CHAPTER ONE
THE STARTING EARLY STARTING SMART COLLABORATIVE MULTI-SITE STUDY: PURPOSE AND METHOD

...The first five years of life are a time of enormous growth of linguistic, conceptual, social, emotional, and motor competence. ... The pace of learning, however, will depend on whether and to what extent the child's inclination to learn encounter and engage supporting environments. There can be no question that the environment in which a child grows up has a powerful impact on how the child develops and what the child learns.

National Research Council, Committee on Early Childhood Pedagogy

Starting Early Starting Smart (SESS) is a unique research collaboration designed to test effectiveness and generate applicable knowledge concerning the design and implementation of integrated systems of child-centered, family-focused and community-based services that target at-risk children from birth to the beginning of the K-12 school experience. A rapidly accumulating research consensus emphasizes the importance of these years in establishing the foundation of physical, cognitive, and social-emotional (mental health) development that sets the trajectory of later youth development, including school readiness and success. Growing knowledge about the importance of the 0-5 years, and increasing understanding of the opportunities for lasting positive impact in these years, have increased public and professional concern about adequate public and private services in these critical early years of life.

The motivating intent behind the SESS collaboration is to contribute to usable knowledge for promoting supportive environments for positive development in children ages 0 to 5 who are in circumstances of risk. SESS has a particular focus on strengthening the family environment through behavioral health interventions for caregivers, and in supporting the social-emotional development of children. These issues are central to building and sustaining supportive early childhood environments, yet they are often marginal to existing systems of early childhood care. The SESS collaboration supports a family of service programs designed to strengthen supportive environments for young children at risk by integrating behavioral health services for children and their families into non-threatening service settings (primary health care or early childhood education settings).

Major Findings

The SESS programs had two overarching objectives. First, SESS was to improve the access of families and young children to a comprehensive set of needed services. Second, the initiative was aimed at improving caregiver, family and child mental health in support of strong early childhood development. The SESS programs improved outcomes for participating families along a range of these intended benefits.

- **SESS increased access to needed services**. Participation in SESS increased access to needed services for participating families in the area of basic needs (e.g., transportation, shelter) necessary to enable use of behavioral health services, and the targeted areas of parenting services, caregiver mental health, child mental health and substance abuse treatment for those in need.

- **SESS decreased drug use among caregivers who were problem users.** Caregivers participating in SESS who were identified as problem drug users decreased their use of drugs relative to problem drug users who received standard of care treatment only.

- **SESS programs helped participating caregivers strengthen their home environment by:**

    - reducing verbal aggression among caregivers,

    - increasing nurturing interactions between parents and children,

    - increasing the use of positive reinforcement and appropriate discipline practices while families of preschoolers were in the program,

    - reducing parental stress among caregivers with high levels of stress.

- **SESS improved the social-emotional and cognitive development of preschool children by:**

    - Reducing externalizing problems (e.g., aggressive behavior, acting out) and internalizing problems (e.g., withdrawal) in SESS classrooms

    - improving language skills (e.g., receptive language).

These findings punctuate the growing consensus that supporting and strengthening positive early childhood environments must be a national priority. The SESS collaboration was initiated and supported through a unique and highly successful public-private partnership. The Substance Abuse and Mental Health Services Administration (SAMHSA) and its three centers, the Center

for Substance Abuse Prevention (CSAP), the Center for Substance Abuse Treatment (CSAT), the Center for Mental Health Services (CMHS), and the Center for Substance Abuse Treatment (CSAT), partnered with the Casey Family Programs (CFP), a private foundation, to initiate and support the SESS project. The program has also benefitted from involvement and advisement of the U.S. Department of Education; the Health Resources and Services Administration, and the Administration for Children and Families of the U.S. Department of Health and Human Services. Twelve grantees across the country designed and implemented the programs studied through the SESS multi-site evaluation. These grantees, the sponsoring organizations, and an additional grantee funded as the cross-site center for data coordination and analysis constituted the Steering Committee that designed and implemented the multi-site research reported in this volume.[1]

The method for achieving this intent is a multi-site demonstration and evaluation that constitutes "a proving ground for identifying, refining, and documenting effective practices that engage, involve, and strengthen families of young children at high risk" (CFP & U.S. DHHS, 2001: V). The SESS research was designed a) to test the effectiveness of family-centered integration of behavioral services into customary settings as a general approach to strengthening the environments of support for young children and b) to learn from the experience of programs that adapt this common approach to opportunities, constraints, and needs in local settings. The collaborators believe that the exploratory component of the SESS research design is appropriate to the current state of evidence-based knowledge about policy and practice in this area.

This volume documents the SESS approach as developed across the participating grantees, describes the multi-site data and analysis, reports findings, and documents lessons produced over the four years of the initial SESS collaboration. The first year of the intervention, initiated in October of 1997, was devoted primarily to planning and preparation so that the research effort and the program interventions could be initiated simultaneously (see SESS Phase I Report, April, 1998). This report documents and reports findings from the implementation of the SESS programs in years 2 through 4. The remainder of this introductory chapter provides a brief overview of the background, purpose, and design of the SESS project, and introduces the remaining chapters in the report.

BACKGROUND AND PURPOSE

SESS purposes are embedded in growing public awareness and scientific understanding of the importance of the earliest years of life and strong caregiver-child relationships in setting the

[1] **The participating grantee organizations were:** Asian American Recovery Services, Inc. San Francisco, CA; Child Development, Inc. Russellville, AR; Children's National Medical Center Washington, DC; Johns Hopkins University Baltimore, MD; Division of Child and Family Services Las Vegas, NV; The Tulalip Tribes, Beda?chelh Marysville, WA; The Women's Treatment Center Chicago, IL; Boston Medical Center Boston, MA; University of Miami Miami, FL; University of Missouri Columbia, MO; University of New Mexico Albuquerque, NM; and The Casey Family Partners Spokane, WA.

essential foundation for later success in school and life. Research in early childhood education has made it clear that school success is not dependent on cognitive skills alone. Social-emotional (mental health), cognitive and physical development are complementary, mutually supportive areas of growth that require active attention from infancy to school entry (Bowman, Donovan, and Burns, 2001; Knitzer, 2002). Furthermore, the social-emotional health of young children has been shown to be strongly related to strong parent-child relationships (NICHD Early Child Care Research Network, 1996). Tronick (1989) emphasizes the importance of emotional communication from infancy, and suggests that "the effectiveness of emotional communication between infants and caregivers contributes to a child's eventual well-being" (Bowman, Donovan, and Burns, 2001:48). The importance of child-adult relationships extends to the school setting. Children with more positive relations to their teachers are more able to exploit the learning opportunities in the classroom (Howes and Smith, 1995). The SESS model is based on the theory that children with strong relationships with healthy adults will be better prepared for life.

The SESS program approach is also grounded in the growing knowledge and awareness that many families fall through the cracks in our service system because of fragmentation, poor infrastructure, lack of appropriate service, or cultural or individual barriers to service access. Effectively addressing behavioral health issues for caregivers in high risk environments, and providing adequate education and support in parenting and family well-being, will require increasing access and utilization of behavioral health and parenting services.

Accordingly, SESS can be understood in the context of four sequential sets of purposes.

1. **Create integrated service collaboratives.** Collaboratives between early childhood centers, primary care centers, and the SESS programs were a cornerstone of the SESS approach. SESS recognized that recruitment and service of SESS families could occur most easily in natural service settings. Furthermore, SESS recognized the importance of developing strong relationships with service providers to expand the ability to provide needed services to families. There are similarities in approach and procedure across the SESS collaboratives, but each community system has unique features, and the local collaborations are defined by the populations they serve.

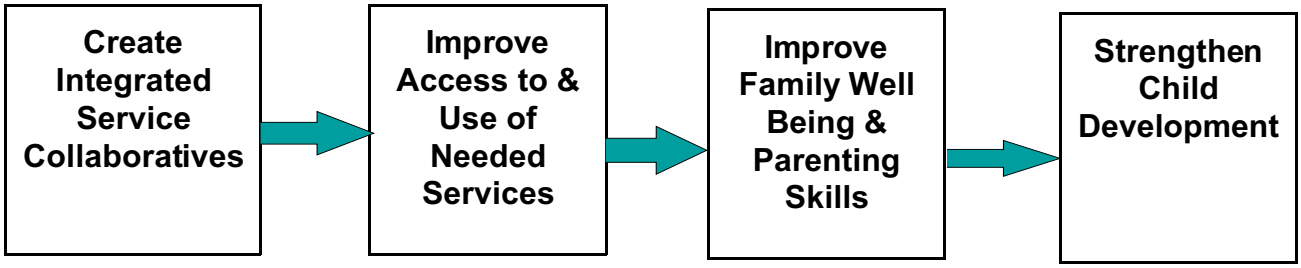
2. **Improve access to and use of services.** This includes direct services to families, but also includes services to systems that support these families. For pre-school children, this includes strengthening the capacity of the pre-school classroom to identify and respond to their developmental needs. In this instance, teachers may be provided training and technical assistance on issues of behavioral health.

3. **Improving parenting skills and overall family well being** in recognition that a strong and nurturing family environment is consistently documented as one of the most important assets a child can have for prevention of problem behaviors and support of positive outcomes. Family well being includes the behavioral health of care givers,

parenting skills, and the establishment of a safe, nurturing, educational and supportive home environment. SESS providers cannot remove every risk factor from the lives of young children and families, but we can support families in providing developmental opportunities that will nurture their children.

4. **Strengthen child development.** Ultimately, the accumulation of accomplishment in the above areas are expected to strengthen the early childhood development in ways that are known to support success in school and the social environment. The importance of these achievements cannot be minimized. All families want a better future for their children, an we know from longitudinal studies that the path established early in life is critical.

Exhibit 1.1
SESS Purposes



To access families that are often not in the mainstream of service access and use, SESS programs partner with primary care institutions, and early childhood education institutions. These settings are used because they represent non-stigmatizing places where parents take their children for service. These service settings represent windows of opportunity in which care givers are particularly open to helping services that may benefit their child. Five of our programs are in primary care settings; seven are in early childhood education settings – five of these are Head Start programs, and two are in child care settings.

METHODS

To ensure a strong scientific basis for project conclusions, lessons and recommendations, SESS has implemented a rigorous multi-site, multi-level research design. The research has the following major features.

1. A multi-site sample including 12 sites that share common features (e.g. behavioral health focus, family-centered, strength-based), but are individually designed to meet the particular needs of the population and community they serve. The multi-site design allows testing of the overall effectiveness of the shared integrated services model across different settings, as well as testing of differences in effectiveness of individual site designs.

2. A large sample of at-risk families, including 1,584 families participating in SESS and 1,303 at-risk families in comparison or control groups that receive the normal standard of care for their setting (e.g., Head Start classroom, child care center, or pediatric clinic).

3. Experimental (5 sites) or quasi-experimental (7 sites) designs with randomized assignment of treatment and control families, or identification of comparison families similar to SESS participants. The cross-site analysis of differences between treatment and comparison or control groups uses statistical methods (i.e., propensity scores and covariance models) to ensure the comparability of treatment and comparison families.

4. A comprehensive instrumentation package designed to provide reliable and valid measurement of multiple outcomes with respect to service access and utilization (parenting services, substance abuse treatment, caregiver and child mental health services, physical health services, basic needs services); family well-being and parenting (caregiver substance use, caregiver mental health, conflict behavior, parenting practices, home learning environment); caregiver-child interaction; and child development (social-emotional and cognitive). When applicable, published instruments were selected. Caregiver interviews are conducted one-on-one by carefully trained and culturally appropriate interviewers.

5. A video-tape protocol for collecting data on caregiver-child interaction for infants and pre-school children. Video-tape scenarios were coded by trained coders to assess the degree of positive and nurturing interaction between caregiver and child. This non-self report data on caregiver-child interaction is a strong component of the study measurement design.

6. A repeated measures design with three repeated outcome measurements and five repeated service access and utilization measurements for early childhood sites, and four repeated outcome measurements and six repeated service access and utilization measurements for primary health care sites. Careful tracking and retention procedures produced follow up data sufficient for analysis on 84 % of the baseline sample across all sites. Retention rates were much higher in some sites.

7. The nature and amount of program contact was documented for each participating caregiver and child. This data helps to clearly specify the nature of the interventions as delivered in each site, and provides an indication of the differences in program services received by individual caregiver and child participants in the study.

8. Comprehensive process data on the design and implementation of each intervention was gathered using systematic protocols in 3 site visits to each program. These data contribute to the documentation of intervention designs, and support the explanation of differences in outcomes across sites.

The data collected through this design have been thoroughly checked and corrected prior to analysis. A systematic quality check documented an error rate well below 1 % in data ready for analysis. All measures were analyzed to establish reliability and validity across sites and across cultural groupings. The study design was particularly sensitive to issues of cultural appropriateness across the diverse sample, allowing exceptions to measures that were judged culturally inappropriate for some populations.

Complete and accurate data sets, at both individual and program levels, have been used to conduct systematic and rigorous statistical analysis of two-point in time and longitudinal outcomes. These analyses have been conducted for all sites pooled, for clusters of similar sites, and for each site individually. Positive early and longitudinal findings have been reported in brief summary reports.

