service by incorporating best practice principles)
- Extensive trainings for service providers and opportunities for staff to learn about each other's services

Prevention Services in the Pilot Communities

- The SIG-E pilot sites recorded 645 prevention services in the Minimum Data Set (a national prevention data system), with a total of 2,050 people participating. Services covered community-based processes, such as training and technical assistance; education, such as parenting services; information dissemination, such as the development of printed materials; and problem identification and referral, including families receiving preventive assessments.
- Incorporation of mainstream services into locations comfortable to families

CLIENT-LEVEL OUTCOMES

A small sample of families in the pilot sites participated in a client-level evaluation.

Significant findings included:

- Improved parenting skills and comfort with parenting (Native American families)
- Decreased domestic abuse (Caucasian families)
- Improved interest or pleasure in things [indicator of positive change in mental health] (Caucasian families)

The evaluation also found:

- A trend toward increased social support (Caucasian families)
- Sites identified children with a developmental delay, and connected all of them to appropriate services.

LESSONS LEARNED

The SIG-E project taught providers and decision-makers a variety of lessons:

- An explicit focus on substance abuse is necessary to assist affected families.
- Communities and service providers need to anticipate and tailor services to be responsive to various cultural groups.

[2] Oregon Child Health Information Data System (formerly FamilyNet), developed by the State of Oregon, Department of Human Services, Office of Family Health.

- Child Welfare is a critical partner in developing effective early childhood systems, to create strategies for overcoming families' (particularly families from frontier and ethnic/cultural minority groups) fears and encouraging them to participate in services.
- Leadership is crucial, both at local and state levels.
- Individuals and communities that actively engage in the system development process experience successes.
- Collaboration takes considerable time and energy.
- Systems change requires flexibility, extensive on-site training and technical assistance, and investment in cross-system communication and training.
- Communication between state and local levels is vital.
- Additional resources (time and money) increase services.
- Successful implementation of activities and Starting Early Starting Smart (SESS) principles requires extensive on-site training and technical assistance, and the inclusion of multiple partners.
- Logic models are a useful planning and management tool.
- Connecting with families at partner sites increases cross-agency collaboration.
- Health promoters (promotoras), natural helpers, and cultural liaisons increase service engagement of families within the cultural group and enhance provider response to the cultural community.
- Reaching out to families where they are increases client access to services.
- Public-private partnerships increase the sustainability of service enhancements.
- Local realities sometimes interrupt progress or continuity of efforts.
- Carefully consider the format of data collection tools. Ongoing training is necessary to collect the data.
    - Clients were reluctant to participate in the evaluation and share sensitive information, including CSAP-required GPRA data.
    - Survey length was burdensome to clients and providers.
    - Translation of forms required investment of time and funds, identification of appropriate contractors, and adjustment of data collection timelines.
    - Incentives may have increased the number of surveys that were completed.

Summary and Conclusions

Funds and focused attention helped state and local systems take on system development and collaboration tasks; progress was achieved, as evidenced by both policy level and program level changes. SIG-E stakeholders and site participants developed clarity on expectations regarding data infrastructure. Funds provided to the pilot sites helped communities build their local systems, increase service capacity, improve service quality, and reach different cultural groups.

PROJECT BACKGROUND & GOALS

In 2003, the Center for Substance Abuse Prevention (CSAP) awarded Oregon a State Incentive Grant (SIG-E) Enhancement for Early Childhood Prevention.

Project Goals

The goals of the SIG-E project were to:

1. Institutionalize data systems that collect information about the status of Oregon's prevention system and its ability to meet the needs of youth ages 0 to 6, and

2. Implement and evaluate Starting Early, Starting Smart prevention demonstration projects to build a knowledge base for successful implementation of integrated substance abuse prevention services throughout the state.

This project was intended to help continue Oregon's efforts to provide comprehensive services and supports to children ages 0 to 6 and their families, particularly focused on preventing caregivers' substance use and mental health issues, and promoting children's healthy physical, emotional, and social development. This project included statewide early childhood systems development and data infrastructure work, as well as community-level service system development (early childhood and behavioral health) and direct service components.

The project facilitated local system development and direct service enhancement through the funding of four pilot sites, one of which was to be a site serving Native American families and another serving Hispanic/Latino families. The sites were:

- Klamath Tribes, serving tribal families and Spanish-speaking migrant Head Start families through culturally specific service approaches and staffing
- Lake County, serving any family residing in this frontier county, but particularly focused on Lakeview and North County
- South Lane County, serving Family Relief Nursery families in Cottage Grove and childcare providers through Lane Family Connections; bi-lingual staff supported Spanish-speaking families in this site
- Western Washington County, serving Spanish-speaking families through a promotora model, a culturally responsive model to engage families in services

From the beginning of the project, leadership focused on the importance of the cultural responsiveness of SIG-E services, system development, and interactions with the diverse pilot site communities.

Local-level system goals include increased collaboration, increased capacity for seamless care, identification of behavioral health needs, increased services, and increased use of evidence in service delivery planning and implementation.

Local-level child and family goals of the project included improved parenting, improved parent-child relationships, improved quality of relationships, age-appropriate development, reduced parental substance abuse, and improved parental mental health.

Training and Technical Assistance

The evaluation team and project administration hosted four all-site meetings that included training on specific topics for the pilot site staff, including logic model development and use, evaluation and program monitoring tools, risk and protective factors, storytelling/marketing the program's message, and the impact of trauma on the brain.

Program and evaluation staff also visited each pilot site a minimum of twice, and provided support via conference call meetings.

The Northwest Early Childhood Institute was contracted to provide training and technical assistance to pilot sites based on their local needs and interests. This training and technical assistance involved staff from the Scientific Affairs Committee visiting the sites and meeting with program staff.

In addition to these training opportunities, the project sponsored several training series in multiple locations around the state on a variety of topics including system development, the impact of substance abuse/addition on brain functioning, and child development. These trainings were open to the wider early childhood system beyond the pilot sites.

Pilot Site Implementation

Administrative/ bureaucratic processes slowed the timelines for recruiting, selecting, and contracting with pilot sites. Local planning and implementation needed to occur before direct services could begin. The combination of these factors resulted in a shorter time period for involving families in the evaluation. Originally, the research design included 6 and 12 month follow-ups with families enrolled in SIG-E services. The second follow-up time point was dropped due to the extremely small sample and shortened time period.

Program Reporting and Monitoring

Pilot sites reported their progress to the project coordinator quarterly, through narrative reports describing their successes and challenges, financial status, and activities related to the SESS principles they had selected as part of their proposal. They also entered prevention activities into the Minimum Data Set on-line data system.

Program staff used this information to monitor progress and activities and to identify areas for feedback, training, or technical assistance. Program staff also learned about each site through e-mail and phone communications and visits to each site.

Near the completion of the pilot site grant period, each site completed a sustainability plan. This plan detailed the activities that would continue after the end of the grant, as well as the resources that would be in place to continue them.

Evaluating Change

The evaluation team developed and implemented a multi-method approach to assessing the SIG-E project's outcomes. In addition to the structured interviews and surveys, which collected both quantitative and qualitative data, the evaluation team attended all key project functions and meetings, and immersed itself in project activities to serve as participant observers of this system change effort. By gaining firsthand experience, developing a fuller understanding of the sites and the local and state dynamics, the evaluation team interpreted the findings of the evaluation activities more accurately and noted even small successes or when the quantitative data were inconclusive.

The following section of the report details the methods used in this evaluation.

METHODS

The project evaluation began with the development of a project-level logic model and logic model development with each of the four pilot sites. Logic models are a planning tool that help clarify the linkages between resources available to a project or initiative, planned activities, expected outputs (i.e., numbers to be served or trained, etc.), and expected outcomes and goals.

In order to evaluate the state-level systems change efforts of the SIG-E project, the evaluation team collected data to document and describe the status of Oregon's early childhood and behavioral health systems through state-level key stakeholder interviews and quantitative surveys focused on indicators of systems change. The evaluation team observed local-level systems changes by collecting similar data through local-level key stakeholder interviews and surveys.

In each pilot site, staff collected data on participating families to describe the service population and document client-level outcomes.

To document and measure changes in data infrastructure through the course of the project, the evaluation team collected information through Early Childhood Behavioral Health conference calls, review of documents (including meeting minutes) of teams working on database development (Integrated Client Database/Integrated Client Services Data Warehouse; Partner Shared Reporting System; FamilyNet Family & Child Module; Family Manager and other agency-specific databases or data systems), state and local key stakeholder surveys, and phone calls with key informants.

Research Questions

The SIG-E evaluation team drafted a set of research questions based on the original proposal and revised them with feedback from the project's Data and Evaluation Committee in November 2004. The questions were intended to cover a range of interests and were then linked to various measures and data collection activities. The research questions were reviewed by the original project director, executive committee, and advisory committee. While the specific research interests varied somewhat over the lifetime of the project, and related to changing leadership and partners, including local SIG-E sites, the broad questions remained the same:

- Are the state early childhood system partners and behavioral health system partners increasing their collaboration over time?
- What are the factors influencing success in building collaborative systems?
- Are the statewide data systems for prevention and intervention services for families with young children becoming more integrated at the client level?
- To what extent are the pilot sites successful at implementing SESS (Starting Early Starting Smart) components?

These questions were answered by a variety of evaluation activities, including several rounds of state and local level key stakeholder interviews, document reviews and compilation, and parent/caregiver and provider surveys about participating families.

Data and Evaluation Committee

At the start of the project, the evaluation team convened a group of representatives from the project's Advisory Committee to serve as the Data and Evaluation Committee. This group helped create and provided feedback on the research questions, methods, and measures for each component of the evaluation.

Institutional Review Board

NPC Research submitted a description of the evaluation procedures and measures to the Institutional Review Board (IRB) at Portland State University, for external feedback on the evaluation plan. The review included evaluation design, analysis plans, consent forms and procedures, survey instruments, and interview questions.

Evaluation Trainings

The evaluation team conducted a training at an all-site meeting, to introduce staff from each pilot site to the evaluation procedures and tools. Most of the pilot sites sent their project coordinator or evaluation liaison, but not necessarily the person/people who was going to complete the surveys or collect the families' surveys. The trained staff returned to the site to share this information with their local direct service staff. The evaluation team conducted trainings at each pilot site on the Home Observation for Measurement of the Environment (HOME) tool. Sites used the Ages and Stages Questionnaires and Ages and Stages Social Emotional Scale, but obtained training independent of the evaluation team. Evaluation staff conducted site visits, phone consultations, and/or e-mail communications with sites that requested additional information, clarification, or support on the evaluation plan.

Site Visits and Quarterly Progress Reports

The evaluation team met key staff in each pilot community to learn about the local project's design. The evaluation team attended all-site meetings and participated in conference calls with the sites. They reviewed and participated in feedback to sites on their quarterly progress reports and sustainability plans. These activities ensured that the evaluation team was aware of the progress made, the activities conducted, and the challenges and accomplishments of each site.

Logic Models

Logic models are "a systematic and visual way to present and share your understanding of the relationships among the resources you have to operate your program, the activities you plan, and the changes or results you hope to achieve" (W. K. Kellogg Foundation, 2004).[3]

The evaluators used the project's grant proposal and implementation committee to develop a project-level logic model that covered resources, activities, outputs, short-term (project) outcomes, and long-term (high-level) outcomes for systems change and data infrastructure goals. The evaluators worked with each of the four SIG-E pilot sites to develop site-specific logic models that described their resources, planned interventions, target populations, and short and longer term outcomes. This process ensured reasonable and logical connections between planned interventions and expected outcomes, and defined roles and responsibilities. The evaluation team used an ecological framework to analyze these components at the system, agency, and client levels (e.g., Koroloff, Walker, & Schutte, 2003).[4] Program staff used the logic models throughout the project to discuss implementation and progress, and the evaluators used them at the end of the project to assess the project's accomplishments. To view the project and site-level logic models, please see Appendices A and D.

[3] W.K. Kellogg Foundation. (January 2004). Logic Model Development Guide. http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf

[4] Focal Point: A National Bulletin on Family Support and Children's Mental Health: Quality and fidelity in Wraparound, 17(2), Fall 2003. Assessing the Necessary Agency and System Supports. http://www.rtc.pdx.edu/PDF/fpF0303.pdf

State-level Key Stakeholder Interviews and Collaboration Surveys

Evaluation staff conducted state-level key stakeholder interviews in Fall 2004 (Round 1), Fall 2005 through Winter 2006 (Round 2), and Summer 2007 (Round 3). The purpose of these interviews was to gather stakeholders' perspectives on accomplishments, challenges, and needs of Oregon's early childhood system; its links with behavioral health systems; and coordination of client data collection across systems (data infrastructure). The evaluation team conducted collaboration surveys in Rounds 1 and 2. Because of low response rates in the previous rounds, the evaluation team did not conduct these surveys in Round 3. The Early Childhood Team (the executive committee for the latter part of the project) adjusted the interview questions in Round 3 to include questions of primary interest to that group.