Data Analysis Procedures and Considerations

The cross-site and cooperative agreement nature of the SESS project posed several unique challenges for the over-time data analysis. These issues are listed below:

- *Non-uniformity in instrumentation.* Because the SESS project operated according to cooperative agreement arrangement, grantees were free to choose whether they could adopt the cross-site instrumentation in total. Furthermore, because some sites served infants and others served preschoolers, instrumentation appropriate for one age group was not necessarily appropriate for others. While this latter concern is an issue for the child outcomes and will be discussed more fully in the following chapter, the nonuniformity was nevertheless an issue for the parent/caregiver measures as well. Table 1.1 below displays the parent/caregiver measures by site to illustrate the analysis issues that presented themselves as a result of this nonuniformity. The analysis team opted to use the full data set for each measure; therefore sample sizes will differ across measures.

Table 1.1
SESS Measures Administered Across Time Points

SESS Measures Administered	Waves of data collected	1 AARS	2 CDI	3 CNMC	4 JHU	5 Nevada	6 Tulalip	7 WTC	8 BMC	10 Miami	11* UM-C	12* NM	13* Casey
Home Inventory (Infant or Child)	**Baseline**	X	X	X	X	X		X			X	X	X
	Wave-2	X	X	X	X	X		X	X	X	X	X	X
	Wave-3	X	X	X	X	X		X	X	X	X	X	X
	Wave-4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	X	X	X	X	X
CTS	**Baseline**		X	X	X	X	X	X	X	X	X	X	X
	Wave-2		X	X	X	X	X	X			X	X	X
	Wave-3		X	X	X	X	X	X	X	X	X	X	X
	Wave-4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	X	X	X	X	X
BSI (Short or Long)	**Baseline**		X	X	X	X		X	X	X	X	X	X
	Wave-2		X	X	X	X		X	X	X	X	X	X
	Wave-3		X	X	X	X		X	X	X	X	X	X
	Wave-4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	X	X	X	X	X
PDMI	**Baseline**	X	X	X	X	X	X	X			X	X	X
	Wave-2	X	X	X	X	X	X	X			X	X	X
	Wave-3	X	X	X	X	X	X	X			X	X	X
	Wave-4	N/A	N/A	N/A	N/A	N/A	N/A	N/A			X	X	X
PSI	**Baseline**		X	X	X	X	X	X			X	X	X
	Wave-2		X	X	X	X	X	X	X	X	X	X	X
	Wave-3		X	X	X	X	X	X	X	X	X	X	X
	Wave-4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	X	X	X	X	X
ASI	**Baseline**	X	X	X	X	X	X	X	X	X	X	X	X
	Wave-2	X	X	X	X	X	X	X	X	X	X	X	X
	Wave-3	X	X	X	X	X	X	X	X	X	X	X	X
	Wave-4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	X	X	X	X	X

NOTE: **Sites 11, 12, 13** administered different modules at different waves depending on the age of the target child. These three sites have both infants and older children in their SESS project.

- *Data administration patterns.* Data administration patterns at the early childhood and primary care sites differed because the age of the children at the primary care sites was considerably younger than at the early childhood sites, and developmental change in these younger children was felt to be more detectable with four points of administration rather than three. Table 1.2 below shows the data administration patterns for the early childhood and primary care sites.

Table 1.2
SESS Data Administration Patterns
Parent/Caregiver Measures

	Baseline	6 mos. after baseline	9 mos. after baseline	12 mos. after baseline	18 mos. after baseline
Early Childhood Sites	X		X		X
Primary Care Sites	X	X		X	X

Because early childhood and primary care sites differed in their data collection patterns, and because repeated measures MANCOVA requires uniformity in the number of time intervals, the longitudinal analyses reported here utilize the first three data points for observations in each setting. Differences in interval between observations are adjusted for through a time co-variate.

- *Missing Data and Data Imputation.* Overall, missing data in the Starting Early Starting Smart study was very low, and for almost all items, the amount of missing data was less than two percent. However, because the existence of missing data in any data set may reduce and complicate the precision of calculated statistics, SPSS EM-Algorythm was used to impute missing data.[2]

- *Attrition Bias.* For SESS, attrition was a minor problem since the number of subjects who attrited were relatively small over time (see Chapter 3 for more detailed discussion), and they were not demonstrably different from the rest of the sample. Analyses using a propensity score as a covariate for attrition suggested that no added value was achieved in

[2] Prior to imputation, Missing Value Analysis was carried out to determine the extent of the missing values in the each module. Variables were checked for distributional problems (defined as skewness > 2 and/or Kurtosis > 6). Based on the shape of each variable distribution, log transformations were used to correct for normality. Where missing data was 2% or less and randomly missing, the data were imputed on the basis of the entire data set using EM algorithm method. When 2 - 5% data were missing, additional investigations were carried out to determine the pattern of missing values. If the values were randomly missing, the variables were imputed on the basis of the complete data set, otherwise the variables were imputed by site. For more than 5% missing data, the data were imputed separately by site. Following imputation, values were checked to determine the need for rounding of out-of-range values. Missing data were imputed for cases where the instrument was administered to all respondents but where some items may not have been answered. Imputation was not conducted in cases where the data were missing because whole modules were not administered at particular sites.

using attrition propensity scores. It was concluded that differential attrition is not a threat to interpretation of experimental analyses in the SESS data set.

- *Longitudinal Analysis Procedures.* SESS data has many features that presented challenges in developing an adequate analysis model. The study involves data collected from 12 sites over three or four time points. The scope of the study involved modeling different measures and outcomes where some functioned in many roles as either mediator, moderators, or suppressor to answer the research questions posted earlier. The clustering of outcome measures by primary care and early childhood sites, and by other factors such as racial/ethnic background made it infeasible to use hierarchical modeling techniques which require a larger number of sites with uniform data than were available in the SESS sample.

  Within this context, the analysis team used doubly multivariate repeated measures analysis. For most of the instruments used in SESS, two to four outcomes were usually included as dependent variables. Three types of adjustments were adopted to the multivariate repeated measures analysis in all SESS analyses, adjustments for non-equivalence at baseline, adjustments due to time variability between interviews, and variability in sample size. Adjustments for non-equivalence were established by using a propensity score for each subject as covariate in the model. Time variability was adjusted for because the primary care and early childhood sites had different time intervals between administrations. Primary care sites had a total of four interviews over the 18 months period of the study with three six months intervals. Early childhood sites had three interviews over the 18 months period of the study with two nine months intervals. For example, three outcome measures; anxiety, depression, and hostility make up the brief symptom inventory (BSI) instrument. The multivariate approach allows us to analyze these outcomes as clusters to account for the co-variations among them and make an omnibus statement on BSI as a whole, as well as the individual outcome measures.

  Longitudinal analyses focused on finding whether the differences between SESS programs participants and non-participants on the outcome measures have a specific trend and how these trends influenced by the type and nature of the outcome. Linear and non-linear trends were assessed. A linear trend on any outcome suggests either a constant increase or decrease in the differences between the participant and standard service comparison groups over time. Similarly, a non-linear trend either a fluctuation in the pattern of the differences over time. These trend analyses are the focus of this final report.

ORGANIZATION OF THE REPORT

The remainder of this report is organized in 8 chapters that systematically explicate data, analysis and findings within the framework of SESS purposes presented in this chapter. More specifically, the chapters address the following specific topics.

- **Chapter Two: The Sess Study Participants: Sample and Family Characteristics** profiles the demographic, risk, and need characteristics of SESS families. The analyses demonstrate the diversity of SESS participants across sites, and present the analyses that identify participants in each site who are in need of specific services.

- **Chapter Three: SESS Programs** summarizes shared characteristics of SESS programs that define the SESS program model. The chapter also summarizes patterns of variation and adaption of core program characteristics to meet local opportunity and need.

- **Chapter Four: SESS Outcome Findings: Service Access and Utilization by SESS Families** presents and interprets findings concerning the degree to which SESS participants experience increased access and utilization of behavioral health, parenting and family, and basic services. The chapter also presents data on barriers to service utilization as perceived by SESS participants.

- **Chapter Five: SESS Program Outcomes for Caregiver** summarizes Behavioral Health findings on program impacts on caregiver behavioral health for all SESS participants relative to standard of care comparison families, and for SESS participants with an indicated need for specific services.

- **Chapter Six: SESS Program Outcomes for Parenting and Home Environment** summarizes findings on program impacts on parenting methods, caregiver-child interactions, and learning opportunities and support in the home for all SESS families relative to standard of care comparison families, and for SESS families with a need for specific services.

- **Chapter Seven: SESS Program Outcomes for Infants and Toddlers** presents and interprets findings on parent -child interaction as measured with videotaped interaction methods.

- **Chapter Eight: SESS Program Outcomes for Children** summarizes findings on program impacts on social-emotional and cognitive development in SESS children relative to standard of care comparison families.

CHAPTER TWO
THE SESS STUDY PARTICIPANTS: SAMPLE AND FAMILY CHARACTERISTICS

The population of young families served by SESS programs are recruited from primary health care centers and early childhood centers across the country. These centers are located in rural regions, inner city locations, and suburban settings - neighborhoods and communities that are home to immigrant families from different countries of origins and a variety of racial and ethnic groups. The two types of SESS settings deliver services which, generally, are age-specific. Children served include infants, toddlers, and pre-school age children. Within each SESS site, the population reflects the varied circumstances, strengths, and risks that argue for the delivery of individualized assessments and approaches.

This section of the final report describes the SESS population and the implications of population characteristics for service delivery and outcome analysis. The source of participant information is the baseline survey instrument, which was administered to nearly 3,000 participants at seven early childhood sites and five primary care sites.[3]

The chapter has three main sections:

- The first section describes number of participants and their distribution between treatment and control groups and primary and early childhood settings.
- The second section describes the demographic and socioeconomic characteristics of the overall SESS sample. Population descriptions include age and ethnicity of participants, household composition, income sources, social and health resources.
- The third section describes the risk characteristics of the population. Behavioral risk (e.g., substance use, mental health problems) and demographic risk (e.g., income, education, employment) are both described.

[3] One of the early childhood sites is not included in the outcome analysis, nor is the program described in subsequent chapters on program interventions. The site was unable to implement the program to capacity because the public housing community they served was dispersed and they discontinued the study. However, the baseline information from this program enhances our understanding of the populations sites proposed to serve.

SUMMARY OF FINDINGS

Sample Characteristics

- The sample size at baseline for the study was 2,907, with 1,595 participants and 1,309 comparison/control families. Site sample sizes ranged from 133 to 549.

- Early childhood sites used comparison group selection methods, with comparison group families drawn from other early childhood programs with no SESS programming. The number of families recruited into comparison groups was lower than the number of participant families (1,138 participant families, 857 comparison families).

- Primary care sites used control group selection methods. Therefore, the number of participants and control families was equivalent at these sites.

- The retention rates from baseline to the 18-month follow-up was 65.3%. Differences were negligible between participant and comparison families.

SESS Family Characteristics

Demographic Characteristics

- SESS children fell into two distinct age groups. At baseline, 28.1% were under the age of 1, and 66.2% where between 3 and 5.Infants and toddlers were recruited from primary care sites, preschoolers from early childhood sites.

- Most (95.1%) primary caregivers were women. Almost all caregivers (91.5%) were 40 or younger, 11.5% were under 21 and around half were between 21 and 30. The average age of the primary caregivers was 24.

- The sample represented a diversity of racial/ethnic groups; almost half the sample (44.2%) was African-American.

- For 20% of SESS families English was a second language. Languages spoken predominantly in the home include Spanish (10%), Chinese (7.4%), dialects and other Asian languages (7.4%), and Haitian Creole (1.9%).

- Most children were living with their biological or adoptive parent (94%). A little more than one-third (38.5%) lived with both parents, the average household size was 4.6, and the average number of children in a family was 2.58.

Socio-Economic Characteristics

- SESS successfully recruited families with low socio-economic background into its programs. One-quarter of all SESS families were classified as high-risk according to the Annie E. Casey risk index, a measure of socio-economic risk, compared to only 12% of the general population.

- Approximately one-third (38%) of caregivers had not received their high-school diploma, with considerable variations across sites. Around half of the caregivers were employed at baseline, with most in technical (45.3%) or administrative work (27.7%). Yearly incomes for the average household of 4.6 members was $11,040, far below national poverty level of $19,950 for this household size.

- Around one-quarter of all caregivers received public assistance, and did not have insurance (29.3%). Slightly fewer (17.1%) children did not have health insurance.

Behavioral Health Characteristics

- In addition to recruiting low-income families into the study, SESS also was successful in recruiting families with a history of behavioral health issues. Half the sample reported a family history of substance abuse problems, around one-third (30.9%) had visited a mental health specialist, support group or treatment facility in the past 12 months. Around one-third (28.3%) of all caregivers reported significant physical aggression problems with their partners.

- SESS was also successful in recruiting children with behavioral health issues. Around one-quarter of the target children were reported by their teachers as being deficient in social skills.

SAMPLE CHARACTERISTICS

An important SESS principle is recognizing that the well-being of caregivers and children are interconnected. Caregiver problems and caregiver strengths have repercussions on all household members, especially children, and, similarly, children influence family relationships and family needs. Consistent with the SESS philosophy is the SESS program's intent to mutually serve caregivers and children, and the cross-site study's aim to assess the well-being of both caregivers and children. Accordingly the study sampled dyads consisting of the study index child and the child's primary caregiver.

Nearly 3,000 caregiver/child pairs (n=2,907) were in the SESS study. Although pairs included only one caregiver and one target child, many SESS family and household members also

received services through SESS, but were not part of the research component of the study. The sample had the following characteristics:

- *Sample Size.* The number of participants in each study site varied greatly. The sample size of baseline treatment groups at the study sites ranged from 52 (Site 13) to 336 (Site 4). Similarly, the comparison group sizes ranged from 45 to 212. Total sample size ranged from 133 to 549.

Table 2.1
Number of SESS Participants at Baseline by Site

Site		Treatment	Comparison	Total
Early Childhood	Site 1	137	85	222
	Site 2	132	116	248
	Site 3	141	149	290
	Site 4	337	212	549
	Site 5	100	83	183
	Site 6	113	88	201
	Site 7	178	124	302
Primary Care	Site 8	100	103	203
	Site 10	121	121	242
	Site 11	78	71	149
	Site 12	110	112	222
	Site 13	66	67	133

- *Early Childhood/Primary Care Population Differences***.** Of the 2,907 families in the sample, 1,005 (68.6%) were associated with the seven early childhood sites, and 912 (31.4%) were associated with the primary care sites.. The site that serves the smallest population is a primary care site, and the site with the largest number of participants is an early childhood site. For the most part, early childhood sites included all children in some aspect of SESS service provision, which is why sample sizes are higher at many of these sites than at primary care sites.

- *Treatment and Comparison Group***.** Somewhat more than half of the SESS participants were assigned to the treatment group. There were nearly 1600 dyads (n=1,598) in the treatment groups and slightly more than 1,300 (n=1,309) in the comparison groups. Sizes of the treatment and comparison group were also influenced by the host setting. The

comparison groups for early childhood sites are entire groups of service recipients from similar early childhood centers, often fewer in number. (For example, a treatment group for a single SESS site may serve five centers, but the comparison group may be two or three centers). The primary care sites, which have nearly a 50-50 split for treatment and comparison groups, draw their population from one or more referral agencies or sources, and randomly assign individual participants following referral.

- *Retention Rates.* The overall retention rate for the total sample of SESS families (treatment and comparison) was 65.3%, with negligible differences between participant and standard of care comparison group members. For early childhood sites, the retention rate at the 9-month follow-up was 79.7% and 65.5% at the 18-month follow-up. Retention rates for the primary care sites were slightly lower; 71.6% at the 6-month follow-up, 61.5% at the 12-month follow-up, and 64.8% at the 18-month follow up.

Table 2.2
Retention Rates: Total Sample, Early Childhood and Primary Care Sites

	Treatment		Comparison		Total	
Baseline	1447	100%	1244	100%	2691	100%
6 month follow-up (PC sites only)	342	74.2%	311	69.0%	653	71.6%
9 month follow-up (EC sites only)	896	78.8%	694	80.9%	1590	79.7%
12-month follow-up (PC sites only)	294	63.8%	267	59.2%	561	61.5%
18-month follow-up	939	64.9%	818	65.8%	1757	65.3%

SESS FAMILY CHARACTERISTICS

The intake module of the SESS baseline and follow-up interviews provide detailed data concerning the demographic characteristics of the SESS participants. The following section provides a brief description of the children and families served through the SESS initiative, including a comparison of client characteristics across program setting and individual sites.

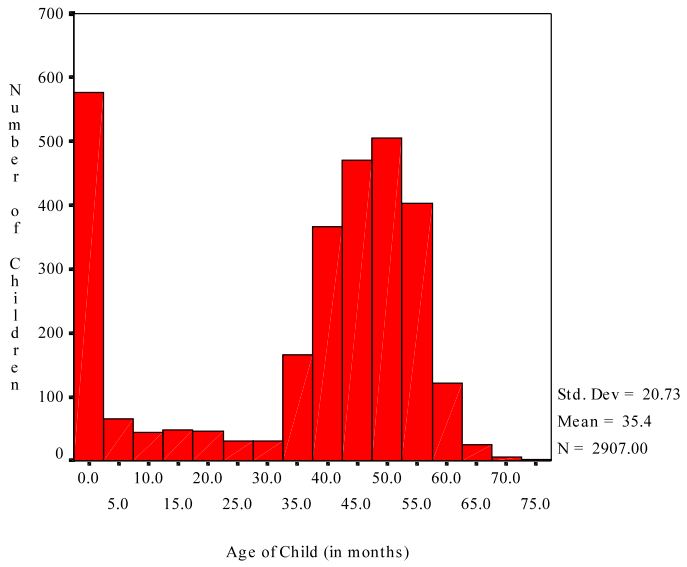
Age of Target Children

The SESS initiative examined the impact of program interventions implemented in two distinct organizational settings: primary health care organizations that provide pediatric and adult care to families of newborn and infant-age children, and early childhood education centers targeting

children of preschool age. Consequently, SESS target children from early childhood sites are older than those from primary care sites.

Exhibit 2.1 shows the distribution of SESS children (participant and control combined) by age. At baseline, the vast majority of SESS children were either newborns or preschool children around the age of 4. The age of children at early childhood sites ranged from 2.7 years old to 6.1 years old with an average age of 4 years. The age of primary care children ranged from 0 to 5.9 years old, with an average age of 8 months. Among primary care children, 47.6 percent were six weeks of age or under at baseline, and 26.8 percent were between six weeks and one year.

Exhibit 2.1
Age of Children in Total Sample at Baseline
(N = 2,907)



The following table reports the age of target children in yearly increments for the full sample, and for the early childhood and primary care subsamples. Table 2.4 reports the average age and age range at each site. Most SESS children were either less than one years old or between three and five years old at baseline. Across all early childhood sites, the approximate age at baseline was 4. Few children were between the ages of one and three years old (7.6%) since this age group was not targeted in a focused way. Two primary care sites recruit exclusively from prenatal clinics and/or hospital labor and delivery departments. Three other primary care sites recruited families with infants, toddlers, and preschoolers.

Table 2.3
Percentage of Target Children in Different Age Categories at Baseline

	Total Sample (N=2,907)	Early childhood Sample (N=1,995)	Primary care Sample (N=912)
Under 1 Year	28.1	.1	75.2
1 Year to <2 Years	3.5	0.0	11.6
2 Year to <3 Years	4.1	2.9	6.8
3 Year to <4 Years	32.0	44.6	3.4
4 Year to <5 Years	34.2	48.3	2.3
5 Years and Older	3.1	4.0	0.0

Table 2.4
Age of Children in Months by Site
(N = 2,907)

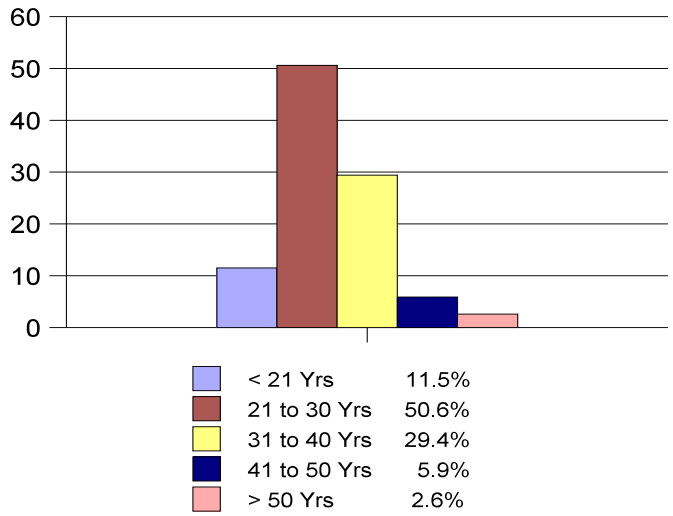
Site		Average Age	Range	Standard Deviation
Early Childhood Sites	1	45	33 to 61	6.95
	2	44	33 to 57	4.33
	3	51	38 to 60	3.94
	4	47	33 to 63	6.89
	5	51	32 to 65	6.60
	6	51	35 to 73	9.19
	7	49	34 to 49	6.72
Primary Care Sites	8	0	0 to 2	.34
	10	0	0 to 4	.74
	11	25	0 to 71	19.25
	12	11	0 to 46	12.63
	13	14	0 to 32	10.02

Caregiver Gender and Age

The vast majority of primary caregivers in the SESS study population were women. In a pool of 2,907 participants, 4.9 percent (n=141) were males. Young caregivers accounted for a significant

portion of the sample, with more than one-third (34%) age twenty-four years or younger at the time of the baseline administration. The average age of caregivers in the sample was 29.

Exhibit 2.2
Age of Primary Caregiver at Baseline
N = 2,907

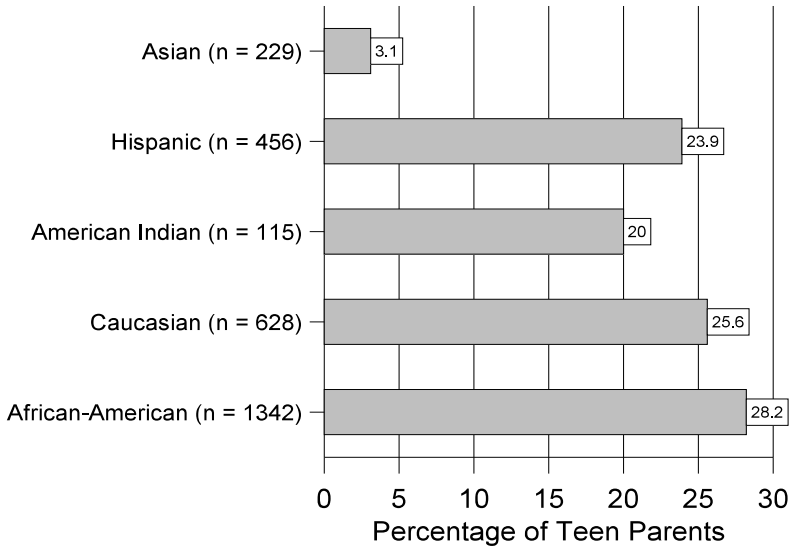


At the time of the target child's birth, one-fifth of the parents served by SESS programs were still teens. This percentage varied significantly across major race/ethnic groups. The percentage of mothers who were under 20 year of age at the target child's birth was found to be highest among African-American (24.5%), Caucasian (21%), and mixed race mothers (19%), slightly lower among American Indian (16%) and Hispanic (13.5%) women and extremely small among women of Asian decent.

Racial/Ethnic Composition and Language of SESS Participants

The SESS programs served a number of families from different racial and ethnic backgrounds. As depicted in the figure below, almost half of the sample was African American (44.2%) followed by Caucasian (16.3%) and Hispanic (13.7%). The rest of the SESS population consisted of Asian/Pacific Islander (7.6%), people of mixed racial heritage (11.4.%), American Indian (3%), and people who were members of groups not listed on the baseline interview (1.0%).

Exhibit 2.3
Teen Parents at Target Child's Birth by Race/Ethnic Group
N = 2,907



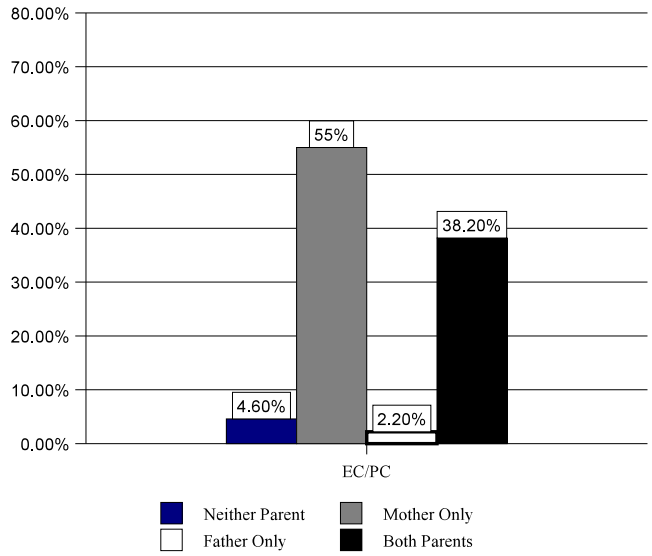
Language of SESS Participants

The client base is also diverse with regard to the primary language spoken by participants, due to the presence of several recent immigrant communities within the SESS service population. For 20% of SESS families, English is a second language. The predominant languages spoken in the home other than English include Spanish (10%), several Chinese dialects and other Asian languages (7.4%), and Haitian Creole (1.9%). Recent immigrants comprise a substantial portion of the service population. At the site level, immigrant populations were largely concentrated in six of the twelve SESS programs, and at one site, almost all participants were non-native speakers.