Local-level Key Stakeholder Interviews and Collaboration Surveys

Evaluation staff conducted local-level key stakeholder interviews in the four SIG-E pilot sites in late Summer through Fall 2005 (Round 1) and again in Fall 2006 through Winter 2007 (Round 2). The purpose of these interviews was to gather the local-level perspectives on the status of the early childhood system, families, client data sharing and data infrastructure, and staff work processes due to the SIG-E grant in these communities. The evaluation team also collected collaboration surveys in Round 1.

Client-level Surveys

To evaluate progress made toward client-level goals, pilot site staff collected data through parent surveys, intake (provider completed) surveys, Ages and Stages Questionnaires (ASQ) and Ages and Stages Questionnaires-Social Emotional Scale (ASQ-SE), and home observations (using the Home Observation for Measurement of the Environment [HOME] tool), and sent this information to the evaluation team. Pilot site staff asked families receiving services through the SIG-E to participate in the evaluation through surveys collected at intake and 6 months after intake[5]. Participation in the evaluation was voluntary and was <u>not</u> required in order for the family to receive services.

Minimum Data Set (MDS)

SIG-E pilot sites documented prevention activities and services that were part of their SIG-E grant. They recorded these services in the Minimum Data Set (MDS), a Web-based data system operated by the Center for Substance Abuse Prevention.

Early Childhood Behavioral Health Conference Calls

The monthly Early Childhood Behavioral Health conference calls were organized and managed by the SIG-E project coordinator, who was also responsible for Oregon Children's Plan sites. The calls included local staff from the pilot sites from both projects.

The purposes of the conference calls were to:

- Facilitate the exchange of information between Oregon Children's Plan and SIG-E sites regarding project implementation,
- Share resources by bringing on guest speakers on topics of interest to the sites, and
- Provide a means for sharing experiences and disseminating successes and lessons learned at the sites.

[5] Though the initial evaluation design included a 12-month follow-up survey, most families had not reached a 12-month follow-up point by the end of the project.

RESULTS

This section outlines the outcomes of the SIG-E evaluation at the system, local, and client levels. For additional details, the summary of findings for each of the evaluation components is located in the appendices of this report.

State-level Systems Results

SYSTEM DEVELOPMENT

The SIG-E project obtained results on state early childhood system development in three main areas: collaboration, policy and funding, and programming.

Collaboration

By the end of the SIG-E project, stakeholders reported movement in the development of collaborations, including increased education and awareness people had gained in different parts of the system.

Stakeholders at both the state and local levels[6] reported similar challenges across the project related to lack of resources (e.g., time, staff, direct services) and the difficulty of communicating and collaborating between state agencies and different disciplines and systems. It was noteworthy that key stakeholders had an increased recognition of the steps that are involved in system change and the amount of time and effort it takes for that to occur. In general, people reported the development of multiple projects and efforts in many communities and across a variety of agencies that cumulatively are moving the system in the desired direction, even though the pace of progress seems slow to some people working in the midst of these efforts. Stakeholders reported that the SIG-E grant offered opportunities for different communities and people in different agencies to share with each other what projects are happening, and what strategies people are using to overcome barriers and address needs. This project created forums for these professionals to learn from each other.

As reported by key stakeholders at both the state and local levels, this project contributed to increased collaboration between state early childhood system partners and behavioral health system partners. As a result, several key outcomes were achieved.

- Substance abuse treatment and mental health providers learned about issues related to early childhood development and parenting (including early screening and identification), and early childhood providers learned about the impact of parental mental health and substance abuse issues on child development and on parenting/family functioning.
- Increased recognition of the steps that are involved in system change and the amount of time and effort it takes for that to occur
- Development of multiple projects and efforts in many communities and across a variety of agencies that cumulatively are moving the system in the desired direction
- Expansion of public-private partnerships to support early childhood efforts
- Reorganization of the inter-agency collaborative work group focused on early childhood system issues to include management staff (decision-makers), now called Oregon's Early Childhood Council; development of priorities toward family member inclusion, public-private partnerships, and setting priorities for early childhood system development activities

[6] For additional detail about the results of the state-level or local-level key stakeholder interviews, please see Appendices B and C, respectively.

Several activities, projects, and events represent significant maturation of the state-level early childhood system development efforts.

Policy & Funding

State leaders, including the Governor, initiated several efforts that have policy implications for the early childhood system.

- Governor's Executive Order No. 07-04 creating the Statewide Children's Wrapa-round Project, to ensure coordination of services for children across agencies, and requiring coordination of funding across state agencies to facilitate services to children
- Additional state funding allocated for early childhood programs such as Head Start
- Early childhood mental health diagnostic codes and treatment guidelines, to allow billing for early intervention services, removing a barrier frequently used as an explanation for why services to this age group were unavailable

Programming

- The Early Childhood Comprehensive Systems Plan incorporates input from multiple stakeholders across the state and outlines strategies for achieving a statewide coordinated set of services across agencies and disciplines for young children
- The SIG-E project funded four pilot sites to implement and test the Starting Early, Starting Smart model and to operationalize best practice principles into local services

DATA INFRASTRUCTURE

One of the initial primary goals of this project was further integration of client data systems across state agencies.

NPC evaluated the development of the state's data infrastructure by documenting key achievements and barriers. Evaluation staff collected information through key stakeholder interviews and updates from players involved in data infrastructure development.

During this project, state and local staff confirmed the complicated nature of sharing sensitive data, confidentiality issues, and workload management.

Data infrastructure efforts moved away from early childhood/cross-system data integration, and toward expansion and development of within-agency database management. The inclusion of behavioral health information in early childhood electronic data gathering forms[7] demonstrates the accomplishment of a link between behavioral health and public health. In addition, the project sparked meetings of a new group of professionals across state agencies and partner organizations with knowledge of data, research, and evaluation, to establish indicators for the early childhood system and develop a plan to measure and monitor them.

The project facilitated:

- The inclusion of behavioral health information in early childhood electronic data gathering forms in the new ORCHIDS[8] data system for Maternity Case Management in Maternal Child Health.
- The development of a Systems Indicator Work Group to develop a plan to measure indicators of early childhood systems development.

[7] Specifically, data forms used by nurses and other staff from the Office of Family Health now include several early childhood and behavioral health items in the Oregon Children's Health Information Data System (ORCHIDS) for Maternity Case Management in Maternal Child Health.

[8] Oregon Child Health Information Data System (formerly FamilyNet), developed by the State of Oregon, Department of Human Services, Office of Family Health.

Local-level Systems Results

In addition to the parallels with the state-level systems development outcomes, key stakeholders at the local level[9] reported additional accomplishments, including increased collaboration between providers, and increased access to and enhancement of services due to the resources of this project.

All of the pilot sites addressed cultural differences that were creating barriers to services, and increased outreach, engagement in services, and provider education. They experienced notable increases in interactions between cultural groups, cultural responsiveness of providers, and developments in relationships between providers and various cultural groups in their communities. For example, in one of the pilot sites, tribal services and community services developed important relationships and changed norms in the local Native American and Latino communities so that families became willing to receive services from agencies that they had not accessed before.

As part of the local system development, pilot sites offered trainings on new approaches and new curricula; resolved conflicts such as turf issues and communication barriers by increasing understanding, negotiation, coordination, and communication; and facilitated opportunities for local agencies staff to develop relationships and learn about the range of services available in the community. The sites increased service availability by offering mainstream services in non-traditional locations comfortable to families, and increased the quality of services by incorporating additional best practice principles. Some pilots sites developed new service models and strategies based on the unique needs of diverse groups in the service area.

The evaluators and state staff found that pilot site understanding and operationalizing of the SESS principles in their services took considerable time and effort. The document developed by Northwest Early Childhood Institute provides a research base for these SESS principles.

PREVENTION SERVICES IN THE PILOT COMMUNITIES

Pilot sites recorded a range of numbers and types of prevention services in the Minimum Data Set (MSD) data system (from 14 in one site, to 314 in another). It is likely that the smaller number is an under-representation based on incomplete entry of activities into the MDS. The number of people participating in these services ranged from 54 to 917 per site (these numbers may include some people who participated in more than one activity).

Prevention Categories

Sites recorded a total of 645 prevention services with a total of 2,050 people participating. Services covered:

- Community-based processes, such as training and technical assistance
- Education, such as parenting services
- Information dissemination, such as the development of printed materials
- Problem identification and referral, including families receiving preventive assessments.

Sites also provided information to the evaluation team about other activities they conducted and services provided during the course of their grants. Please see Appendices E and F for additional detail about the numbers and types of services the pilot sites provided.

Client-level Outcomes

A small sample of families who received direct services in the pilot sites participated in a client-level evaluation. In most cases, these families were those who entered services early in the pilot site's implementation of the

[9] For additional details about the results of the local-level key stakeholder interviews, please see Appendix C.

grant activities, so that enough time would elapse for the program to obtain outcome data on them. However, they received service before the sites had fully adopted the SESS principles and before the system level changes described above had occurred. Families served later likely received greater benefits, but are not included in the data described here. For a variety of reasons, data collection at the client level was complicated and challenging, resulting in small sample sizes for conducting analysis, and therefore inadequate statistical power for detecting some of the significant changes that may have been present.

Despite the small sample, results showed several significant findings for the participating families:

- Improved parenting skills and comfort with parenting (Native American families)
- Decreased domestic abuse (Caucasian families)
- Improved interest or pleasure in things [indicator of positive change in mental health] (Caucasian families)

The evaluation also found:

- A trend toward increased social support (Caucasian families)
- Sites identified 12 children with a developmental delay, and connected all of them to appropriate services.

While substance abuse prevention is a focus of this grant, families were reluctant to share information about their use, therefore the evaluation did not have enough data to measure change in this area. For additional detail about the client-level outcomes, please see Appendix G.

Research Questions: Results

1. **Are the state early childhood system partners and behavioral health system partners increasing their collaboration over time?**

Yes. Key stakeholder interviews illustrated positive development of collaborations both within the early childhood system and between early childhood and behavioral health. Significant cross-system sharing, training, and communication occurred.

2. **What are the factors influencing success in building collaborative systems?**

- Leadership.
- Time and energy.
- Engagement in and commitment to the system development process.
- Communication and training within and across all levels and systems.
- Training and technical assistance, preferably on site.

3. **Are the statewide data systems for prevention and intervention services for families with young children becoming more integrated at the client level?**

No, during this project, data infrastructure efforts moved away from cross-system data integration and toward expansion and development of within-agency database management. However, behavioral health and public health strengthened a connection through the inclusion of behavioral health and child development information being added to electronic data gathering forms for Maternity Case Management in Maternal Child Health.

4. **To what extent are the pilot sites successful at implementing SESS (Starting Early Starting Smart) components?**

Based on local key stakeholder interviews, site visits, conference calls, and analysis of pilot site quarterly reports, pilot sites made significant progress toward understanding the SESS principles and creating locally specific ways to implement them.

LESSONS LEARNED

The SIG-E project resulted in lessons learned to inform continued system development and service delivery enhancement at the state, local, and client levels.

Lessons learned: Project

Leadership is crucial, both at local and state levels.

Successful progress toward creating system changes appeared to be related to leadership and commitment of key decision-makers. Local administration and cultural leadership was crucial for success of the pilot site efforts. Role clarity, definition of a shared vision, and agreement about outcome measurement (what to measure, when, who will do it, and what will the results be used for) were all essential elements.

Engagement in the system development process contributes to success.

Individuals and communities that actively engaged in the system development process experienced successes. This finding mirrored results in a prior SIG project and in other system development efforts. Individuals matter and when groups come together and identify an issue, progress is much more likely to occur. In pilot sites, much progress was made with activities such as:

- Staff outreach efforts
- Linking of existing groups working on similar issues
- Educating and communicating with key partners
- Setting community level priorities
- Implementation of extensive training opportunities for service providers and/or the larger community
- Working through community challenges

These activities successfully increased services to culturally distinct populations.

Collaboration takes time and energy.

When conflicts (personalities, competitiveness, etc.) arise, they slow the process. Working through the conflict enhances process and outcomes. Collaboration and resolving difficulties can be crucial to having system changes move forward.

As system change efforts were implemented, partner agencies:

- Recognized what adjustments needed to be made or what interim steps were necessary to reach the next stage. This type of work requires flexibility and a willingness to collaborate
- Learned about activities in other agencies that were similar to or duplicative with the project activities
- Built relationships with other agency staff
- Negotiated roles and information-sharing strategies
- Underwent mediation to address issues that arose related to access to resources, including grant money and information

Communication between state and local levels is vital.