Family Composition

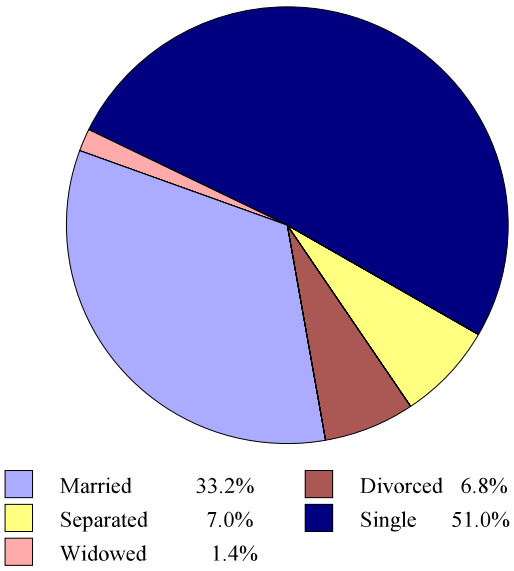
The vast majority of children in the SESS study sample (94%) were living with a biological or adoptive parent at baseline, and only a small percent of children (3.4%) lived with grandparents, or other relatives or friends (1.9%). Exhibit 3.4 depicts the baseline living arrangements of SESS children. Most of the children (55%) lived with either their biological mother, while around one-third (38.5%) lived with both parents.

Exhibit 2.4
Living Arrangements of Target Child at Baseline
N= 2,907



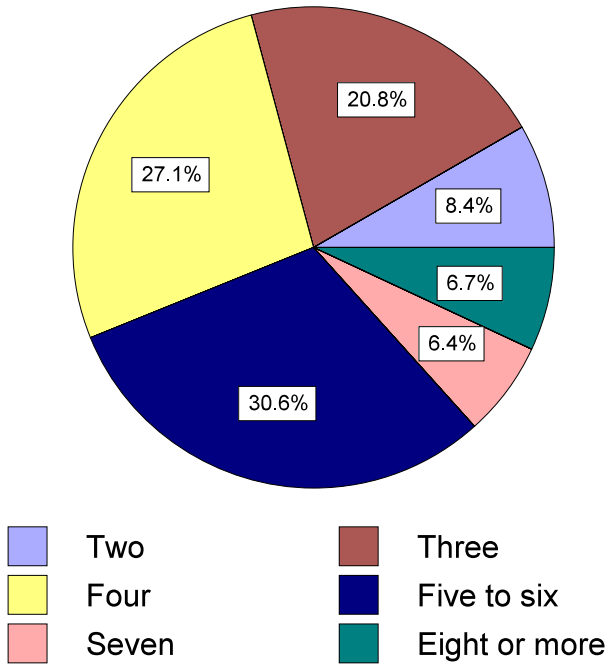
As shown in Exhibit 2.5, the majority of SESS households were headed by a single, divorced, or separated primary caregiver (64.8%). Only 33.3 percent were headed by married parents.

Exhibit 2.5
Martial Status of Primary Caregiver
N = 2,907



The average size of SESS households was 4.6 members. Most households had between three and six family members (see Exhibit 2.6).

Exhibit 2.6
Household Size at Baseline
N = 2,907

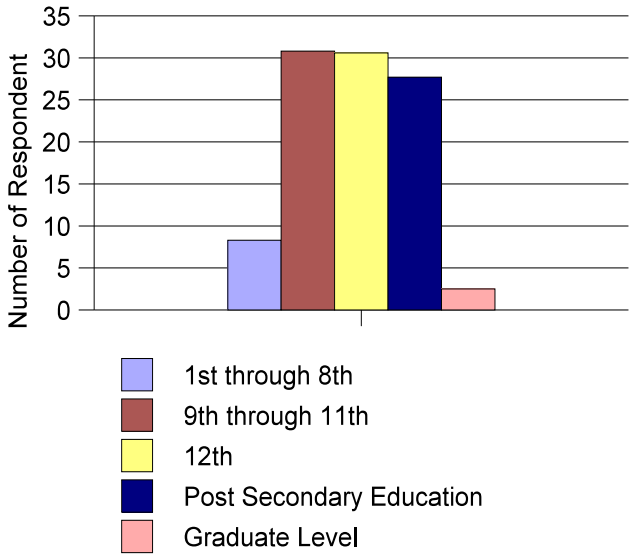


The average number of children per household, including adoptive children, step children, and children in foster care was estimated at 2.58 for the sample.

Educational Attainment

Among the SESS caregivers, approximately 39% had not completed their high school education. Eight percent of clients in the cross-site sample never entered high school.

Exhibit 2.7
Highest Grade of Schooling Completed by SESS Respondents
N = 2,907



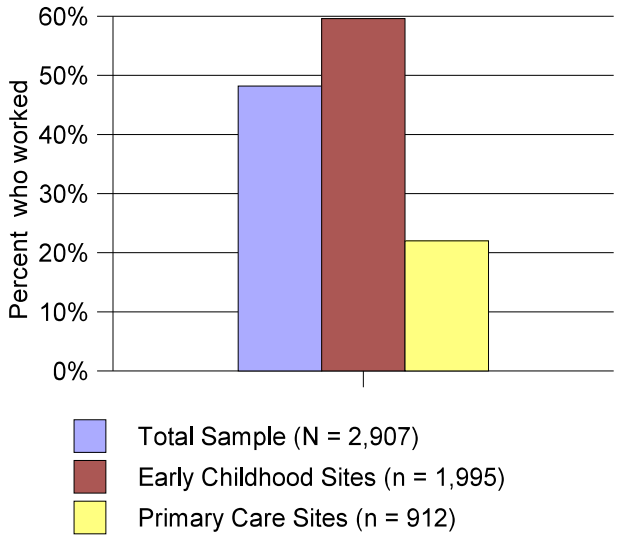
High school completion rates varied across the sites. Only 43 percent of caregivers associated with Site 10 had a high school degree, perhaps a reflection on the high number of recent immigrants in the program sample. Over 80 percent (82.5%) of the caregivers at Site 2 had a high school degree.

At baseline, 21 percent of early childhood clients and 17.9 percent of primary care clients were enrolled in an educational or vocational training program - regular school, GED classes, or trade or technical schools.

Work, Household Income, and Basic Support

SESS participants were recruited through early childhood centers and medical providers and institutions that serve low-income families. At baseline, most SESS caregivers worked in low-paying jobs and/or received assistance from a number of public sources. This section describes sources of household income and other of support for SESS caregivers and their children.

Exhibit 2.8
Percent of Total Number of Respondents Who Worked (Baseline Survey)



Forty-eight percent of all respondents were employed at the time of the baseline administration. Nearly three-fourths were employed in technical (45.3%) and sales or administrative work (27.7%)

Public Assistance and Health Insurance

About a quarter of SESS families received household income from public assistance programs at baseline (in-kind sources of assistance, such as food stamps, WIC, or other non-monetary support). About 30% of SESS respondents lacked health insurance at baseline.

A higher percentage of children than caregivers were insured at baseline. Substantial variation in rates of insured children was found within population subgroups. There was a higher rate of uninsured children in primary care sites than early childhood sites. The children served by Site 6 were nearly all insured, while around 33 percent at three of the sites were uninsured. Site-level variation may be largely attributable to conditions of certain communities. For example, there were almost no uninsured Native American children, suggesting the effectiveness of tribal institutions in providing medical coverage to members. More than one-third of Hispanic children had no insurance, an indication of the institutional barriers encountered by many Hispanic families.

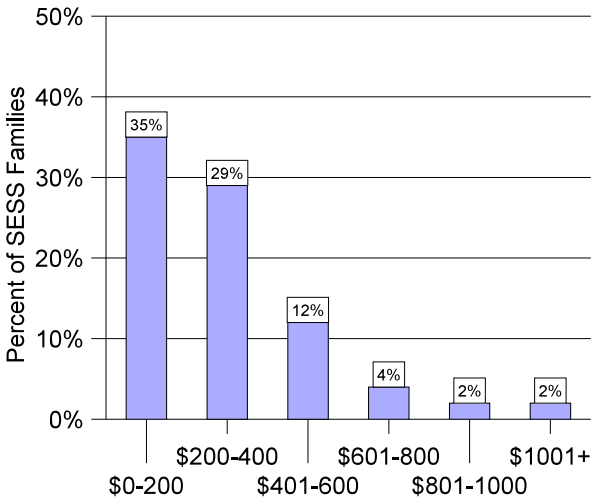
Table 2.5
Percent of Households that Receive Income Public Sources and Caregiver and Target Child Have Insurance

	TOTAL (n=2,907)	Early Childhood Sites (n=1,995)	Primary Care sites (n=912)
Households that Receive Public Assistance	27.8	23.2	37.7
Caregivers with Public Insurance	44.4	35.4	64.9
Caregivers with Private Insurance	26.0	33.0	10.1
Caregivers with no Insurance	29.3	32.2	22.7
Target children who have insurance	82.9	87.9	72.1
Target children who don't have insurance	17.1	12.1	17.1

Household Income

This sub-section considers household income relative to the number of participants in the household. The following graph describes this in $100 increments. (Note that the average number of household members is 4.6.)

Exhibit 2.9
Monthly Income



Monthly household income divided by the number of people in the household

Somewhat more than one-third of families had incomes of $200 or less per month per household member. For the average household of 4.6 members, this equates to a yearly income of $11,040, far below national poverty figures for this household size ($19,950).

The income range does not reflect relative costs of living across sites. Several SESS programs were located in communities with very high housing costs (San Francisco, Boston, and the Washington DC suburbs, for example), while others (Arkansas, for example) were in areas where housing is far less expensive.

RISK AND NEED IN SESS FAMILIES

The SESS approach to integrated services identifies and builds on family strengths to support access and utilization of services necessary to mitigate risks and further strengthen the family environment. The assumption behind the SESS intervention is that the families served by the programs frequently face multiple risks, and that family-centered and strengths-based service integration can help identify specific needs that will help the family achieve greater well-being. The remainder of this chapter presents data on multiple risk measures across the SESS sites, and identifies portions of the SESS sample that are in potential need of services in specific caregiver, family, or child risk areas.

Risk Status of SESS Families

Numerous risk factors have been identified across studies conducted in the areas of juvenile justice, health, mental health, social welfare, and educational research. However, there have been few direct, linear relationships established between specific risk or protective factors and single outcome indicators. This is likely due to the multiple influences and interactions between individuals, family, and social factors as well as the complexity of mechanisms involved in influencing outcomes. Research indicates that the *number* and *severity* of risk factors, rather than the *specific* risk factors involved, are most predictive of infant, child, youth, and family outcomes (Catalano & Hawkins, 1995; Knitzer, 1993; Schorr, 1988; Rutter, Sameroff, Siefer, Baldwin, & Baldwin, 1993; Siefer, Sameroff, Dickstein, Keitner, Miller, Rasmussen, & Hayden, 1996). For example, research on compounded family problems has shown that offspring of depressed parents with alcoholism are three times more likely to abuse alcohol than offspring of parents with depression alone (Merikangas, Weissman, et al, 1985).

The risk and need literature has identified two fairly distinct facets of family risk: behavioral and demographic. In line with these findings, theoretically meaningful summaries of the risks faced by SESS families were developed to describe family challenges and account for them in assessing program-related benefits.

First, poverty is a conglomerate of conditions and events that amount to a pervasive stressor, which may or may not go along with behavioral problems such as substance use or violence in the home (Huston et al., 1994). Poor children and families are often exposed to poor health conditions, inadequate housing and homelessness, environmental toxins, and violent or unsupportive neighborhoods. These children are more likely to do poorly in school, drop out, become teen parents, or engage in delinquent behaviors. These demographic factors were summarized separately in the Annie E. Casey Demographic Risk Index. Information on each index and description of SESS families on each measure is presented next.

Second, psychosocial risk factors, including substance use, mental health, psychiatric history, and parental stress play a prominent role in child emotional and behavioral outcomes. Therefore, these factors were summarized in the SESS Behavioral Risk Index, an index developed specifically for this study. Currently, there are no popularly used standardized instruments that examine multiple behavioral risk factors such as parental substance use, violent conflict, and family involvement with the criminal justice system (Kelleher & Long, 1994; Schroeder, Gordon, Kanoy, & Routh, 1983).

Behavioral Risk Index

Annie E. Casey Demographic Risk Index

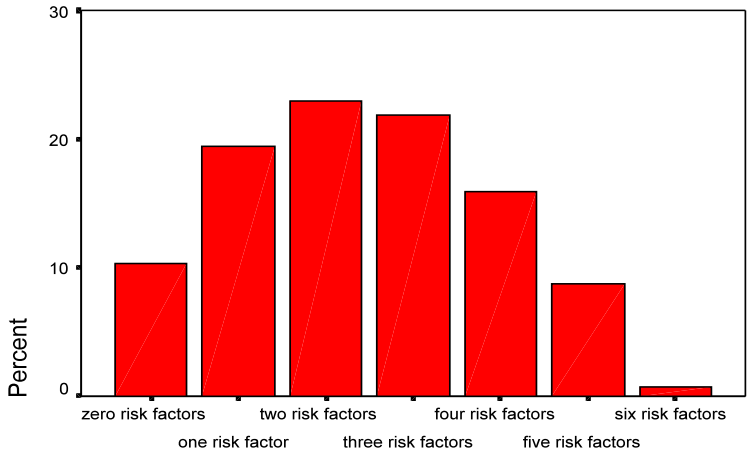
The Annie E. Casey Index is a measure of demographic risk comprised of 6 factors, including poverty status, welfare status, single-parent head of household, employment status, caregiver educational status, and child health insurance status. The distribution of these characteristics and those of the general population are depicted in Table 2.6. Comparisons of SESS families with a national sample of families show that SESS families, on average, are at much higher risk than the national average.

Table 2.6
Annie E. Casey Risk Factors and Prevalence

Risk Factors: Annie E. Casey Risk Index	Prevalence of Risk Factor in SESS Sample (N=2946):	National Average (2000)
1. Family income below poverty line	69%	17%
2. Family receiving welfare benefits	28%	3%
3. Child not living with 2 parents	62%	30%
4. Living with parent(s) without steady, full-time employment	39%	28%
5. Household head a HS dropout	39%	19%
6. Child without health insurance	17%	12%

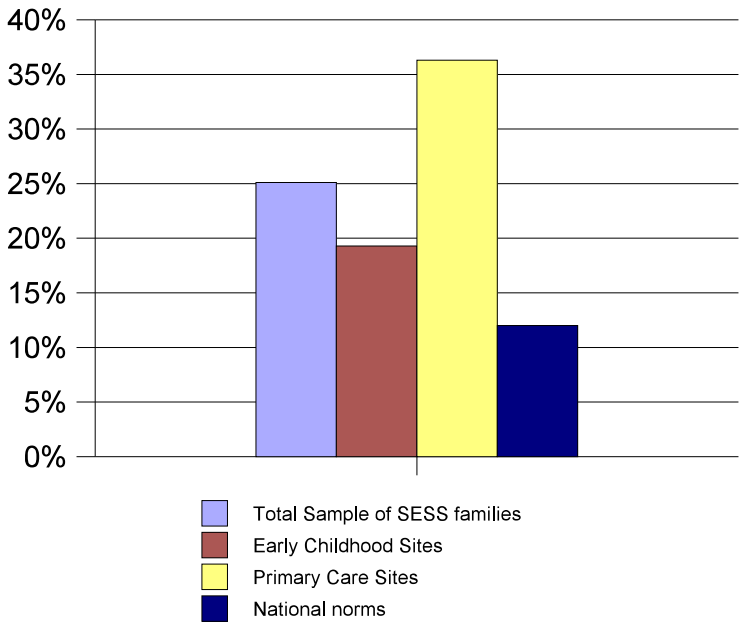
The Annie E. Casey risk index is created by assigning families one point for each risk factor they demonstrate. The summarized index ranges from a minimum score of 0 (low risk, zero risk factors endorsed) to 6 (high risk, all six risk factors endorsed). Exhibit 2.10 shows the distribution of the risk index for the SESS sample.

Exhibit 2.10
Annie E. Casey Risk Index
(higher = more risk) 0-6



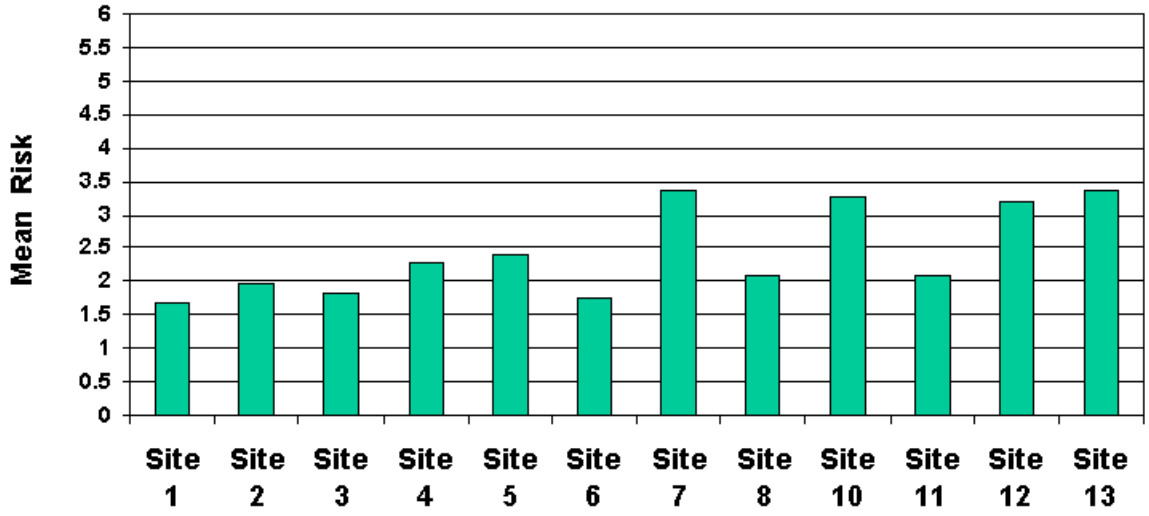
The majority of families exhibit between one and three demographic risk factors. Twenty-five percent of SESS families reported 4 or more risk factors. Families with 4 or more risk factors are considered to be high-risk according to national data. Twelve percent of the general population is considered to be high risk.

Exhibit 2.11
Demographic Risk Index for Families



SESS programs varied in terms of their families demographic risk. As shown in Exhibit 2.12, sites that targeted at-risk families (sites 7, 10, 12, and 13) exhibited higher risk.

Exhibit 2.12
Annie E. Casey Demographic Risk Index by Site



The behavioral risk index for SESS families was developed as a general measure of cumulative behavioral risk factors and includes an array of factors related to behavioral health. The SESS Behavioral Risk Index is a "percent possible" score that ranges from 0 (no self-reported behavioral risk) to 100 (very high self-reported behavioral risk). It was constructed from 18 individual measures of risk and family functioning in an attempt to capture concomitant family challenges (as they were reported to the SESS research staff during interviews).[4] The characteristics of SESS families across these measures are presented in Table 2.7, details for determining risk cut-off points are listed in a table at the end of the chapter.

[4] The 18 risk factors include 1) psychiatric history, 2) substance use history, 3) criminal justice history, 4) caregiver substance use treatment, 5) caregiver alcohol use, 6) caregiver drug use, 7) mental health treatment, 8) mental health symptoms, 9) home environment, 10) physical discipline, 11) violence between parents, 12) parenting stress due to difficult child, 13) parenting stress due to parent-child dysfunctional interaction, 14) child social skills: caregiver report, 15) child problem behaviors: caregiver report, 16) child social skills: teacher report, 17) child problem behaviors: teacher report, and 18) infant regulatory disorders. To calculate the total risk score, all 18 risk factors were counted for each time the family reached the clinical risk criterion on a standard evaluation instrument), and a percent score was created. This percent represents the family's level of cumulative risk on all factors available from the SESS baseline interview, such that a higher score indicates greater cumulative risk. For example, if a family displayed every one of the 18 available risk signs at the baseline SESS interview, their Behavioral Risk Index score would be 18/18 * 100, or 100%. If a family displayed half of the available signs of risk at baseline (9), their Behavioral Risk Index score would be 9/18 * 100, or 50%.

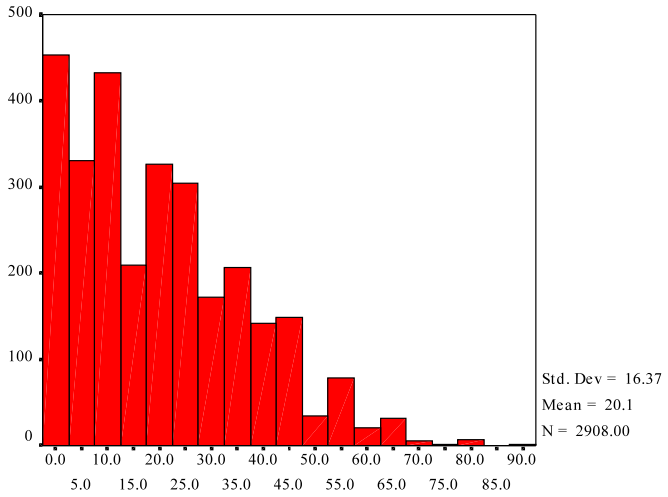
Table 2.7
Behavioral Risk Factors at Baseline

Risk Factor	Total N	Percent
Family history of substance abuse problems	2907	51.6
Family history of mental health problems	2881	16.1
Caregiver problem or binge drinker (self-report, ASI defined)	2873	4.4
Caregiver received mental health care treatment, past month	2904	30.9
Poor home environment (lowest quartile on HOME)	2418	22.4
Criminal history of family member	2859	14.3
Caregiver used drugs in past 12 months (self-reported)	2873	6.5
High physical aggression in caregiver relationship with significant other (above clinical cutpoint)	2877	28.3
Poor child social skills (moderate to significant deficit, teacher report)	1685	24.7
Child has problem behavior (moderate to significant, teacher report)	1685	16.3
Caregiver uses harsh discipline practices (self-report)	2154	1.9

The table displays the behavioral risk characteristics of caregiver's families, caregivers, and the target children. Around one-half of caregiver had family histories of substance abuse, around one-third had received mental health services in the past year, and almost a third were in physically aggressive relationships. According to teacher reports of child behavior, around one-fourth of children had social skills issues. Far fewer (16.3%) reported problem behaviors, nevertheless these percentages exceed national averages.

Exhibit 2.13 displays the distribution of the Behavioral Risk Index score for all SESS families. The greatest number of families reported low overall risk, with the average risk score at 20, representing approximately 4 behavioral risk factors.

Exhibit 2.13
Cumulative Behavioral Risk: SESS Families



As would be expected due to differing recruitment targets, families attending SESS programs at early childhood centers showed lower average risk scores than families attending SESS programs at primary care centers. As shown in Exhibit 2.14 and 2.15, the average risk score at primary care sites was 27.4, compared to 17 at early childhood sites.

Despite commonalities in recruitment within the Early childhood programs and within the Primary care programs, the individual sites served widely variable client populations (racial/ ethnic groups, behavioral needs, SES) within each setting.

Exhibit 2.14
Cumulative Family Risk
Primary Care Families

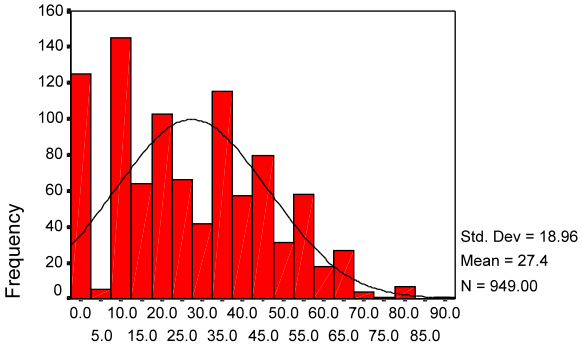


Exhibit 2.15
Cumulative Family Behavioral Risk
Early Childhood Families

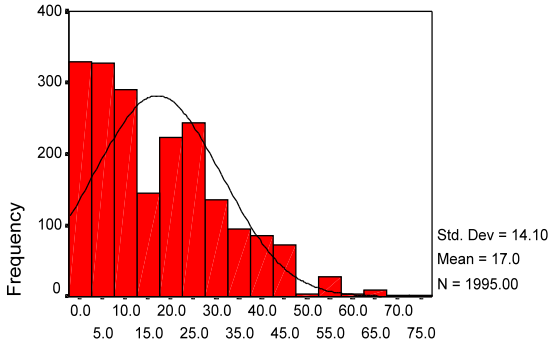


Exhibit 2.16
SESS Behavioral Risk Scores by Site

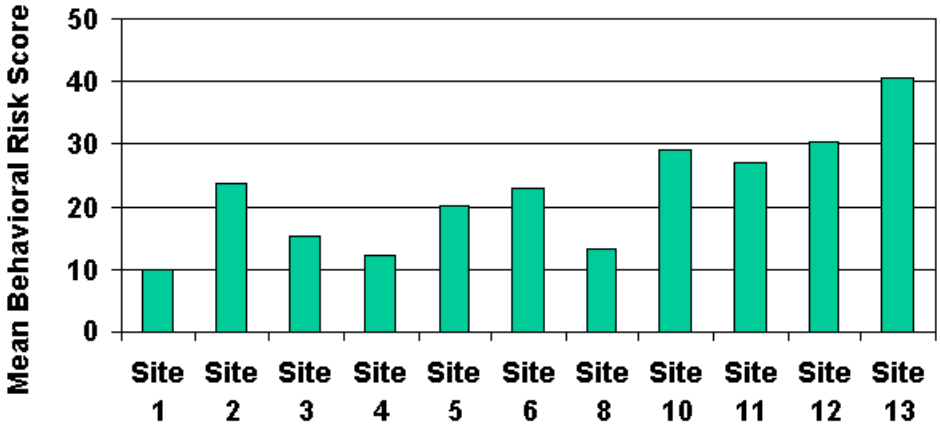


Exhibit 2.16 displays the average family behavioral risk levels at each site. While all SESS families qualify for their programs through an expressed or apparent need for some type of service or assistance, some sites serve populations with a higher concentration of families with multiple serious behavioral needs.

For example, Site 13, Site 12, and Site 10 recruited a majority of families with multiple serious issues. The *average* family Behavioral Risk Index score at these three sites was 41% (Site 13), 30% (Site 12), and 29% (Site 10).

Summary and Conclusion

The SESS multi-site evaluation involves a sample of 2,907 caregiver/child dyads. More than half of the participating dyads are receiving SESS services (n = 1,598), while the remaining caregiver/child pairs (n = 1,309) receive services that represent the standard of care for persons in the primary health or early childhood education settings that host the SESS programs. They provide a comparative benchmark for estimating the service value added by SESS programming. The sample size varies across sites, and pooled analyses are weighted to equalize the contribution of each site to the pooled study findings.