The local partners have specific experience that contributes to the knowledge of the entire system, and the state has an important leveraging and "big picture" role that is also invaluable. Key stakeholders at the local level repeated their call to state partners to pay attention to activities at the local level and state partners heard this request. During the project, information-sharing between communities increased as communities shared with the state and each other what they had learned through their experiences.

Additional resources (time and money) increase services.

Grant money from the SIG-E project paid for staff time that increased services to outlying, rural areas, and to special populations. Most sites reported that these resources helped but still did not fully meet the existing needs. Additional resources would allow projects such as the SIG-E to meet their full potential. In particular, staff need dedicated time to commit to collaboration activities, including increased communication with partner agencies; planning and policy discussions; training of staff on new principles, curricula, procedures, service enhancements, etc.[10]

Successful implementation of activities and SESS principles requires extensive on-site training and technical assistance and the inclusion of multiple partners.

State staff learned that they needed to dedicate resources to visiting pilot sites and providing training and technical assistance in both how to enhance collaborations and how to operationalize the SESS principles, to facilitate these changes occurring at the local level.

Pilot sites learned the benefits of collaborations and the SESS principles. Through working together and building relationships with multiple partners, those providers increased their understanding of each other's services and roles; they learned where to go with questions, referrals, and other client-related issues, which resulted in clients being better served.

An explicit focus on substance abuse is necessary to assist affected families.

Most pilot sites elected to address mental health and screening for children even though the grant was funded by the Center for Substance Abuse Prevention. Families and providers did not provide data on substance use/abuse, and needed support and training in how to raise these and other sensitive issues with families. Pilot sites that anticipated and developed services addressing addiction issues were more likely to identify these issues and support families in accessing needed treatment and supports. Addressing substance abuse issues needs to be anticipated and planned for prior to project implementation.

Substance abuse continues to challenge families, communities, and service providers; a clear focus on and commitment to substance abuse prevention and treatment are needed to assist families and ensure appropriate support for their young children.

Logic models are a useful planning and management tool.

The logic models captured the essential objectives, inputs, outputs, short- and long-term goals. They helped local staff by providing a shared understanding, and visual representation, of the project, and they helped state project staff monitor changes and progress and identify training needs.

Behavioral health agencies connecting with families at partner sites increases cross-agency collaboration.

The SESS approach to connecting with families at partner sites increased cross-agency coordination and collaboration at both the program level and the family level. Agency staff developed relationships with each other and learned more about the services available to families, built trust, and increased referrals and cross-agency partnerships.

[10] Focal Point: A National Bulletin on Family Support and Children's Mental Health: Quality and fidelity in Wraparound, 17(2), Fall 2003. Assessing the Necessary Agency and System Supports. http://www.rtc.pdx.edu/PDF/fpF0303.pdf

Health promoters (promotoras), natural helpers, & cultural liaisons increase service engagement of families within the cultural group and enhance provider response to the cultural community.

These individuals trained other line staff in how to connect with families. They worked with partners and area businesses to increase business/private/broader community support for and investment in prevention services, such as parenting classes.

Direct services must be adapted to meet the needs of the local culture(s).

When communities and service providers anticipate and tailor services to various cultural groups, more families engage in services. Staff from the pilot sites spent time asking the communities they planned to serve what their needs were and how to best meet them, what barriers existed for families, and what factors would increase interest in and retention in services. By implementing these suggestions, they served their local populations more effectively.

Reach out to families where they are.

When direct service providers identify the best locations and strategies for accessing and serving families, more families engage in services. These locations and strategies vary from community to community. Home visiting and the linkage of behavioral health and early childhood services works to serve families in an environment comfortable to them.

Public-private partnerships increase the sustainability of service enhancements.

Pilot sites that engaged public and private sector support maintained components of their direct services beyond the end of SIG-E grant funding.

Be persistent and patient. Local realities sometimes interrupt progress or continuity of efforts.

Some events were scheduled or intended and some were unexpected, including staff turnover or leaves due to pregnancy, maternity, family issues, medical issues, job changes, and retirement; and service closing for breaks or for the summer.

Involve Child Welfare in partnerships.

Child Welfare is a critical partner in developing effective early childhood systems, to create strategies for overcoming families' (particularly families from frontier and ethnic/cultural minority groups) fears and encouraging them to participate in services. One of the pilot sites developed a new relationship with an interested child welfare staff person. With his involvement in the collaboration, the team developed strategies for helping families feel more comfortable accessing services.

Lessons learned: Evaluation

Carefully consider the format of data collection tools. Ongoing training is necessary to collect the data.

Client-level outcomes were difficult to measure using the survey form selected. While evaluators received positive feedback from many partners in developing the research questions and evaluation forms, providers, families, and many pilot site staff resisted completing and collecting them, based on:

- Cultural differences
- The sensitive content of the questions, particularly the inclusion of CSAP-required GPRA questions
- The length of the materials due to an effort to collect information across a variety of outcomes of interest and the inclusion of GPRA items

These barriers contributed to a lack of buy in from families and providers to the evaluation process. Site staff completed a small sample of forms and with some forms missing the more sensitive information, particularly related to substance use. Incentives may have increased the number of surveys that were completed.

Though the evaluation team trained pilot site staff, conducted site visits, and communicated with sites via phone and e-mail, additional (ongoing) efforts were needed to train, remind, and ensure buy-in of all relevant staff into the process.

Translation of forms requires planning ahead and investing resources.

The evaluation team created the forms in English and translated them into Spanish to accommodate the majority of families the pilot sites anticipated serving. Families who spoke languages other than English and Spanish were not included in the evaluation.

In order to have forms in Spanish, the evaluation team had to:

- Identify translators with the expertise in social services to translate terminology accurately, by gathering recommendations from a variety of agencies and colleagues
- Dedicate funds to pay for this professional service
- Adjust evaluation timelines and data collection expectations to accommodate the lead times needed by many translators
- Identify translators who were from the same national, regional, and cultural backgrounds as the staff and families, whenever possible, or alternately hire translators who utilize a universal form of formal Spanish that would maximize its applicability across dialects

Systems-change efforts may not result in immediate client-level changes.

Because the pilot sites engaged in system change efforts (strengthening the local-level early childhood, substance abuse, and behavioral health systems) and worked to implement the SESS principles (such as creation or enhancement of multi-disciplinary teams and implementation of a new developmental assessment process at well-child visits), and because of the timing of the project, families included in the evaluation were those served early in the pilot projects, before sites fully implemented these changes and enhancements.

The original evaluation plan was to survey clients at intake, with follow-up surveys at 6 months and 12 months. Most of the clients had not been served for 12 months before the end of the pilot site projects, and approximately half of the clients reached the 6-month follow-up point during the SIG-E project's timeline. Evaluation surveys therefore became more useful for describing the populations being served than for producing data to show client impact.

These challenges and changes to the original evaluation plan resulted in the following learnings:

- Allow pilot site/project start-up time and do not plan to collect client-level data during planning or early implementation, except for descriptive information and process information (such as outputs and the rate of new clients being served, etc.).
- Plan intermediate data collection points. The 6-month data collection allowed the evaluation team to measure some client-level outcomes even though the 12-month data collection point became infeasible.
- Collect system development indicators. The key stakeholder interviews informed the evaluation and project leadership. Other direct or archival measures of system development might have provided additional information.
- Ensure that pilot sites understand the importance of evaluation activities as a part of their work, through communications from project leadership, contractual requirements, and ultimately the linking of payments to sites' participation in evaluation activities.

APPENDIX A: OVERALL SIG-E PROJECT LOGIC MODEL

Overall Logic Model – SIG Enhancement for Early Childhood Prevention

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
	In order for the program to accomplish its set of activities, it will need the following:	*In order for the program to address its problem or asset, it will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence or service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in the following months/years:*	*We expect that if accomplished, these activities will lead to the following changes in the following years:*
Systems Change	1.State Agencies • Department of Human Services • Department of Education • Oregon Commission on Children and Families • Employment Dept., Child Care Division	1. Meetings to determine definition of roles & coordinate responsibilities of agencies and organizations involved with early childhood system	1. 48 Meetings with early childhood and behavioral health systems' partners (with leaders/ decision makers present) - state level and pilot sites (10 SIG Executive Committee meetings/year for 2 years; 10 SIG Core Staff meetings/year for 2 years; 8 SIG Data & Evaluation Committee meetings)	1. Definition of roles & responsibilities of agencies and organizations that are part of the early childhood/behavioral health systems	1. Early childhood "system" in place (both state and local) a. Visible by general community b. Process in place for sustaining continuous improvement c. Leadership commitment

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
Systems Change cont.	2. Trainings/trainers	2. Training and TA to teach SESS communities & other implementers evidence-based prevention principles, including cultural competency, to child/family service providers & state agency personnel	2. 150 Early childhood and behavioral health service providers trained regionally (3 Regional training rounds @ 10/region)	2. Policy, procedures, law, and funding changes	2. Culturally relevant and appropriate early childhood system (positive outcomes for all children/families regardless of race, etc.)
	3. Site participants' experience doing early childhood work	3. Share experience/learning at the local level with other counties and with state agencies/partners	3. 100 early childhood and behavioral health providers trained, topic specific (5 specific topical trainings @ 20 providers ea.)	3. Increased state-level knowledge about dealing with high-risk children/families	3. Integrated early childhood and behavioral health systems (as measured by key stakeholder report)
	4. Governor and Legislators	4. Invite family participation in planning, implementation, training, and evaluation.	4. Six meetings to transfer information to state (evidence of communication between sites and state) (2 SIG Advisory Committee meetings/year)	4. Greater awareness by mental health organizations, etc., regarding children 0-6	4. Good health and positive development of young children

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
	5. Parents/Families		5. Three meetings to transfer information to Governor, Legislature and other policy makers.	5. Greater awareness by the early childhood system of behavioral health and the behavioral health system (as evidenced by increased identification of children/families assessed)	5. Bonding and attachment in the early years of a child's life
	6. Staff and managers who implement culturally appropriate services		6. Parent representation on all SIG decision-making committees	6. Integration of SESS principles in early childhood and behavioral health systems	6. Parents providing the optimum environment for their young children
	7. Time devoted to collaboration and coordination			7. Services serve all families well, including special populations (as measured by positive child and family outcomes)	7. Children entering school ready to learn
	8. Evaluation team and data			8. Increased family involvement in early childhood system (as measured by parent representation on policy boards)	

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
Data Infrastructure Development	1. FamilyNet	1. Meetings of various groups of partner agencies to discuss data coordination efforts a. Determining common identifier b. Developing policies & procedures c. Developing common reporting mechanisms for service outputs & outcomes d. Sharing client-level service information on active clients/ participants	1. Common client identifier, when applicable	1. Pathways are built for behavioral health indicators, including appropriate interventions, outcomes and service coordination	1. Client-level early childhood & behavioral health data available and piloted in FamilyNet
	2. Integrated Client Database (ICDb) (archival data)	2. Providing information about behavioral health elements to include in FamilyNet	2. Behavioral health elements established by FamilyNet	2. Pathways are developed for screening, referral and case coordination for children at risk for behavioral health disorders	2. Coordinated reporting data mechanisms developed
	3. Partner Shared Reporting System (PSRS) (summary data)	3. Testing of FamilyNet in pilot sites		3. Diversified number and type of users of the data system (e.g., physicians, childcare professionals)	3. Introduction of FamilyNet to behavioral health providers

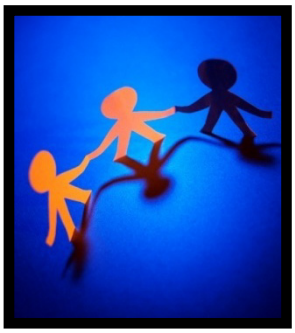
	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
	4. Evaluation team 5. Pilot sites				4. Early childhood service providers collecting behavioral health information and sharing information with behavioral health providers

APPENDIX B: STATE-LEVEL KEY STAKEHOLDER RESULTS ROUND 3

Key Findings from the State Incentive Grant – Enhancement for Early Childhood Prevention

State-level Key Stakeholders Round 3 (2007) Report Summary

Project Overview



In 2003, the Center for Substance Abuse Prevention (CSAP) awarded Oregon a State Incentive Grant Enhancement for Early Childhood Prevention (SIG-E). This project was intended to help continue Oregon's efforts to provide comprehensive services and supports to children ages 0 to 6 and their families, particularly focused on addressing caregivers' substance use and mental health issues, and promoting children's healthy physical, emotional, and social development. In addition to work at the state systems level that is focused on early childhood and behavioral health[11], the SIG-E project funded four pilot sites in Oregon to conduct local systems opment and service delivery enhancements.