The age distribution of children in the SESS sample at baseline was bi-modal. The great majority of children in primary care programs were less than one year old; the ages of early childhood children at baseline clustered relatively tightly around the average age of four. Primary caregivers in the sample were nearly all female (95%) and one-third were under 25 years of age. The sample members were diverse in racial/ethnic identity. Nearly half were of African American descent, with more than 10 percent in each of three different racial/ethnic groups–White, non-Hispanic, Hispanic, or American Indian. Most children lived with at least one biological or adoptive parent. In two-thirds of the cases, the caregiver was single, divorced, or separated. Thirty eight percent of caregivers had not attained a high school diploma; just over half were not employed outside the home; and 13 percent lived in homes with no employed adult member. More than one in four SESS households received some form of cash public assistance, and about 30% of caregivers had no health insurance. All of these characteristics varied significantly across sites. SESS programs reached diverse populations with distinct characteristics.

To provide a more focused profile of relative need in the sites, the behavioral and demographic characteristics of the SESS families were explored, and these data show that while there were differences across sites, SESS successfully recruited families at high risk and in need of services into the programs. Families had significant histories of substance abuse. Caregivers indicated a history of mental health issues and conflictual relationships, and children had significant social skills and problem behavior issues.

SESS is based on the assumption that families will have unique combinations of needs, and that services must be tailored to the number and pattern of needs present in each family. This chapter demonstrates that many SESS families have multiple behavioral and/or demographic risks, and that the degree and pattern of risk varies across sites and across families. Subsequent reports under the extended SESS grant will explore site-level differences in risk and the extent to which risk is related to family and child outcomes at particular sites.

Table 2.8
Detailed Description of Behavioral Risk Index Measures
Criteria for Determining Persons at Risk for All Risk Factors

Risk Factor	Definition	Source Measure
1. Psychiatric History	Person is at risk if: (1) Any relative on either side of the target child's family is reported (by the caregiver) to have had psychiatric problems.	Addiction Severity Index: Family History Section
2. Substance History	Person is at risk if: (1) Any relative on either side of target child's family is reported (by the caregiver) to have had substance abuse problems.	Addiction Severity Index: Family History Section
3. Criminal Justice History	Person is at risk if: (1) Someone living with the target child has been involved with the criminal justice system in the past 6 months (arrested, in jail, on probation, on parole)?	Addiction Severity Index: Family History Section
4. Caregiver Substance Treatment	Person is at risk if the child's primary caregiver (1) Received inpatient or outpatient Substance treatment OR (2) Indicated an unmet need for these services.	Service Access, Utilization, and Satisfaction survey
5. Alcohol Use	Person is at risk if the child's primary caregiver: (1) Meets ASI definition of "binge drinker" (>4 drinks/sitting women, >5 drinks/sitting men) OR Meets ASI definition of "problem drinker" (>2 drinks 3+ times/week women, > 3 drinks 3+ times/week men)	Addiction Severity Index
6. Drug Use	Person is at risk if the child's primary caregiver (1)Used any elicit drugs in the past month	Addiction Severity Index
7. Mental Health Treatment	Person is at risk if the child's primary caregiver (1) Received inpatient or outpatient Mental Health treatment OR (2) Indicated an unmet need for these services.	Service Access, Utilization, and Satisfaction survey
8. Mental Health Symptoms	Person is at risk if the child's primary caregiver has (1) Clinically elevated score (T-score greater than 63) on two or more subscales of the BSI- Short Form (Per BSI Manual)	Brief Symptom Index, Short Form
9. Home Environment	Person is at risk if: (1) Percentage endorsed on the HOME measure is in the lowest quartile of the SESS sample (<69.5). (Per recommendations from B. Bradley for SESS data)	Home Observation Measurement of the Environment, Infant/ Toddler & Preschool versions
10. Physical Discipline	At risk if: (1) The caregiving parent slaps and spanks more than "sometimes," on average (Harsh Discipline Subscale >3.45)	Parental Discipline Methods Interview

	(Similar to clinical levels reported in CTS manual for the CTSPC, & passed review by Site 2 researchers)	
11. Violence between Parents	At risk if the parent couple reports (1) More than 3 "violent" acts in the past year, which includes item 10 (Threw something at partner) through item 19 (used weapon), perpetrated by both partners OR (2) Any incidence of "severe violence," which includes item 15 (hit with object) through item 19 (used weapon), perpetrated by both partners (Per CTS manual, p. 121, & source article)	CTS Respondent Form; CTS Significant Other Form
12. Parenting Stress Due to Difficult Child	At risk if the child's primary caregiver has (1) Percentile greater than 90 on the Difficult Child subscale of the PSI (Per PSI Manual)	Parental Stress Index
13. Parenting Stress Due to Parent-Child Dysfunctional Interaction	At risk if the child's primary caregiver has (1) Percentile score greater than 90 on the Parent-Child Dysfunctional Interaction subscale of the PSI (Per PSI Manual)	Parental Stress Index
14. Child Social Skills: Caregiver Report	At risk if the caregiver reports that the target child has (1) Moderate to Significant Deficit in social skills functioning	PKBS Caregiver
15. Child Problem Behaviors: Caregiver Report	At risk if the caregiver reports that the target child has (1) Moderate to Significant Deficit, Problem Behavior	PKBS Caregiver
16. Child Social Skills: Teacher Report	At risk if the teacher reports that the target child has (1) Moderate to Significant Deficit in social skills functioning	PKBS Teacher
17. Child Problem Behaviors: Teacher Report	At risk if the teacher reports that the target child has (1) Moderate to Significant Deficit in social skills functioning	PKBS Teacher
18. Infant Regulatory Disorders	At risk if the target child scores as $ Deficient on the Infant-Toddler Symptom Checklist compared to same-aged peers.	Infant-Toddler Symptom Checklist

CHAPTER THREE
THE SESS PROGRAMS

The SESS initiative was designed to encourage and support the implementation of service interventions to promote the social-emotional and cognitive development of very young children in situations of risk. SESS designers competitively funded grantees who proposed their own program designs within broad guidelines. Local programs applying known principles of effective early intervention could be designed to fit local need and opportunity, and provide lessons for developing similar interventions elsewhere.

The common guidelines for SESS programs were few, and reflected established principles of effective community-based interventions for at risk families.

- Effective early childhood interventions "build on the existing network of early childhood services" (Knitzer, 2001:4). SESS funding required that programs partner with existing early childhood services at primary health care centers or early childhood education institutions. These settings are used because they represent non-stigmatizing places where parents already take their children for service.

- Social and health services planners and providers increasingly recognize that the categorical approach to service delivery, a model that is characterized by centralized locations, highly defined diagnoses, and limited perspective services, has serious service access and delivery deficiencies. Multiple and related family needs are often not adequately addressed; the lack of a preventive orientation means that crises frequently trigger services, with more expensive prescriptions and consequences; and many barriers to service mean that families often do not access them voluntarily. The SESS solicitation required that programs build local collaborations designed to meet the particular constellation of priority needs within the population they serve, and to flexibly respond to the particular needs of each family. Collaborations were required to include behavioral health service providers – substance abuse prevention, substance use treatment, and adult and children's mental health.

- Effective early childhood interventions are supportive of families (Knitzer, 2001:10). SESS grantees were asked to develop programs and intervention procedures that actively involve family members in the assessment and service process. In addition, grantees developed mechanisms for involving families in project planning, feedback and decision making.

Within these broad parameters, SESS grantees "developed interventions tailored for their particular settings, communities and families." (Hansen et al, pg. 3). The multi-site evaluation collected data on program design and implementation through three standardized site visits, data on service contact, and focused questionnaires and interviews. These data document the

similarities and local adaptations in the strategies and services of SESS programs. This component of the study contributes knowledge concerning effective strategies for engaging and serving families to promote the positive development of young children at risk.

WHAT MAKES SESS DIFFERENT?

Integrated services programs to serve the needs of young children and their families are not new. Head Start programs include needs assessment and referral services, and Early Head Start has strengthened this assessment and referral capability for families with children ages 0-3 (DHHS, 2002). However, SESS programs differed from other service integration programs serving young children in important ways. First, SESS programs were more than assessment and referral programs. They wove assessment, referral, and behavioral health service delivery itself into the daily fabric of activity in early childhood education and health care settings. Second, SESS programs focused on successfully engaging caregivers, and on creating a program environment that kept families involved. This was done in two ways. Care coordinators and other SESS staff develop one-on-one relationships with caregivers to build trust and involvement. SESS programs also worked to create a welcoming atmosphere and provided supportive activities to families, making the program itself a caring community. Third, SESS programs put the family at the center of the service program, and involved them in the identification of needs and the development of solutions, often including participation in the governance of the programs themselves. Each of these defining program emphases can be illustrated with specific examples of how programs put them into action.

Integrating Behavioral Health and Related Services into Host Agency Settings

SESS programs integrated services into the host agency in a variety of ways, including co-locating educational and other group services on-site, and in some instances co-locating independent behavioral health services on-site. More importantly, SESS programs wove SESS staff, including care coordinators and behavioral health professionals into the daily work activity of the host agency. The SESS projects brought together work groups that typically mix the necessary skills and orientations of para-professionals, professional specialists, and service providers in the host setting. Fashioning shared, productive and supportive work procedures among these team members was crucial to collaboration and service integration. SESS programs developed various forums and procedures to build effective workgroups, and produced important lessons including the following.

- ***Locating integrated services staff in host settings.*** SESS projects placed behavioral health and care coordination staff in early childhood education classrooms, and in primary care service settings. These staff provided direct services to children and caregivers, and provided consultation with host setting staff. The collaboration between SESS line staff and host setting staff enriched the capacity of staff in the host setting to do their jobs. Paying close attention to and encouraging the ways in which SESS staff can be a benefit to the host agency helped build strong work groups. In SESS, mental health

consultants have enriched the classroom through curricula focusing on social-emotional development and prevention-oriented topics; they have worked with classroom teachers and Head Start professionals in problem-solving groups, and they have expanded the teachers resources in addressing children=s needs. In some settings, the SESS project was part of a one-stop, multiple service center in which informal, multidisciplinary groups form and develop informal communications and consultation patterns.

- ***Building strong, supportive relationships between professional and para-professional staff.*** Effective family-centered service integration requires a team that melds the skills of para-professionals skilled in working with families in context, and those of professionals skilled in addressing specific service needs. Developing strong and supportive relations between para-professionals and professionals is crucial to building effective teams for integrating services. Paraprofessionals often bring information, understanding, and insight to addressing the needs of families and the community, and have essential skills to communicate effectively and build strong relationships between families and the project. SESS projects have developed approaches to integrating paraprofessional staff with existing staff; in many cases, the paraprofessional staff formed the front line of intensive case management and program service delivery to families. In some programs, regular staff meetings brought para-professional and professional staff together in substantive discussion of case problems. In this way professionals provided commentary on specific questions or issues. These meetings foster understanding of the complementarity and importance of BOTH the professional and para-professional activities in support of families. Some SESS programs clearly established policies within which professional staff (e.g., a mental health professional) served as resources to family support workers as needed. For example, training in observation and recording information useful for assessment and effective service delivery is important for para-professionals who provide a large part of the program contact that families have with SESS programs. Para-professional were trained to identify Ared flag@ indicators of substance abuse, physical or sexual abuse, neglect, or mental health problems and to follow procedures for engaging professional staff to confirm the indicators and take appropriate action.

- ***Developing communication with host agency staff.*** In several SESS sites, program implementation was seriously impacted and delayed because of resistance by existing agency staff in host or collaborating agencies. In some instances, improved communications and bringing existing staff into program work groups was sufficient to reverse initial resistance, particularly when it was based on lack of knowledge or familiarity. In other instances, perceived conflicts of interest or threats to current work environments persisted. The potential for conflict with staff in collaborating or host agencies must be carefully assessed, and means of addressing and ameliorating this potential should be part of program planning.

- ***Using multidisciplinary staff interaction in identifying needs and planning services.*** The SESS approach assumed the interactive involvement of all program staff in the

needs assessment process. For example, staff team meetings identified those needs that could be met through para-professional attention and those that required focused professional intervention. Meetings that served this purpose involved professional and para-professional employees and typically met frequently, e.g., once a week. Some programs used case presentations for discussion as a means of enhancing collective staff capacity to make assessment decisions and develop needs-based service plans.. Typically, multi-disciplinary teams comprised members from different organizational and disciplinary backgrounds, representing different service perspectives. These teams provided a setting for professional dialogue to identify priority services, and to plan an orderly progression of services to meet multiple needs. Involving professionals in the MDT strengthened the ways in which they assessed client needs and their approach to setting service priorities in their own organizations.

Engaging Caregivers and Sustaining Family Participation

SESS programs worked to develop ways of working with families, both in case management and service delivery roles, that helped reduce the inhibitions and demeaning relation that these families often feel in traditional service settings. The core of this approach in SESS programs was the family-centered, personal approach that was focused in the relation between case manager (e.g, family support worker) and family. This one to one relationship was strengthened and supported by creating a comfortable and caring program environment. Creating this environment required developing service delivery methods that did not require the family to conform to traditional institutional transaction costs (e.g., red tape, travel to central and often inconvenient locations, conformity to hours, and so on). The following points identify several promising practices that different SESS programs adopted to work effectively with families to accomplish service objectives.