State-Level Key Stakeholders

NPC Research staff interviewed 23 state-level key stakeholders across the state and across systems in 2004 (Round 1), 16 state-level key stakeholders in 2005-06 (Round 2), and 17 state-level key stakeholders in 2007 (Round 3). The purpose of these interviews was to gather stakeholders' perspectives on accomplishments, challenges, and needs of Oregon's early childhood system; its links with behavioral health systems; and coordination of client data collection across systems. Oregon's Early Childhood Team (ECT)[12] became the SIG-E project's Executive Committee in 2006. For the third round of state-level interviews, the ECT requested some additional questions specific to their role and interests.

Summary of Results[13]

Information gathered during Round 3 of state-level interviews for the SIG-E project indicates:

- Some of the challenges identified in Rounds 1 and 2 were addressed
  - Resource limitations,
  - System complexity and
  - Partners' understanding of the various service systems, and
- Identification of additional accomplishments and challenges that have occurred since the earlier interviews were conducted,
  - Systems development,
  - Increased resources, and
- Steps needed in order to continue making progress in improving and linking systems.

[11] Behavioral health includes substance abuse prevention and treatment, and mental health services.
[12] Now called Oregon's Early Childhood Council
[13] For additional details about the Round 3 State-level Key Stakeholder interviews, please see the full report. Contact Juliette Mackin (mackin@npcresearch.com) or Judy Weller (weller@npcresearch.com), 503-243-2436.

BIGGEST ACCOMPLISHMENTS INCLUDE:

Systems Development

- Release/implementation of the Early Childhood Comprehensive Systems Plan (ECCS)
- Reorganization of the state early childhood leadership work groups[14]
- Development of private-public partnerships and other new partnerships (e.g., with Northwest Early Childhood Institute)
- Implementation of the Statewide Children's Wraparound Project
- Submission of recommendations from the SIG Early Childhood Cross Systems Forum in May 2007 to the Steering Committee for the Statewide Children's Wraparound Project
- Continued development of the Oregon Model work (supporting children's social-emotional development)

Increased Resources

- Legislation/plans to strengthen the system (e.g., increased funding for Head Start)
- Adoption of early childhood mental health diagnostic codes and treatment guidelines
- New facilities/infrastructure to support families (e.g., state hospitals, housing)
- Improvements in cross-cultural service delivery, providing more culturally appropriate services

Stakeholders also identified accomplishments that were part of the *proces*s of systems development, such as increased visibility (increased awareness of early childhood issues in the general population and within behavioral health), increased collaboration and coordination (e.g., working toward a shared agenda), improved communication across disciplines and programs, the formation of other groups and partnerships that are working toward early childhood system development, learnings/insights gained through the SIG-E project, and a willingness to invest in the early childhood system.

MAJOR CHALLENGES:

Even though Round 3 key stakeholders identified increased resources as a major accomplishment, they also considered the need for additional resources (funding, personnel, time) to be a challenge, as did stakeholders during Rounds 1 and 2. Stakeholders in all 3 rounds of interviews agreed that additional leadership and communication are needed in order to improve the early childhood system. Round 3 stakeholders pointed out that getting the necessary people/agency representatives together to do early childhood systems work is a challenge (e.g., agencies/representatives, family members, people of color, and ethnic minorities missing from the table; ECT/Steering Committee member scheduling conflicts). Other challenges include inter-agency tension and lack of coordination, inconsistent quality of county Commissions on Children and Families, lack of demonstrated positive outcomes, and the need for workforce training in early childhood behavioral health issues. Stakeholders identified challenges related to evidence-based practice: the need for consistent requirements, funding, and additional research.

STEPS NEEDED IN ORDER TO CONTINUE MAKING PROGRESS IN IMPROVING AND LINKING SYSTEMS. GREATEST NEED:

While gains were made in systems development, and resources increased over the course of the SIG-E project, additional work in the process of developing systems and resources is needed in the following areas to improve the early childhood system at the state level:

[14] The Early Childhood Team and Steering Committee merged to create Oregon's Early Childhood Council.

Systems/policy level

- New partners (broader than government)
- Restructure ECT [which has recently occurred]
- Prioritizing prevention as a state policy
- Continued investment in the Statewide Children's Wraparound Project
- The establishment of standards (competency requirements in all 3 systems)/cross-system understanding
- Policy changes (e.g., for multiple funding strategies)
- Cross-systems training/workforce development

Agency level

- Coordinated data systems/indicators
- Leadership
- Communication/engagement (e.g., between state ECT and Partners for Children and Families; public awareness of the relationships between early childhood and behavioral health)
- Common goals and agreements (such as those among partner organizations)
- Collaborative planning
- Cross certification (e.g., the early childhood/mental health certificate offered at Portland State University)
- Common/shared screening

Program level

- Health screening (each time a child enters the system)/immunization
- Additional development of integrated services for families (e.g., parenting education)
- Additional involvement of families in the planning and decision-making process

Additional resources are also needed

- All levels and types of resources (trained staff, dedicated staff time, flexible dollars, more dollars for early childhood, infrastructure, service delivery, behavioral health consultation to early childhood providers)
- Braided resources (the ability to merge funding for enhancements and service integration)
- Staff across systems who are educated/understand the importance of the connections between early childhood and behavioral health issues

DATA INFRASTRUCTURE

As in Rounds 1 and 2, Round 3 stakeholders were divided on the question of whether or not client information should be shared across different systems. Those that believed such sharing should take place reported needs for

1. Shared values across agencies regarding data,
2. Agency agreements to share data,
3. Family-level permissions to release data, and
4. Data systems that are capable of sharing data with other data systems.

APPENDIX C: LOCAL-LEVEL KEY STAKEHOLDER RESULTS ROUND 2

SUMMARY OF FINDINGS

PROJECT OVERVIEW

In 2003, the Center for Substance Abuse Prevention (CSAP) awarded Oregon a State Incentive Grant (SIG-E) Enhancement for Early Childhood Prevention. This project is intended to help continue Oregon's efforts to provide comprehensive services and supports to children ages 0 to 6 and their families, particularly focused on preventing caregivers' substance use and mental health issues, and promoting children's healthy physical, emotional, and social development. This project has included statewide early childhood systems development and data infrastructure work, as well as community-level service system development (early childhood and behavioral health) and direct service components.

LOCAL-LEVEL KEY STAKEHOLDERS

NPC Research staff interviewed local-level key stakeholders in the four SIG-E pilot sites (Klamath Tribes, Lake County, South Lane County, and Western Washington County) at two points in time. They conducted the first round of interviews during late summer and fall 2005. The second round of interviews occurred in fall 2006 and winter 2007. The purpose of the second round of interviews was to gather the local-level perspectives on the post-SIG-E status of the early childhood system (accomplishments, challenges, what was learned, and the resources still needed for development of the early childhood system); families (whether they are getting substance abuse and mental health services, whether staff are comfortable asking them about those issues, families' goals); and staff work processes (individualized direct services, cross-disciplinary work).
The following section summarizes the findings from the second round of local-level key stakeholder interviews. The emergent themes are grouped in categories based on the interview questions.

RESULTS

Accomplishments achieved by SIG-E pilot sites

Local-level key stakeholders reported the following accomplishments following implementation of the SIG-E project in their communities:

- The amount of collaboration (for example, between tribal and other community agencies; community projects, such as brain development training; new referral sources)
- The amount of services available to families
- Enhancements in direct services (for example, adopted standardized screening tools, including the Ages and Stages Questionnaire and the Ages and Stages Questionnaire-Social/Emotional Scale)
- Greater understanding (of roles, people, child development) on behalf of staff as well as members of the community; increased understanding of the complexity of the challenges of trying to collaborate across systems; knowledge about what other agencies do and where to make referrals
- Greater community awareness (e.g., regarding early childhood development)
- Relationships (Inter-agency as well as within the community)

- Increased numbers of trainings/education
- Development of a system/coordination of care for children 6 years old and younger

Barriers and challenges to SIG-E pilot sites

Local-level key stakeholders reported the following barriers and challenges following implementation of the SIG-E project in their communities:

- Resource limitations (transportation, personnel, families without insurance)
- The time and work it takes for collaboration/coordination (merging different perspectives, communication between different organizations, recognizing expertise in other fields)
- Limitations in the ability to provide direct services (e.g., barriers for mental health billing for young children, some people not acknowledging that young children can have mental health issues)
- Personal, sensitive nature of some questions on the evaluation surveys
- Difficulties in changing existing systems and increasing coordination of care (e.g., paperwork issues)
- Staff disappointment due to expectations vs. actual results (e.g., number of referrals lower than hoped)
- Cultural differences and language barriers (finding/hiring Spanish-speaking staff, paperwork in Spanish language, finding Spanish-speaking resources to which referrals can be made; working with people of different educational backgrounds)
- Communication (inter-agency, knowing which resources are available, families moving out of the area resulting in being unable to do follow-up with them)
- Mental health stigma (reluctance of some parents to allow mental health assessment of child)

Lessons learned during the SIG-E pilot project

- Increased understanding of the value of using evidence-based practices
- Awareness on part of different agency members of the need to communicate with each other
- The importance of involving all possible community/tribal resources in planning and service delivery
- How to be better collaborators/communicators
- How to fill gaps in the systems of care
- The importance of hiring people who are a good fit for the philosophy of the program
- The benefits of the ASQ-SE and how/when to use it
- How to do better community outreach (meet families, childcare providers where they are)
- Taking a prevention/early intervention approach with families results in families identifying their own needs and availing themselves of services, and is less threatening than a directive approach
- The challenges faced by child care providers (e.g., getting training for state childcare certification [needs to be in home or otherwise accommodate time and access constraints due to the nature of their work]; low pay; need for support groups for childcare providers)

Resources still needed by SIG-E pilot sites

Most resources that respondents said are still needed require extended funding beyond the SIG-E grant period:

- Project coordinator to coordinate systems and ensure ongoing training and communication continues
- Continued resources for family support worker
- Staff (culturally-sensitive staff to work with children and families in Latino and Tribal communities; child psychiatrist; Alcoholics Anonymous groups that are specific to race/culture)
- State investment in prevention/early intervention
- Continued measurement of services
- Pool of mental health consultants
- Culturally sensitive advisors to work with children and families within Tribal and Latino communities
- Increased infant-toddler resources/building capacity within the community (e.g., a child psychiatrist)
- Additional training (social-emotional, child care provider certification)
- Relationships at the community level (physicians, mental health professionals, dependency counselors) to allow systems to change
- Continued collaborative and multi-disciplinary teams

Substance abuse/mental health treatment for families in SIG-E pilot sites

- For the most part, those families who were identified as needing treatment were referred to the proper services, though one site reported more success getting families mental health treatment than substance abuse treatment
- More consistent protocol for the referral process (e.g., a flow chart) would be useful

SIG-E staff comfort with hard questions (such as asking a family about alcohol or drug use)

- Most staff are comfortable with asking families questions about personal and sensitive topics
- Some families are uncomfortable responding to questions about alcohol use, drug use, or other questions that they feel are invasive or put their families at risk of being judged or involved with the child welfare system

SIG-E families' goals

- Accessing/obtaining additional resources (health coverage, treatment services, transportation, mentors)
- Independence (being able to support their families and manage family life)
- Meeting basic family needs (food, housing, gas money to get to work)
- Normalcy; to have a happy and healthy family
- Understanding and education (childhood development, parenting skills, roles, language skills)
- Cross-generational connections and stable relationships

Individualization of services in SIG-E pilot sites

- Everyone interviewed indicated that they either completely or usually individualize their services
- Services are based on the individual needs of each family

Cross-disciplinary work in SIG-E pilot sites

- Respondents indicated that they are cross-disciplinary in their work
- Dealing with the differing aspects and demographics in each site requires a multi-disciplinary team in many cases
- Teams look at several different levels of involvement for meeting the needs of children and families

CONCLUSION

While most of the accomplishments and barriers identified in these interviews were consistent with the Round 1 local-level key stakeholder interviews, the Round 2 interviews identify some new themes and areas of concern. New accomplishments included the amount of services offered to families, community participation, and the building of relationships at the client and inter-agency levels. New barriers/challenges included balancing expectations against the actual outcomes of the pilot project, the merging of a variety of different perspectives on behalf of experts in different fields involved in the grant, and implementing evaluation tasks into their project work.

The main challenges can always be traced back to the issue of funding; whether it be the need for more time or people, more funding was a root concern for most interviewees. That being said, almost all of those interviewed regarded the SIG-E project as making positive inroads into solving problems that have been persistent in their respective communities and helping to provide services and supports for families whose main goals are simply to have healthy and positive relationships with their children.

For additional information, contact Juliette Mackin at NPC Research, mackin@npcresearch.com, 503-243-2436.