- ***Using intensive personal contact by individual staff members.*** Personal contact was particularly important for successful recruitment of at-risk populations whose members may have had histories of alienation from schools, health care institutions, social service agencies and other public and private sector institutions with which they had interacted and from which they sought services. Such contact, including contact by para-professionals with *cultural understanding and experience*, was often enhanced by alternative approaches that go beyond traditional diffuse invitations and outreach. "Gentle persistence@ was often important for initially engaging families through personal contact with the case manager. Repeated contacts whether intentional (e.g., telephone calls, home visits) or opportunistic (e.g., initiating discussion at a Head Start family night) were crucial. Flexibility in meeting times and tolerance for missed appointments, particularly in initial contacts, were important and further demonstrated concern on the part of staff.

- ***Using naturalistic situations to engage families and deliver services***. SESS staff typically used concrete, natural situations to deliver services and convey messages related to the holistic needs of the families. These approaches included for example: 1) regular

(in some cases frequent) home visits by para-professional and professional staff; 2) periodic informal "family nights" during which parenting and child development lessons were reinforced through meal sharing and informal group discussions; and 3) special community events arranged through the SESS program, ranging from culturally-focused ceremonies to health fairs. For example, to enhance the use of home visits as a mechanism for providing services, some programs created curricula for home visits, in which family support workers raised and discussed issues of common concern and need for parents. In some instances, these discussions were consciously designed to be Atransparent@ to the program participant. The Ateacher@ was trained to move naturally into topics, using the natural flow of dialogue with the parent, rather than given the impression of a lecture. Para-professional case workers were very receptive to these curricula, and found them useful in keeping focus in home visits and making them productive.

- ***Organizing and utilizing collaborative relationships to meet basic needs.*** In addition to working directly with families, SESS projects identified needs that require referral to programs external to the host agency or SESS staff. These organizations may have been formal SESS collaborators, or community resources not formally linked to SESS. In family-centered case management, it is often the case that families perceive immediate need for basic services and assistance that must be taken care of before moving to issues of concern to the service provider (e.g., behavioral health). These basic needs, including for example food, clothing, shelter, and transportation, cannot be set aside because they are not the project's Atargeted@ needs of the family. For case managers, helping meet these needs is fundamental to the principals of gaining trust, showing understanding and respect, and working together that have been identified above. From a service effectiveness point of view, these needs may be near the foundation of a hierarchy of need, and must be met (at least in the short term) before families are able to address other issues. SESS projects identified important preliminary lessons concerning approaches to meeting basic needs.

- ***Using support groups.*** Programs created support group and discussions of shared issues and concerns among care givers. These groups helped break down feelings of isolation for some participants and generated ideas for addressing shared concerns in the context of facilitated discussion. They reinforced the feeling of shared problem solving, rather than being told how to do it right.

- ***Creating and supporting a comfortable and nurturing social environment*** was an important asset for recruitment and retention. The lessons in this area ranged from the simple to more complex program arrangements. For example, the value of sharing meals as a way of creating comfortable, enjoyable social environments is a widely-used social program strategy that is accepted (indeed encouraged) across cultures and one which was stressed by many of the SESS projects. Sharing a meal as a means of facilitating comfortable social settings ranged from snacks at Aany meeting longer than an hour@ to substantial meals at monthly family nights. One program created Anatural support groups@ among participating families as a means of engaging families and sustaining

program effects. These groups, which were in addition to rather than in lieu of other support groups, were an integral part of the participants program involvement, and were composed of extended family members or friends who were likely to be part of the families social context as the index child matures. They, and other comparable approaches, created comfortable opportunities for participating families to share concerns and suggestions and were successful in attracting participation in some programs.

Family Involvement in Services and Program

SESS programs strived to be *family centered*, through engaging and involving families in the identification and resolution of their own unique needs. The vantage point of family-centered services was the client, and the collaborative partners who supported the family-centered integration frequently assessed the service system from the family's point of view. Service barriers were recognized as internal due to family members' lack of knowledge, psychological resistance to acknowledging and using services, sense of cultural alienation, and so forth. Barriers were logistic due to personal, neighborhood, and community factors such as inadequate funds, inadequate transportation, inconvenient service locations, restrictive eligibility criteria, and long waiting periods.

- ***Involving families in needs assessment.*** SESS program experience highlights important considerations in the issue of whether and where families should be involved in needs assessment and service planning decisions. Families were included in MDT or staff assessment and planning sessions in order to further the objectives of 1) showing respect for family perceptions and responsiveness to family priorities; 2) building trust through open procedures and discussion; and 3) enhancing family perceptions and skills in accessing and working with service providers. On the other hand, including families could have the unintended consequence of inhibiting the efficiency of professional discussion because confidentiality concerns limited the open discussion of similar family circumstances needs, and service options. Some programs found that the MDT assessment setting was a strained environment for achieving the family goals identified above, and that valuable program contact time could serve these goals better in other settings (e.g., home-based planning and self-assessments of progress).

- ***Involving families in program governance.*** SESS programs involved participating families in programmatic decision making. Families had representation in the governance of local programs, and in the SESS Steering Committee. As the programs matured they involved families more extensively, including peer technical assistance and networking activities of SESS family representatives across sites, and a Family Institute that has been established among SESS families.

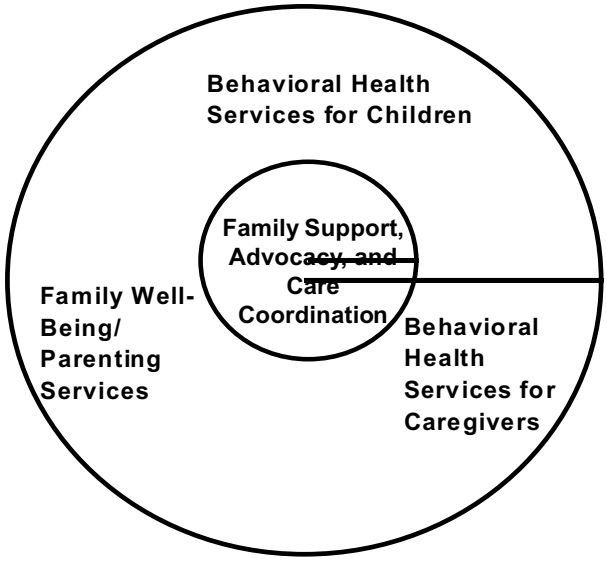
- ***Ensuring cultural competence in staff and cultural appropriateness in program procedures and services.*** The SESS family and relationship-centered service philosophy required a strong commitment to culturally appropriate care management and service delivery. Methods of ensuring cultural sensitivity included recruiting staff who shared the

cultural milieus of SESS families, ensuring linguistic compatibility, and ensuring program procedures, service content, and evaluation instrumentation and procedures that were sensitive to cultural differences.

COMMON SERVICE COMPONENTS

SESS programs offered behavioral health services that addressed a range of family and child needs. These services were anchored by care coordination, a service area directed toward facilitating service access, coordinating multiple services, and providing continual client support. Care coordination and three major areas of behavioral health services; (1) behavioral health services for adults, (2) behavioral health services for children, and (3) family well-being and parenting services were provided by all SESS programs. Together, they formed a framework of services that created the uniform approach required by the funding agencies. Figure 3.1 summarizes the configuration of common service components in SESS programs.

Exhibit 3.1
Integrating the Core SESS Services



In addition to the services directly provided to SESS families, the SESS programs cooperated with community agencies and the host settings to strengthen service integration commitment, skills, and procedures in the location service network. This was an important program area because cooperation within host settings was integral to effective assessments of service needs and service delivery, and because many services were referred to collaborating agencies. Throughout the discussion addressing SESS service areas, the host setting, its staff, and other collaborating agencies will be acknowledged as contributors to SESS efforts.

Care Coordination

Care coordination was the hub of the SESS service framework, a component that linked SESS clients to other needed services. Care coordination (provided by case managers or family advocates) exemplified the SESS approach of "building trust and rapport with families through an ongoing, supportive relationship. . . [with a] central person who is in frequent contact with the family through telephone calls, home visits, and meetings onsite and elsewhere in the community" (Hansen et al, pg. 15). While providing a steady level of support, the care coordinator assessed service needs and family strengths, brokered services provided by other agencies, and provided support to the client in meeting basic needs.

Care coordinators assisted families and children by meeting and addressing unmet basic needs that were destabilizing for families, and by addressing acute needs that required focused and expert treatment or assistance. Meeting basic needs served several purposes. Often a way to develop trust between families and the SESS provider and bring them into the network of SESS services, meeting basic needs prevented problems from escalating, and, for families who also suffered from behavioral health problems that required treatment was a way to assure basic needs were not sacrificed because the family caregiver was in treatment. The table below provides examples of how basic and acute needs were met by SESS care coordinators.

Table 3.1
Types of Basic and Acute Needs Addressed by Sess Care Coordinators

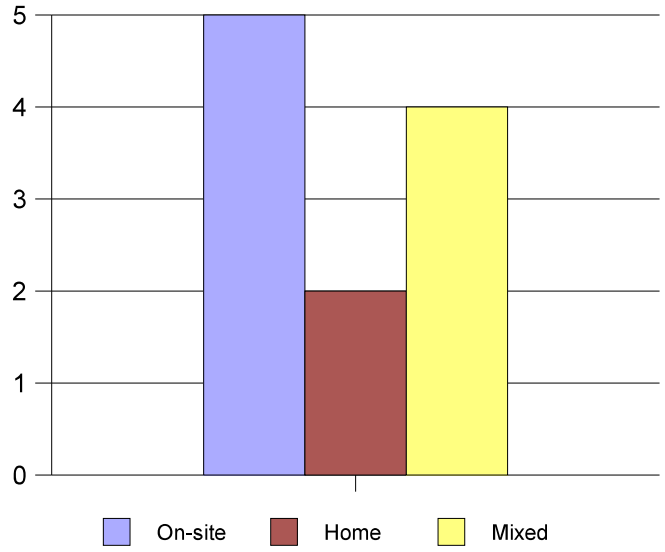
Basic Needs	*Acute Needs*
▸ Housing (assisted with negotiating with landlords regarding rent, home-buying assistance, assistance with home repair) ▸ Health care (e.g., assisted families in obtaining private health care insurance, Medicaid) ▸ Legal (e.g., child custody, divorce, etc.) ▸ Transportation ▸ Child care ▸ Family management information and consultation ▸ Parenting skills development	▸ Substance abuse treatment ▸ Mental health treatment ▸ Domestic violence ▸ Immigration/deportation/visa issues

Basic need services, family management and parenting skills were typically addressed directly by care coordinators. More acute needs, those requiring specialized treatment, were often met by collaborating agencies.

Location of care coordination services

The SESS programs offered services in three major types of locations: the host setting, the home of the client, and other provider agencies. Five programs offered services primarily on site, two sites offered services primarily in the home, and the remaining four sites offered services both at home and on site. Four of the site-based programs were early childhood sites. All of the home-based sites were primary care sites, and the three mixed delivery sites included both early childhood and primary care sites. Exhibit 3.2 displays these distributions.

Exhibit 3.2
Service Location



The percentages of services offered at home, at the host setting, and in other locations, are shown in Table 3.2.

Table 3.2
Location of Care Coordination Services

Site	% Delivered at Client's Home	% Delivered at Host Setting	% Delivered at Other Locations
Early Childhood Sites			
1	10	83	7
2	1	89	11
3	49	3	49
4	3	95	1
5	33	56	10
6	2	94	4
Primary Care Sites			
8	36	53	13
10	53	43	4
11	67	18	16
12	69	14	17
13	20	68	12

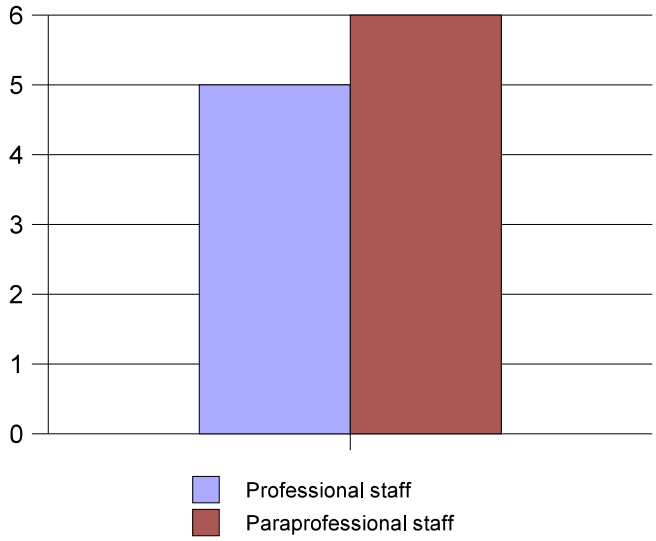
The differences between primary care and early childhood sites is indicative of the different opportunities for engaging families at the host setting. Case managers located at most early childhood sites were able to visit with families regularly on site. The early childhood program which delivered most of the services in the client home, Site 3, did not have these opportunities because children were bussed to and from the centers: parents did not show up daily to drop children off or pick them up. At primary care settings, the home setting was the necessary location for most services because parents did not regularly visit the primary care site.