APPENDIX D: PILOT SITE LOGIC MODELS

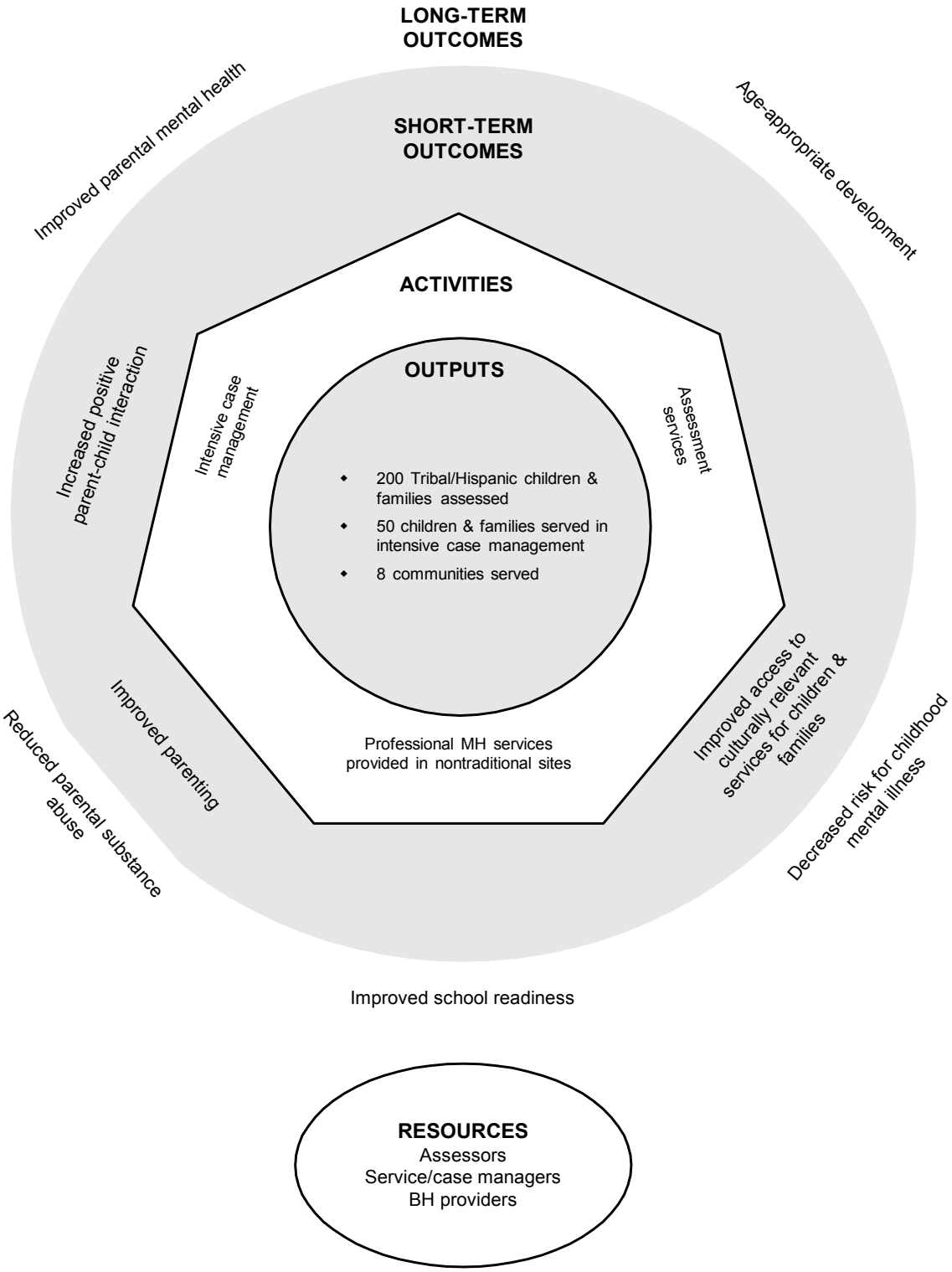
Klamath Tribe Logic Model – SIG Enhancement for Early Childhood Prevention (Rev. 1-28-05)

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
	In order for the program to accomplish its set of activities, it will need the following:	*In order for the program to address its problem or asset, it will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence or service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in the following months/years:*	*We expect that if accomplished, these activities will lead to the following changes in the following years:*
Client level	Assessors Service/case managers Behavioral Health (BH) providers	Assessment services Case management Information & referral Care Coordination Follow up post discharge Parent support & education Family advocacy Professional BH services provided in non-traditional sites (sites comfortable to those being served)	200 Tribal/Hispanic children and families assessed A minimum of 50 children and families served A minimum of 8 communities	Increased positive parent-child interaction & relationships Improved parenting Improved access to culturally relevant services for children and families	Age appropriate development Improved school readiness Decreased risk for childhood mental illness Improved parental mental health Decreased parental substance abuse rates

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
Intra-agency level	Klamath Tribes: Tribal Health and Family Services Klamath County Mental Health Oregon Child Development Coalition of Klamath (Migrant Head Start) Klamath Youth Development Center Klamath Alcohol & Drug Abuse, Inc. Department of Human Services, Child Welfare Klamath Family Partnership (a multiple agency group)	Identify, train, and supervise natural helpers (family care coordinators) within tribal & Hispanic communities - bilingual/bicultural Referral, advocacy, and flexible BH services Augment Native Am and Hispanic traditional cultural programs by incorporating community agency services. Make sustainable changes in infrastructure, to be consistent with the community vision and evidence based practices Create a system of identifying and tracking at risk children 4. Train BH & early childhood professionals culturally competent services	Staff in BH &child serving agencies able to provide culturally relevant services. Staff & natural helpers have increased assessment & intervention skills and info & access to referral resources Remove barriers to the array of available services Ongoing training to ensure all services provided in a culturally competent manner Increase understanding and use of flexible services	Access to culturally relevant services for children and families Data collection, policies, procedures, protocols and other infrastructure consistent with the community vision & evidence-based practices	Mutually beneficial relationships Increased access to services Promote & support cultural competency Increased competency of service providers at all levels
Note: Each agency will have its own resources, activities, etc.					

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
System level	Member agency leadership (KFP)	Develop Memo of Agreement between member agencies	A minimum of 8 Memos of Agreement developed	Ensure services are delivered at non-traditional sites	Systemic changes in behavioral health and early childhood settings that improve access, integration, and availability of behavioral health services
		Develop referral, advocacy, and flexible systems	Maintain meeting minutes/notes	Increase access to services	
		Work in coordination with KFP to foster community based systems of care	Implement a County-based system of care model	Establish/strengthen collaboration between community agencies	Increased positive outcomes for children & families
	Parents & extended family	Include & support families in all aspects of project design and decision-making	Develop a prevention system for Tribal/ Hispanic at risk children and families.	Establish mechanisms for service integration to promote positive outcomes for children	Implement family-centered service system

Klamath Tribe Logic Model – Client Level
SIG Enhancement for Early Childhood Prevention



Lake County Draft Logic Model – SIG Enhancement for Early Childhood Prevention (revised 2-8-05)

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
	*In order for the program to accomplish its set of activities, it will need the following **resources**:*	*In order for the program to address its problem or asset, it will accomplish the following **activities**:*	*Activities are expected to produce the following **evidence or service delivery**:*	***Short-term changes** expected in the following months/years:*	***Long-term changes** expected in thee following years:*
Client level	1.Trainer [CAHMI will train the "screening specialist" (medical assistant) and primary care clinicians in the use of the screening tool.]	1.Train "screening specialist" in each primary care setting	1. 2 trained specialists in each primary care office (there may more than 2)	1, 2, 3. Early access to behavioral health services to children & families 0-6 in settings that are normal & familiar to them.	
	2.Screening Specialist (primary care medical assistant)	2.Conduct screening using agreed upon screening tool	2a. estimated 300 children screened for behavioral health risks 2b. Well-child visits provided in two primary care offices	2. Change in content of well child visit in primary care	2a, 2b. Age-appropriate development
	3. Early Intervention/Family Coordinator (EIFC)	3a. Work with families in their homes	3. 60-120 children/families screened positive for behavioral health risks will have follow up plan	3a. Co-location of services	3a. Improved parenting

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
		3b. Develop an individualized follow up plan, including: A&OD Tx, MH counseling, in-home training, parent education, psychiatric consultation, evaluation, other		3b. Increased family support	3b. Improved parental mental health 3c. Reduced parental substance abuse
	4. Primary Care clinician practice leadership	4a. Include screening and follow up recommendations in patient visits. 4b. Participate in advisory committee	4. New process to accommodate screening within clinic	4. Practice redesign-enhanced well-child care visits	4a. Sustainable practice redesign 4b. Dissemination of model throughout Network 4c. Increased reimbursement for well child visits to eventually cover costs of screening
	5. CAHMI	5. Help select evidence based screening tool	5. Agreed upon screening tool	5. Use of screening tool	

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
Intra-agency level	Agency Partners: PCPs LCMH	1. Make sustainable changes in data collection, policies, procedures, protocols, and other infrastructure to be consistent with evidence-based prevention	1. All services provided in a culturally appropriate and competent manner, including sensitivity to family's language, race, ethnicity	1. Sustained screening and service, and coordination protocols	1a. Increased services 1b. Ensure cultural competency 1c. Mutually beneficial relationships
Note: Each agency will have its own resources and activities, etc.					
System level	1. Coalition (UPIC) of traditional & non-traditional behavioral health providers, family members, GOBHI	1a. Hold monthly multi-disciplinary team meetings 1b. .Find ways to increase and improve cross-agency communication.	1, 2. medical providers in coalition	1. Strengthened connection between health care, behavioral health, and non-traditional providers. 2. Involvement of Mental Health Organization and Fully Capitated Health Plans	1. Increased collaboration 2. Sustained screening, service, and coordination protocols

Lane County Draft Logic Model – SIG Enhancement for Early Childhood Prevention (1-30-05)

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
	In order for the program to accomplish its set of activities, it will need the following:	*In order for the program to address its problem or asset, it will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence or service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in the following months/years:*	*We expect that if accomplished, these activities will lead to the following changes in the following years:*
Client level	1. Substance Abuse and Mental Health Service Providers	1. Provide onsite substance abuse and mental health services at child care and other early childhood sites	1. Fifty families and 100 children receive substance abuse & mental health services at child care and other early intervention childhood sites	1 Early access to behavioral health services to children and families 0-6 in settings that are normal and familiar to them	1. Reduced parental substance abuse 1. Improved parental mental health
Intra-agency level	Lane Co. Health & Human Services LaneCare Options Counseling ACES/Emergence Counseling Cottage Grove Community Partnership Lane ESD United Way's Success By 6 DHS SDA 5	1. Train early childhood providers to screen & refer for behavioral health problems, as well as prevention & intervention skills	1a. Twenty providers trained 1b. Increased, improved screening & referral for behavioral health, prevention, and intervention 1c. Fifty families and 100 children screened and referred	1, 2. Early access to behavioral health services to children and families 0-6 in settings that are normal and familiar to them	1, 2. Reduced parental substance abuse 1. Improved parental mental health

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
	Contracted mental health & substance abuse therapists Family Relief Nursery Lane Family Connections A Primary Connection South Lane Family Resource Center Head Start Healthy Start Community Safety Net Parent Partnership Teen Parent Program Birth To Three Commission on Children & Families Lane Co. Department of Children & Families	2. Train OHP panel providers to increase skills in serving young children & link as needed to community based services 3. Develop & integrate (into EC & behavioral health systems) changes in policies, procedures, and protocols based on changes in family support services	2. Five OHP panel providers trained 2b. Improved services to young children & links to community based services	3. Sustained screening and service, and coordination protocols	3. Increased services 1-3. Mutually beneficial relationships
Note: Each agency will have its own resources, activities, etc.					

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
System level	1. Collaborative Team ECT + additional members (including families) from Creswell & Cottage Grove 2. County and Providers	1. Create and implement a "system of care" for children & families with behavioral health risks & problems 2. Integrate provision of family support services across providers (wrap-around funds, non-traditional site staff training & support, on-site mental health and substance abuse consultation for non-traditional providers, linkages to community-based treatment	1. System of care model 1, 2. All services provided in a culturally appropriate and competent manner, including sensitivity to family's language, race, ethnicity	1, 2. Increased capacity for seamless care 3. Involvement of Mental Health Organization and Fully Capitated Health Plans	1. Increased collaboration 1, 2. Increased services 1, 2. Ensure cultural competency

Washington County Draft Logic Model – SIG Enhancement for Early Childhood Prevention (1-28-05)

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
	In order for the program to accomplish its set of activities, it will need the following:	*In order for the program to address its problem or asset, it will accomplish the following activities:*	*We expect that once accomplished, these activities will produce the following evidence or service delivery:*	*We expect that if accomplished, these activities will lead to the following changes in the following months/years:*	*We expect that if accomplished, these activities will lead to the following changes in the following years:*
Client level	• Parent Educators/ Promotoras, agencies participating in collaboration, and families	• Train co-facilitators from settings where Latino families are already engaged • Provide evidence-based parent education and support in settings where families are already actively engaged. • Provide individualized education, screening, & support to families, serve as bridge between culture & language, early childhood & behavioral health, help prepare families for participation in parent education & behavioral health services, help families & systems better understand each other • Provide screening, prevention & early intervention services	• **96** parents/ caregivers receive education and support • A minimum of **4** co-facilitators trained • Provide individualized parent support and education to **150** Latino families • Help **150** Latino families identify and participate in appropriate services and resources to address needs	• 80 % of families complete parent education • Capacity is expanded to provide culturally-specific Incredible Years or similar curriculum • Latino families have access to culturally-specific services • Increased use of non-traditional and traditional behavioral health services. • Early access to behavioral health services to children & families 0-6 in settings that are normal & familiar to them	• Improved parenting • Improved parent-child relationships • Improved parental mental health • Reduced parental substance abuse • Age-appropriate social and emotional development • Improved school readiness

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
		• Coordinate and facilitate access to behavioral health services for Latino families		• Established or strengthened collaboration between behavioral health providers & non-traditional providers	
Intra-agency level	**Partners:** • Washington County Department of Health Human Services (Mental Health/OHP) • LifeWorks NW • Morrison Child & Family Services • Promotora Provider (to be selected) • Community Action Organization/ Head Start • Oregon Child Development Coalition/Migrant & Seasonal Head Start/Oregon Pre-Kindergarten • Virginia Garcia Memorial Health Center	• Participation in System Design Work Group • Assess organizational training needs regarding culturally competent behavioral health service delivery • Participation in training and consultation • Identify organizational changes needed to provide non-traditional services in natural settings.	• 12 agency representatives participate in System Design Work Group • 25 to 50 staff trained in evidence-based practices In early childhood behavioral health, culturally appropriate service delivery, alternative service modalities, assessment and referral processes, etc.	• Make sustainable changes in data collection, policies, procedures, protocols, and other infrastructure to be consistent with evidence-based principles • Increased organizational capacity to provide culturally competent services. • Increased capacity to provide appropriate and non-traditional early childhood behavioral health supports and services	• Increased use of evidence-based principles and practices • Sustained capacity to provide culturally competent, non - traditional behavioral health services.

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
	• Commission on Children & Families • Childhood Care & Education Advisory Committee • Cascadia Behavioral Health • Lutheran Community Services • Youth Contact • CODA • ChangePoint • DePaul				
Note: Each agency will have its own resources, activities, etc.					
System level	• Professional Training and Development • System Design Work Group • Promotoras • Families	• Train early childhood & behavioral health professionals to increase capacity to support children's development & respond to behavioral concerns • System Design Work Group meets regularly to identify system development/changes needed and strategies to achieve system goals.	• 25 to 50 trained EC & BH professionals • Key system design recommendations are identified	• Linking System Design Work Group recommendations with other planning processed in the County • **BH:** Increased knowledge of EC MH & treatment approaches, increase capacity to provide services in non-traditional settings, increase cultural com-	• Improved system-wide collaboration • Evidence-based practices and principles and culturally competent services are integrated into service delivery system • Increased access to, and participation in culturally competent an non-traditional behavioral health services

	Resources	Activities	(expected) Outputs	Short-term (project) Outcomes	Long-term (high level) Outcomes
				petence in cultural influences in child rearing & perception & provision of BH services • **EC:** Increase knowledge in BH issues in young children/families, screening & referral to BH services, establishing environments that support children's development, strategies to identify & address emergent behavioral concerns, engaging parents as partners, increasing cultural competence in cultural influences in child rearing & perception & provision of BH services • Recommendations for System change/design are approved and implemented.	

APPENDIX E: MDS SUMMARY

SIG-E MDS Summary

SIG-E pilot sites documented SIG-E grant-related prevention activities and services. They recorded these services in the Minimum Data Set (MDS), a Web-based data system operated by the Center for Substance Abuse Prevention. Each pilot site selected categories of services and codes from an established list that best fit their local activities. They then entered information about the number of each activity and demographic characteristics of participants. Because data are at the activity level and do not identify participants, individuals who received more than one prevention service are duplicated in the following counts.

Pilot sites offered a range of numbers and types of prevention services, from 14 in one site to 314 in another. The number of people served (duplicated count) ranged from 54 to 917. The total number of prevention services recorded was 645, with a total of 2,050 people participating (duplicated count).

The types of prevention services offered by the pilot sites fall into the following categories:

Community-based process (162)
- Assessing community needs (1)
- Formal community teams (17)
- Community team activities (91)
- Training services attendees (21)
- Technical assistance services attendees (20)
- Systematic planning services (12)

Education (59)
- Parenting/family management services participants (18)
- Peer leader/helper program participants (19)
- Small group session participants (22)

Information dissemination (41)
- Health promotion attendees (1)
- Original printed materials developed (13)
- Original newsletters developed (1)
- Original resource directories developed (2)
- Printed materials disseminated (24)

Problem identification and referral (383)
- Prevention assessment and referral attendees (383)

APPENDIX F: ADDITIONAL SERVICES PROVIDED BY THE SITES

SIG-E Additional Final Project Results by Site

SIG-E sites participated in activities in addition to those reflected in the evaluation's client-level survey forms (which captured intensive services to families) and project quarterly reports. In an effort to include those additional activities in descriptions of the project efforts and results, and to document all of the areas where the SIG-E pilot sites made an impact, the pilot sites completed a form listing each activity that their sites participated in as part of the SIG-E project. They included information from the time of implementation through November 2006.

To ensure inclusion and not duplication of all activities in the additional results reporting form, each community partner was asked to complete those sections of the form that applied to their activities and to send that information to the site's coordinator, who compiled it in one form before submitting it to NPC by December 1, 2006.

SIG-E ADDITIONAL FINAL PROJECT ACTIVITIES BY SITE

SIG-E SITE: Klamath Tribal Health DATE: 11/29/06

PEOPLE WHO CONTRIBUTED TO THIS FORM: Jennifer Haake

Activity	Site Participation
Home visits	Purpose of home visits: • Initial assessments/case openings • Ongoing child/parent interventions (Tribal site) • Collaborative assessments &/or intervention visits with agencies clients were referred to • Follow up assessments Our visits occurred in many places besides the home; client choice established the site Number of home visits completed: unable to supply this data due to short turn around time
Training/classes (examples: parenting class, Spanish class, Circle of Security training)	Name/type of training/class: see attachment which contains all this info Who facilitated: When training/class(es) took place: How many people attended:
Peer consulting/natural helper/promotora	N/A for Klamath How many peer consultants does the site have? Purpose of peer consulting: (For example, outreach and linkage across systems, across cultures, and across disciplines) How many people have received peer counseling?
Mental health treatment	Did SIG funds pay for people to receive MH treatment? Yes, for family counseling, individual counseling of parents, interventions with children in individual settings and in classrooms (Headstart for Tribal & Hispanic) and home based parent child (Tribal site only) How many people received MH treatment due to SIG? Unable to provide because of short turn around How many treatment sessions took place? Unable, same reason
Alcohol and Other Drug Treatment	N/A for Klamath site Did SIG fund pay for people to receive AOD treatment? How many people received AOD treatment due to SIG? How many treatment sessions took place?
Respite care (Services that provide people with temporary relief from tasks associated with caregiving)	N/A for Klamath site Did SIG funds pay for respite care? How many people received respite care due to SIG? How many respite care sessions took place?

Activity	Site Participation
Groups such as skill building, socialization, system building	N/A Type of group that took place: Was the group for professionals, adults or children? How many adults/children attended socialization groups?
Relationship interventions (e.g., domestic violence)	N/A for Klamath (i.e., not separate from therapy) Purpose of intervention(s): How many interventions occurred?
Transportation	Did SIG funds pay for transportation for clients? Yes, for 2 clients: • For a child in early intervention who could not safely ride their bus 3 times/week we paid mom's gas until the kid could ride the bus • For a child who needed to be assessed by CDRC in Portland, support parent taking them to appt and back Purpose of transportation (type of activity people were transported to/from): How many people received transportation? How often was transportation provided?
Children's classroom interventions	Purpose of intervention(s): Multiple OCDC classroom situations and kids, 1 Tribal kid in regular Head Start How many interventions occurred? Unable to provide detail
Child care setting interventions	Purpose of intervention(s): Only if you consider OCDC Head Start as providing childcare How many interventions occurred?
Support groups	*N/A for grant specific items;* OCDC does monthly parent groups so 18 of them in the 2 years, unable to supply more detail in timeframe Purpose of support group(s): How many people attended support groups? How many support groups occurred?
Basic needs (food, clothing, medical services, housing, help getting OHP)	Basic need(s) provided: 2 Tribal families: • Paid for pluming repairs so family would maintain supported housing (i.e., keep family stable in housing, had been homeless) • Paid for first month rent so family could access housing • Also helped a number of families access OHP and other resources, have no way to count this Also, • We provided funds for co-pays to insurance, OHP etc. so families could get kids in for hearing evaluations, basic physical exams when the kid had delays in a number of areas etc Was person/family referred to another agency/service? Number of people receiving help with basic needs and/or services:
Multi-Disciplinary Team (or equivalent) meetings	How many agencies make up your MDT? How many MDT meetings took place? How many cases were reviewed at MDT meetings?

Activity	Site Participation
Child advocacy	Did anyone at the site advocate with Child Welfare or go to court on behalf of a client? Any other types of advocacy? How many times?
Leveraging Funds	Did other people/agencies bring funds to the table?
Site-Specific Activities	
Klamath:	Number of screenings? Over 250 but unable to say exactly as we screened all OCDC kids and many more Tribal kids than we opened. Actually set up a birth to 5 screening system for the Tribe. Outreach to families? In-home supports and services? Number of KFP meetings (monthly except August times 2 years), collaboration meetings(every other week for 18 months, monthly for final 6 months, 2 hr per meeting), and core team (clinical meeting, weekly for final 18 months of project for 1 hour, maybe didn't meet 6 weeks during the entire time) meetings? Number of families who received mainstream behavioral health services?

SIG Educational Event Master List

Date	Event/Speaker	Place	# of participants
2/4/06 all day	Dr. Bruce Perry Healthy Brain Development	K. Falls; we helped KFP finance this day, and also had scholarships for Tribal & Hispanic parents	750
5 16 to 20, 2006	Healing the Wounded Spirit Conf	K Falls	3 or 4 of the SIG partner's staff were able to attend;
6/05	Circle of Security 1 day training i	Portland	Sent 5 of the SIG partner's staff
6/29/06; 8a to noon	Diane Lia: Attachment & Trauma	Tribal Admin Conf Room in Chiloquin	50 Tribal and community professionals
7/18 Tues 6-8 pm	OCDC Prevent ion Party: Healthy Brain Development, Gabe Gomez	Malin OCDC	35 Hispanic parents
August 3 6hours	Gabe Explosive Child for the Tribe	K. Falls	50 Tribal and community professionals
9/27 Wed 6-8 pm	Tribal Prev. Party: Healthy Brain Development, Gabe Gomez	K. Falls	50 Tribal parents or grandparents
10/4,5,6/06 9-4:30	COS training Glen Cooper	K. Falls	60 community professionals, Nursing students and paraprofessionals (includes Tribe and Hispanic community)
10/27 Fri 9 to 4p	Chris Curry training on behavioral interventions	K. Falls	25 community professionals, paraprofessionals and families (includes Tribe and Hispanic community)
11/4/06 8:30 to 9:45	Dr. Willis, Keynote, Early Childhood conference	Klamath Community College	90 community professionals, paraprofessionals, EC students (included the Tribal and Hispanic Community)

IMPACT OF THE SIG - Klamath

There are many areas where the SIG may have made an impact on children and families, as well as on the early childhood, mental health, and substance abuse systems. In order to reflect that information so that it can be presented to the legislature and others, please discuss ways that the SIG had an impact on children, families, and systems. Some possible areas of impact to discuss are listed below. Please add to this list any additional areas where you have seen the SIG project make an impact.

Areas of Impact
Did the SIG contribute to families staying together? How? How many families? **Yes, by providing supports (financial and informational) as well as interventions which decreased home stress/parent stress. One of our core beliefs is that helping a family stay stable in things like housing, child care etc. helps them remain consistent in keeping therapy and treatment visits, which increases the family/child's potential for positive change thereby impacting the family as well as the child. I'm unable to tell you how many, my educated guess would be at least 7 or 8 of the Tribal families, not sure we could identify this info for the OCDC families.**
Were foster care costs saved as a result of the SIG? How? **Costs, probably not. What we did impact (again more in Tribal families) was the child being able to remain in 1 f. home rather than being moved multiple times because the f. parent couldn't cope; we helped with intervention and routines for the children, listening and problem solving with the f. parent, at times acting as mediator between parent, f. parent and/or child welfare.**
When children are removed from child care (due to their behavior, etc.), parents without other child care resources are forced to quit their jobs to take care of these children. Has the SIG helped keep these parents keep their jobs (for example, by training child care providers to identify developmental problems or by providing parenting classes)? **Yes, in that all our trainings etc. included staff from OCDC Head Start and child care situations, and many of our child specific interventions were addressing classroom issues in OCDC classrooms as well as work with the families of these kids. I don't believe we actually provided an intervention in a home or licensed day care, only in regular and OCDC Head Start and early intervention.**

SIG-E ADDITIONAL FINAL PROJECT ACTIVITIES BY SITE

SIG-E SITE: Lake DATE: 12/18/06

PEOPLE WHO CONTRIBUTED TO THIS FORM: Mauri Seehawer & OHSU

Activity	Site Participation
Home visits	Purpose of home visits: We used home visits to conduct the state required Home Inventory. Not very many parents requested this service and most of the surveys were filled out in the office that was in a non-traditional setting. Number of home visits completed: 7.
Training/classes (examples: parenting class, Spanish class, Circle of Security training)	Name/type of training/class: Parenting Classes, AOD classes Breaking Barriers, Cognitive restructuring. Who facilitated: Mental Health and AOD counselors. When training/class(es) took place: Throughout the year, parenting started this summer. How many people attended: Depended on the class, anywhere from 6 to 20.
Peer consulting/natural helper/promotora	How many peer consultants does the site have? Yes. Purpose of peer consulting: (For example, outreach and linkage across systems, across cultures, and across disciplines) Outreach to families in very remote isolated areas. How many people have received peer counseling? 6.
Mental health treatment	Did SIG funds pay for people to receive MH treatment? Yes. How many people received MH treatment due to SIG? 28. How many treatment sessions took place? 597.
Alcohol and Other Drug Treatment	Did SIG fund pay for people to receive AOD treatment? Yes. How many people received AOD treatment due to SIG? 7. How many treatment sessions took place? 196.
Respite care (Services that provide people with temporary relief from tasks associated with caregiving)	Did SIG funds pay for respite care? Yes. How many people received respite care due to SIG? 3. How many respite care sessions took place? 12.
Groups such as skill building, socialization, system building	Type of group that took place: Child socialization group with ESD. Parenting classes and women's support group. Was the group for professionals, adults or children? Children age 3. Adults in parenting class. How many adults/children attended socialization groups? Groups are small usually 3 to 5 children with 2 to 3 adults. 4 to 6 adults in parenting classes.
Relationship interventions (e.g., domestic violence)	Purpose of intervention(s): To protect the children from domestic violence. How many interventions occurred? One family where father had to go to treatment a total of 8 sessions.

Activity	Site Participation
Transportation	Did SIG funds pay for transportation for clients? Yes. Purpose of transportation (type of activity people were transported to/from): To and from appointments, groups and respite care. How many people received transportation? 12. How often was transportation provided? This varied with each person.
Children's classroom interventions	Purpose of intervention(s): Advocate for child, educate parents and teacher about certain symptoms from certain diagnosis. How many interventions occurred? 4.
Child care setting interventions	Purpose of intervention(s): None. How many interventions occurred?
Support groups	Purpose of support group(s): None. How many people attended support groups? How many support groups occurred?
Basic needs (food, clothing, medical services, housing, help getting OHP)	Basic need(s) provided: Yes. Was person/family referred to another agency/service? Yes. Number of people receiving help with basic needs and/or services: 12.
Multi-Disciplinary Team (or equivalent) meetings	How many agencies make up your MDT? 3 to 7 depending on the family. How many MDT meetings took place? At least 4 times a month sometimes more. How many cases were reviewed at MDT meetings? Usually only one case at a time for each meeting. All cases with the SIG were staffed.
Child advocacy	Did anyone at the site advocate with Child Welfare or go to court on behalf of a client? Yes. Any other types of advocacy? At school for IEP. Advocation for basic needs. How many times? 11.
Leveraging Funds	Did other people/agencies bring funds to the table? Occasionally.
Site-Specific Activities	
Lake:	Purpose of interviews completed by OHSU at site (e.g., with doctors): See attached reports. How many interviews took place? Interview results: Number of UPIC and MDT meetings? 80 to 100. This includes weekly meetings with MH, AOD, and DD staff. Monthly UPIC and Early Child Intervention, DHS family planning, and Community Resource Team meetings. Number of parents in behavioral health services whose children were screened? 18. We have Mauri's list of screenings that were completed. Have any more been completed since that list was compiled? Yes. If so, how many: 62.

SIG-E ADDITIONAL FINAL PROJECT ACTIVITIES BY SITE

SIG-E SITE: South Lane County DATE: December 4, 2006

PEOPLE WHO CONTRIBUTED TO THIS FORM: Family Relief Nursery, Lane Family Connections, DHS/Child Welfare, Head Start

Activity	Site Participation
Home visits	Purpose of home visits: Prevention and Referral Provide prevention and intervention services to ensure early access to behavioral health services to families of children 0-6 in settings that are familiar to them (i.e. Head Start, Relief Nursery, child care settings, home environment, etc.) The Child Care Family Advocate position provides a key role in the Lane Early Childhood System Development Project, a pilot project funded to enhance mental health and substance abuse services to high risk families in the south region of Lane County (Cottage Grove, Creswell and surrounding areas.) Key components of the project include early screening and facilitated referrals to mental health and substance abuse treatment, parenting education and support, care coordination and family advocacy. Services provided in English and Spanish. Number of home visits completed: 527 (includes 46 in-home child care providers and 4 child care centers).
Training/classes (examples: parenting class, Spanish class, Circle of Security training)	1. Name/type of training/class: Atypical Social-Emotional Development of Young Children: Neurological and Parental Influences Who facilitated: Redmond Reams, PhD When training/class(es) took place: 9/22/2006 How many people attended: 137 2. Name/type of training/class: Using Videotaping and Reflection as an Effective Tool When Working with Children and Families in Therapeutic Settings Who facilitated: Cindy Roberts, MA When training/class(es) took place: 10/6/2006 How many people attended: 36 3. Name/type of training/class: Understanding Attachment: The Circle of Security Approach Who facilitated: Glen Cooper When training/class(es) took place: 10/28/2006 How many people attended: 185 (to include 3 child care providers) 4. Name/type of training/class: Working with Young Children and Families: Medication and Behavioral Strategies

Activity	Site Participation
	Who facilitated: Bob Nickel M.D., Kurt Freeman Ph.D., Ted Taylor Ph.D., Preschool Social Emotional Team When training/class(es) took place: 11/3/2006 How many people attended: 115 Name/type of training/classes: CPR Certification Training Who facilitated: Lane Community College South Lane County Campus When: 10/21/06 How many attended: 11
Peer consulting/natural helper/promotora	How many peer consultants does the site have? 1 Purpose of peer consulting: To help women with children 0-6 who have A&D issues maintain their recovery or get into treatment. How many people have received peer counseling? 27
Mental health treatment	Did SIG funds pay for people to receive MH treatment? Yes How many people received MH treatment due to SIG? 35 How many treatment sessions took place? 167
Alcohol and Other Drug Treatment	Did SIG fund pay for people to receive AOD treatment? Yes How many people received AOD treatment due to SIG? 7 How many treatment sessions took place? 348
Respite care (Services that provide people with temporary relief from tasks associated with care giving)	Did SIG funds pay for respite care? No, but families who came to Family Relief Nursery to meet with Mental Health Consultants were provided with access to respite care at the Nursery as needed. How many people received respite care due to SIG? How many respite care sessions took place?
Groups such as skill building, socialization, system building	Type of group that took place: Parent Focus Group: this group gave the parents a chance to actively participate in system changes. Was the group for professionals, adults or children? Adults How many adults/children attended system building groups? 5/1x per month Accessing Success families in conjunction with Family Relief Nursery families attended a "Safari in the Park" this summer funded by both FRN and Accessing Success with 300 adults and children in attendance. (Socialization skills)
Relationship interventions (e.g., domestic violence)	Purpose of intervention(s): To provide the family with resources and referrals, support and a safety plan. How many interventions occurred? 7 due to domestic violence and 2 due to child molestation allegations.

Activity	Site Participation
Transportation	Did SIG funds pay for transportation for clients? Yes Purpose of transportation (type of activity people were transported to/from): To attend Parent Focus Group, Parents for Recovery support group, parenting classes, Outpatient MH/A&D assessments or treatment. How many people received transportation?18 How often was transportation provided? Approximately 2x per week
Children's classroom interventions	Purpose of intervention(s): SIG MH consultants provided strategies that helped classroom teachers/interventionists offer an environment that worked for the SIG kids. In the case where the class was not the best placement, the MH provider worked with the staff to continue SIG and other services for the family. How many interventions occurred? 4
Child care setting interventions	Purpose of intervention(s): to provide the child care provider with the tools to identify children with special needs and the tools to manage the child's behavior in order for the child to remain in child care. How many interventions occurred? 8
Support groups	Purpose of support group(s): Parents for Recovery is a support group for women with A&D issues trying to maintain their recovery. How many people attended support groups? 3-8 per meeting 2x a month. How many support groups occurred? 16 Purpose of support group(s): The Child Care Provider support group provides a link to resources, training, and other providers in the community. How many people attended support groups? Averages 8-10 providers per meeting 1x a month How many support groups occurred? 16
Basic needs (food, clothing, medical services, housing, help getting OHP)	Basic need(s) provided: All the aforementioned basic needs to include assisting 4 families in getting free MH medication through SLMH and helping with transportation so they could get to work. Was person/family referred to another agency/service? YES Number of people receiving help with basic needs and/or services: 31
Multi-Disciplinary Team (or equivalent) meetings	How many agencies make up your MDT? 6 How many MDT meetings took place? 27 How many cases were reviewed at MDT meetings? 61
Child advocacy	Did anyone at the site advocate with Child Welfare or go to court on behalf of a client? Yes Any other types of advocacy? How many times? 7
Leveraging Funds	Did other people/agencies bring funds to the table? Yes, funds to support the early childhood trainings. Except for the Circle of Security and the Video Taping & Reflect Class, the SIG grant only paid ½ of the cost.

Activity	Site Participation
	The SIG MDT was given a grant of 1,500 from Cottage Grove Community Partnership for Positive Alternative Activities for the older siblings of the SIG families ages 7-17.
Site-Specific Activities	
Lane:	How many of the families at the Family Relief Nursery were SIG families? 32 Purpose of training/support for childcare providers: To provide the providers with the tools to identify children at risk or with special needs and the tools needed to manage the behavior. Also to provide them with a link to resources and other child care providers in the area. How many childcare providers were trained? 22 14 child care providers attended 10 sessions of "Creating a Climate for Growth." 5 have attended "Make Parenting a Pleasure" and 2 are taking ESL. ASQ, ASQ-SE Training: 52 child care providers were trained, 10 teen parents in their life skills class, and the Pediatric Nurse Practitioner. How many conflict resolution meetings did the site have? 5 How many people attended conflict resolution meetings? 6

IMPACT OF THE SIG - Lane

There are many areas where the SIG may have made an impact on children and families, as well as on the early childhood, mental health, and substance abuse systems. In order to reflect that information so that it can be presented to the legislature and others, please discuss ways that the SIG had an impact on children, families, and systems. Some possible areas of impact to discuss are listed below. Please add to this list any additional areas where you have seen the SIG project make an impact.

Areas of Impact
Did the SIG contribute to families staying together? YES How? By providing the families with the support and resources needed and working with the different agencies involved with the families. These families were able to access MH services, Accessing Success Peer Support, and wraparound funds due to SIG How many families? 25 that were DHS/Child Welfare involved were able to keep their children or have them returned due to SIG, which involved interventions and support by Family Relief Nursery, Head Start, EC Cares, and A Primary Connection, in connection with DHS/Child Welfare. Due to the changes in DHS/Child Welfare in regards to what they will now respond to it is even more vital that families receive the services that the SIG grant has been able to provide in order to keep families together and our children safe. The SIG grant has improved our ability to reach the most at risk families in our community. Although DHS/Child Welfare had been a referral source in the past, the grant has significantly improved this collaboration. Triaging through the MDT team has also allowed the community agencies to partner more effectively and provide the most appropriate placement for children and families without duplicating services.
Was foster care costs saved as a result of the SIG? Yes How? Due to the services that SIG allowed us to provide to the families such as MH services and Accessing Success Peer Support the families were able to receive much needed services which increased the likelihood of each family in working towards and maintaining healthy family relations. In addition there were three families that received a SIG MH assessment which helped with permanency planning.
When children are removed from child care (due to their behavior, etc.), parents without other child care resources are forced to quit their jobs to take care of these children. Has the SIG helped keep these parents keep their jobs (for example, by training child care providers to identify developmental problems or by providing parenting classes)?
Yes, there have been 5 different situations where children were either removed from a child care setting and it was difficult trying to find another child care provider who would accept the child or where the child was about to be removed from child care. Due to the Child Care Family Advocate the child care providers had support, resources, and were provided with training to identify a special needs child and the tools to manage the unacceptable behaviors allowing the child/ren to remain in their care. A single father of two was also provided with help in regards to missing to much work when he would have to leave to take care of a sick child. The Child Care Family Advocate was able to provide this father with resources to find a child care provider who would accept children when they are not feeling well which allowed this father to keep his job.

SIG-E ADDITIONAL FINAL PROJECT ACTIVITIES BY SITE

SIG-E SITE: Washington Co. DATE: December 2006

PEOPLE WHO CONTRIBUTED TO THIS FORM: Erin Sewell and Mark Lewinsohn (LifeWorks NW) and Diana Stotz (CCF)

Activity	Site Participation
Home visits	Purpose of home visits: family support, parent education, information about child development, referral to com services for basic needs, mental health services, etc. Number of home visits completed: more than 480 to more than 130 families (through September 2006)
Training/classes (examples: parenting class, Spanish class, Circle of Security training)	Name/type of training/class: Incredible Years (6 12 week classes); Make Parenting a Pleasure (1 12 week class) Who facilitated: Erin Sewell, Karol Aragon, Rocio Prudencio (LWNW promotora staff); Carmen Titus (OCDC); Ignolia Duyck (VGMHC) – partner staff (OCDC, VGMHC) co-facilitated when feasible When training/class(es) took place: throughout project starting in Sept 2005 How many people attended: just over 100 parents attended some sessions Trainings sponsored by SIG grant for early childhood and behavioral health professionals included: ASQ & ASQ-SE training; Circle of Security Training; Community Capacitation training series (Popular Education, community outreach, domestic violence, child abuse, mental health, health issues, coordination and collaboration, cultural competency, etc.); Motivational interviewing; Incredible Years facilitator training; Make Parenting A Pleasure facilitator training…with additional trainings to be offered winter/spring of 2007. More than 350 people participated in one or more of the training sessions offered.
Peer consulting/natural helper/promotora	How many peer consultants does the site have? Purpose of peer consulting: (For example, outreach and linkage across systems, across cultures, and across disciplines) How many people have received peer counseling?
Mental health treatment	Did SIG funds pay for people to receive MH treatment? No How many people received MH treatment due to SIG? Promotoras assisted more than 63 children/families to access community based mental health treatment services (through Sept 2006). Primarily families served through home visits How many treatment sessions took place? unknown
Alcohol and Other Drug Treatment	Did SIG fund pay for people to receive AOD treatment? How many people received AOD treatment due to SIG? How many treatment sessions took place?

Activity	Site Participation
Respite care (Services that provide people with temporary relief from tasks associated with caregiving)	Did SIG funds pay for respite care? How many people received respite care due to SIG? How many respite care sessions took place?
Groups such as skill building, socialization, system building	Type of group that took place: Was the group for professionals, adults or children? How many adults/children attended socialization groups?
Relationship interventions (e.g., domestic violence)	Purpose of intervention(s): How many interventions occurred?
Transportation	Did SIG funds pay for transportation for clients? Purpose of transportation (type of activity people were transported to/from): How many people received transportation? How often was transportation provided?
Children's classroom interventions	Purpose of intervention(s): How many interventions occurred?
Child care setting interventions	Purpose of intervention(s): How many interventions occurred?
Support groups	Purpose of support group(s): How many people attended support groups? How many support groups occurred?
Basic needs (food, clothing, medical services, housing, help getting OHP)	Basic need(s) provided: child care, health care, mental health, OHP, emergency food, emergency shelter/housing, transportation, etc. Was person/family referred to another agency/service? Yes, referred and supported in accessing services through a range of community agencies Number of people receiving help with basic needs and/or services: More than 200
Outreach	Through participation in open houses, community resource fairs, and other outreach activities, promotoras provided community resource and program information to more than 500 families (through September 2006).
Multi-Disciplinary Team (or equivalent) meetings	How many agencies make up your MDT? How many MDT meetings took place? How many cases were reviewed at MDT meetings?
Child advocacy	Did anyone at the site advocate with Child Welfare or go to court on behalf of a client? Any other types of advocacy? How many times?

Activity	Site Participation
Community system planning meetings	The SIG work group generally met monthly throughout the project, beginning in January 2005 (more than 12 times) to identify issues, training needs, do problem solving about barriers to service, etc. Improved cross agency coordination/collaboration reported as a result of these meetings, improved access to services for families as well as agencies learned more about what each other does. County Mental Health participated consistently in the work group, and as a result of getting consistent information about the promotora approach and it's success in assisting Latino families to access mental health services, County Mental Health has funded an additional promotora position (effective August 2006) and will assume funding responsibility for the two positions funded through the SIG initiative in January 2007. County Mental Health believes the promotora approach will help increase the Latino penetration rate in mental health services. The SIG work group also sponsored two meetings with early childhood representatives and Child Welfare staff to learn more about each others services and systems. SIG work group and focus on early childhood mental health has been incorporated into meeting structure of the Childhood Care and Education Advisory Committee (Early Childhood Team for Washington County) and Childhood Care and Ed Committee has agreed to have at least two meetings per year that focus on early childhood mental health. Initial meeting with mental health focus held in September 2006. As a result of the meeting, County Mental Health has added Head Start, OCDC, New Parent Network, EI/ECSE to definition of 'system' for purposes of establishing multi-system involvement for eligibility for Intensive Treatment Services (children's system change initiative). A representative from Morrison Child and Family Services Early Childhood Mental Health Consultation has also been added as a member of the children's system change initiative advisory committee to assure that early childhood mental health issues are incorporated into planning in the children's mental health system.
Leveraging Funds	Did other people/agencies bring funds to the table?
Site-Specific Activities	
Washington:	Purpose of family needs survey and how it was used: Survey was used in the late spring/early summer (soon after promotoras were hired) to gather information from Latino families in partner agencies about where they feel most comfortable receiving services, and their primary areas of concern related to their families and young children. How many surveys were distributed? Surveys were distributed/completed at open house events at the start of the migrant season at OCDC, and at Virginia Garcia Memorial Health Center clinic waiting rooms in June/July 2005. How many surveys were completed & returned? More than 70 surveys completed Survey Results: Families reported being most comfortable receiving

Activity	Site Participation
	services at home or at 'school' (Head Start centers). Primary areas of concern identified included: basic needs (food, health care, child care, etc); lack info/ awareness of services available and how to access; concern about ability to access services due to language barriers; how to support their children's English language development; parenting and info about child development; how to deal with behavioral concerns.

IMPACT OF THE SIG - Washington

There are many areas where the SIG may have made an impact on children and families, as well as on the early childhood, mental health, and substance abuse systems. In order to reflect that information so that it can be presented to the legislature and others, please discuss ways that the SIG had an impact on children, families, and systems. Some possible areas of impact to discuss are listed below. Please add to this list any additional areas where you have seen the SIG project make an impact.

Areas of Impact
Did the SIG contribute to families staying together? Yes and it reunited some families that had already been separated. How? By assisting them to complete child welfare family plan requirements, probation requirements, community resource team requirements, respite care, basic needs, mental health treatment, drug and alcohol treatment, and any other problems that might prevent families from succeeding due to large amounts of stressors. How many families? 10.
Were foster care costs saved as a result of the SIG? Yes. How? By successfully helping families with connections to resources and funds for treatment and transportation to resources in such a remote area.
When children are removed from child care (due to their behavior, etc.), parents without other child care resources are forced to quit their jobs to take care of these children. Has the SIG helped keep these parents keep their jobs (for example, by training child care providers to identify developmental problems or by providing parenting classes)? We had some children removed from the home, not child care, and then returned due to providing parenting classes. We also locate some child care that is very rare in our remote area so parents could go to work.
We also developed systems change between the doctors' offices, mental health and alcohol and drug. We now have protocol for referrals and communication between the offices. This has lead to meetings with the doctors to problem solve, doctor office representation in mental health QA meetings, and cooperative treatment. We still have a long way to go, but there is now a process in place to continue with system changes.

APPENDIX G: CLIENT-LEVEL OUTCOMES SUMMARY

State Incentive Grant – Enhancement for Early Childhood Prevention

Client-level Results Summary

April 2007

In 2003, the Department of Human Services Addictions and Mental Health Division, contracted with NPC Research to provide evaluation for the State Incentive Grant for Early Childhood Prevention (SIG-E) at the state and local systems levels for four pilot sites (Klamath Tribes, Lake County, S. Lane County, and W. Washington County), and for client level outcomes. The pilot sites utilized the Starting Early Starting Smart (SESS) approach, which integrates traditional behavioral health services into easily accessible, non-threatening settings where parents naturally and regularly take their young children. The pilot sites implemented a variety of activities to serve families in their communities, including screening and assessment, parenting education, peer mentoring, referrals to community resources, and behavioral health treatment. Project services were designed to produce the following outcomes:

Outcomes	***Summary of Results***
Parenting practices	Significant change: Native American families reported parenting to be less difficult over time.
Parent-child relationships	Non-significant (no change).
Quality of adult and family relationships	Significant change: Caucasian families reported decreased domestic abuse over time.
Child development	All 12 children diagnosed with a delay were connected to services.
Parental substance abuse	Minimal substance use was reported; change over time could not be measured.
Parent mental health	Significant change: Caucasian families reported improved mental health on one question. Trends indicated increases in social support for Caucasian families as well.

Client-level outcomes were measured through surveys completed by service providers and the parents/caregivers at the start of services (130 families) and 6 months after starting services[15] (49 families). Each of these areas was measured using multiple tools[16]. The table above indicates

[15] The original intent of the client-level evaluation was to measure client outcomes at three points in time (intake, 6 months and 12 months); however, slow start up and implementation challenges limited the available data to the first two time points. Most data submitted by the sites were the intake time point only; a subset of families has data at follow-up.

[16] For details on the methods, measures, and results of the client-level evaluation, please see the full report. Contact: Juliette Mackin, Evaluation Director, at NPC Research, (503) 243-2436 x114 or Mackin@npcresearch.com.

changes from intake to follow-up. The outcomes sample includes 49 families from two of the four pilot sites (Klamath Tribes and S. Lane County) for whom the evaluators received Provider and Parent/caregiver Surveys at intake *and* follow-up. The HOME[17] was completed at intake and follow-up for 22 families from the two sites in the sample.

Demographics of parents/caregivers: 92% (of 47 responses) female; age range of 16 to 64, with a mean age of 33 (median age 32); 7 (14%) Native American, 23 (47%) Hispanic/Latino, and 19 (39%) Caucasian respondents.

Risk and Protective Factors: 84% of families had one or more of the following risks: 1) parental mental health issue, 2) parental substance use issue, 3) family conflict, 4) domestic/partner abuse, 5) low level of parental education, and 6) low income. Risk factors are important because they are linked to other longer-term outcomes for children, including substance abuse and juvenile delinquency. In this study, a greater number of risk factors were associated with less social support, more difficulty parenting, and the presence of domestic violence.

- 22 families (45%) had 1 or 2 of these risk factors at the start of services
- 18 families (37%) had 3 or 4 risk factors at the start of services
- 5 families (10%) had 5 or 6 risk factors at the start of services

Many families also had protective factors, such as positive, caring relationships between child and parent/caregiver, and between adults. Protective factors help buffer the parent/caregiver and child from the negative impacts of risk factors.

Some of the outcome areas measured did not have significant changes over time for this group of families. These areas include parent-child interaction, developmentally effective disciplinary strategies, increased enrichment of the home environment for older children (3- to 6-year-olds), or parent-reported substance use.

There was little reported criminal justice involvement or receipt of inpatient treatment or emergency room care. Many families chose not to report sensitive information, such as use of alcohol or other drugs.

Summary/Conclusions

The SIG-E project had a positive impact in several areas including parenting practices, the quality of the parent/caregiver's adult relationships, and parent mental health, despite some challenges, including loss of employment for some families. Because of the small number of families with evaluation data, some of the results are inconclusive. Additional evidence to support the positive changes in early childhood systems and service provider practices can be found in the overall summary of project findings.[18]

[17] The Home Observation for Measurement of the Environment Inventory is an interview and observational assessment tool used at a home visit to gather information about health, safety, and developmental characteristics of the child's environment and experience.

[18] Please contact Juliette Mackin, Evaluation Director, at NPC Research, (503) 243-2436 x114 or Mackin@npcresearch.com for additional information.