Providers

Across programs, care coordination was usually provided by a professional case manager or a paraprofessional family advocate supervised by a professional case manager. Other variations, used less frequently, were a team consisting of case managers and family advocates (or case workers), a SESS behavioral health specialist, or a provider from a collaborating agency. As shown in Exhibit 3.3, five programs primarily used professional staff, and six used mostly paraprofessional staff. These differences were not dependent upon the service setting, both paraprofessional and professional models were used in both the early childhood and primary care settings. However, the choice of professional or paraprofessional models was associated with the risk level of the clients recruited into the programs. Programs that recruited higher risk

caregivers (those with mental health or substance abuse treatment disorders) were much more likely to have professional case managers than programs who recruited family from the general service population of the host setting.

Exhibit 3.3
Service Provider Expertise



Summary

Care coordination is a flexible strategy for tailoring services to needs of families and for meeting multiple needs of families. As such, care coordination, as exemplified in SESS and other programs using this approach, provided a range of services, some that fulfilled basic and practical family needs, and others that focused on acute, behavioral health needs.

Families from a general service population are, on the average, lower risk than families recruited from agencies addressing high-risk conditions, such as substance abuse. What did this mean for the design and delivery of care coordination services? One characteristic we have seen is that programs targeting high-risk populations were more likely to hire professional case managers than paraprofessional family advocates.

Table 3.3
Recruitment Strategies and Planned Service Intensity

Recruitment Source	Planned similar services	Planned variation
Host setting	1	6
Other agencies, based on risk criteria	4	0

Service delivery varies because care coordination was responsive to individual family needs. In a program with a mixed-risk population - a population selected from the general service setting - care coordination more intense for the high-risk families than for the low-risk families. In a program with a high-risk population, care coordination is likely to be less varied.

Among the SESS programs, the four programs that recruited families based on a behavioral risk indicator(s) planned to have similar service intensity for the majority of SESS clients. All but one of the SESS programs that recruited from the general host setting planned varied service delivery. The exception was a SESS program whose care coordinators/family advocates delivered in-home parenting education services.

The following table summarizes the general characteristics of care coordination strategies program by program.

Table 3.4
Summary of Care Coordination Characteristics

	Setting	Staffing	Service Location	Risk Level of Caregivers
1	Early childhood	Paraprofessional	On site	Lower
2	Early childhood	Professional	On site	Medium
3	Early childhood	Paraprofessional	Mixed	Lower
4	Early childhood	Paraprofessional	On site	Medium
5	Early childhood	Professional	On site	Medium
6	Early childhood	Professional	On site	Medium
8	Primary care	Paraprofessional	Mixed	Lower
10	Primary care	Professional	Mixed	Higher
11	Primary care	Paraprofessional	Home	Medium
12	Primary care	Paraprofessional	Home	Higher
13	Primary care	Professional	On site/Mixed	Higher

Behavioral Health Service Interventions for Caregivers

It is well documented that children with parents with mental health or substance abuse problems often do not develop healthy connections with their parents that help them to become strong and independent adults (Hansen et al., 2001). Children of parents who are not mentally healthy are much more likely to become mentally unhealthy themselves, the result of the influence of

caregivers who communicate poorly, have poor planning skills, poor problem-solving skills and a home with a high degree of disorganization. This disorganization can lead to children developing poor organizational skills, poor peer relationships, and an inability to focus. (Seifer, 2002). Children benefit significantly when behavioral health problems of their caregivers are addressed.

The SESS programs offered behavioral health services (mental health and substance abuse services) on-site or through referrals to outside agencies. The type and amount of services varied because of the nature and severity of behavioral health problems, the concentration of behavioral health problems in the program population, collaborative arrangements, and characteristics of the local setting. As such, the menu of services provided within this service category was broad, and reflected several ways behavioral health treatment could be supported.

- Mental health and chemical dependency assessments and referrals were made, often by care coordinators, for caregivers with identified and serious behavioral health problems. Referrals were supported by facilitating access (identifying specific service providers in an agency, helping with paperwork, and helping with transportation, for example).

- Education regarding substance abuse supported substance abuse prevention among the general program population.

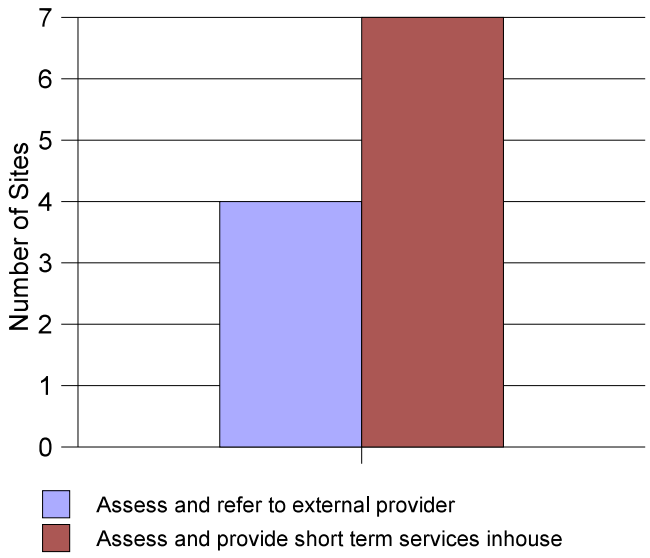
- Support groups for caregivers in recovery created opportunities for peer and professional support for caregivers currently in treatment and/or post-treatment to maintain recovery efforts.

- Financial support for Medicaid co-payments for mental health treatment was a way to reduce financial barriers to treatment.

- Counseling was available for individuals, couples, and families. In addition, short-term crisis counseling addressed family behavioral health needs that were crisis-related (e.g., domestic violence, loss, separation).

The SESS sites developed two general approaches for providing needed behavioral health services for caregivers with behavioral health needs. Some programs implemented their own behavioral health service component, with services provided by SESS behavioral health specialists. Typically, the behavioral health service providers addressed non-acute needs and then supported referrals to agencies for acute treatment. Other programs provided active case management support for caregivers needing behavioral health treatment, but actual services were provided by an outside collaborating agency and/or department within the medical system administering the SESS program.

Exhibit 3.4
Behavioral Health Service Delivery Models for Caregivers



Behavioral health services provided in the host setting accommodated client preferences for scheduling and utilization patterns. Providing the services on-site reduced psychological barriers to service utilization because behavioral health specialists were familiar to caregivers through their on-site presence, and, for some sites, through making home visits with other SESS or host setting service providers.

Staff at three of the early childhood sites noted that even though they were successful in engaging families in SESS direct services and site-based services with relative ease, this tie to the families did not transfer easily to service providers who were not site-based. This observation attests to the importance of SESS's family-centered service approach, and to the persistence of barriers to services outside the immediate program.

Table 3.5 outlines the behavioral health services that were offered across the SESS programs.

Table 3.5
Behavioral Services Offered by Sites

1	Mental health	Consultation with mental health counselors and referrals as necessary.
2	Mental health	Clinicians on-site weekly to provide services. Co-payment strategy developed by SESS for services, psychotropic medications. Covers assessments also.
3	Mental health	Referrals as needed to external providers.
4	Mental health	Individual counseling, referrals, dyadic therapy and family counseling were available for family members.
5	Mental health	Diagnosis and short-term therapy available for caregivers and families on-site. Access was informal and as-needed.
	Substance abuse	Support provided by SESS staff in support groups and family therapy sessions.
6	Mental health	Diagnosis and therapy provided by lead agency therapists and other collaborating agency.
	Substance abuse	Outpatient group sessions and individual sessions provided by collaborating agency. Inpatient services by referral.
8	Mental health	Assessments and evaluations when indicated problem. Short-term treatment as needed. Referrals as needed. Facilitation of clinic visits.
	Substance abuse	Assessments and evaluations when indicated. Referrals as needed and facilitation of referrals.
10	Mental health	Screening, diagnosis, crisis intervention, short-term individual and family therapy in clinic and home settings. Referrals to collaborating agencies as needed.
	Substance abuse	Assessment, diagnosis, treatment engagement, outpatient and residential treatment, recovery support.
11	Mental health	Referrals to outside agencies.
	Substance abuse	Referrals to outside agencies
12	Mental health	Assessments. Some short-term intervention on-site; psychiatric consultation from collaborator for women with dual diagnosis. Referrals as needed.
	Substance abuse	Recovery support by SESS. Referrals to collaborators for treatment.
13	Mental health	Outpatient cognitive and behavioral therapy to parents collocated in SESS offices.
	Substance abuse	Collaborating agency on-site. Intensive outpatient services provided in the office. In-patient services through referrals.

Parenting Classes and Group Support Services

It is universally recognized that parenting has profound consequences on a child's socio-emotional and cognitive well-being that may extend well into adulthood. Children who do not receive supportive and nurturing parenting have been shown to develop a host of problems, including delayed mental and motor development, poor cognitive functioning, emotional problems, poor physical health, poor educational achievement, underachievement, poor job functioning, and adult behavioral health issues. Programs that focus on improving parenting skill through family skills training and parent education have been shown to improve parent-child relationships by reducing family conflict and domestic violence, decreasing family communication problems, and improving family management and functioning (Kumpfer, 1990).

SESS sites provided two types of parenting services:

- **Curriculum-based sessions.** Sessions were either group-based or delivered to individual families in the home. Sessions were directed toward improving parenting skills, knowledge of child development, and parent/child interactions. Sites used a curriculum suitable for their population. Parenting curricula included:

  - Effective Black Parenting Education curriculum
  - The Nurturing Curriculum
  - Families and Schools Together (FAST)
  - Baby and Me bonding groups
  - Strengthening Multi-Ethnic Families and Communities Program

- **Group events.** Group events built social support and provided general and practical information. Group events included:

  - Father's support groups
  - Workshops on kindergarten readiness
  - Workshops on conflict resolution
  - Grandparent's support groups
  - Parent's advocacy groups
  - Cultural awareness groups
  - Recreational events
  - Workshops on skill-building (home-buying, cooking, weatherizing, budgeting, shopping)

Curriculum-based parenting classes or sessions were the most frequently provided sessions, offered by eight of the 11 programs in either group sessions or on home visits. The curriculum-based sessions focused on parenting skills, and topics included child development, effective parenting practices, feedback on parent/child interactions, and positive disciplinary methods. Baby/parent dyadic groups (including sessions videotaping parent/child interactions) were offered by three of the PC sites.

Social support and enrichment activities fulfilled many purposes. They were important for engaging parents in the program, introducing them to SESS service providers, and encouraging mutually supportive relationships among participants. Usually held monthly, activities provided opportunities for families to socialize, participate in enrichment activities, and learn about topics of interest (i.e. budgeting, immigration laws, cooking). In addition, social support meetings provided a comfortable situation for cautious caregivers to begin engaging with the program and the service providers, thus opening the door for future service utilization. Two of the sites that served large immigrant populations found social gatherings for parents to be an effective way to engage a somewhat reluctant population in SESS.

All told, the SESS programs offered many types of parenting services. These are depicted in the table below.

Table 3.6
Type of Parent Service by Program

Site	Parent Service
1	· 8-week parenting education series. · Monthly Parent Club meetings for social activities and trips.
2	· Nurturing Curriculum (Bavolek) offered at each site, some home visits. · Parent Resource Library at each site with books, games, tapes, etc. on parenting.
3	· In-home parenting curriculum for all families, twice a month. · Monthly family support meetings in second year, twice a month for select families. · Parent information group, met monthly. Year 2 only.
4	· Pyramids to Success (Effective Black Parenting), 10- week class offered at least once year. · FAST (Families and Schools Working Together), 10-week curriculum focuses on family strengthening, child development. The entire family is in program. At least once a year.
5	· Information sessions on practical topics (home buying, cooking, stress mgt), drop-in basis.
6	· Parent education classes and assistance available from collaborating agency.
8	· Mom/Baby Dyadic groups: six sessions.
10	· Baby and Me Bonding Groups, 12 week curriculum, offered weekly. · Strengthening Multi-Ethnic Families and Communities, 12-week curriculum, focuses on violence prevention. · Grandmother's Support Group, weekly for 2 hours, for grandmothers who are primary caregivers. · Special Educational Prevention Topic Groups offered monthly.
11	· Parent/family Strengthening class, 4 sessions provided. · One-day family service programs on various topics of interest.
12	· Parent group education classes, 6 sessions, held twice a month. · In-home parenting guidance using curriculum (Partners in Parenting Education) and using Ages and Stages Questionnaire for family review provided by staff (case manager, case worker, and development specialist).
13	· On-site videotaping of parent-child interactions. · Father support groups are held weekly. · Parenting education classes by referrals to one of several agencies; at-home parenting education by SESS coordinators.

Several programs had multiple parenting interventions. The more interventions there were, the more opportunities parents had to participate. One combination that encouraged long-term involvement in group parenting sessions was curriculum-based sessions and support groups. Curriculum-based sessions were limited to 12 sessions at the most (in this sample), but support groups met once or twice a month, sometimes more, for extended periods of time.

Behavioral Health Services for Children

Behavioral health services were also available for the SESS children. For the most part, behavioral health services for children started at approximately three years of age, or the age when many children would be entering Head Start or similar early childcare centers, although there were some services for infants and toddlers. Interventions addressing behavioral health needs of the child included:

For infants and toddlers:

- Physical health care screening
- Identification of developmental issues

For preschoolers:

- Basic prevention curricula focusing on child social-emotional needs and behavioral development.
- Classroom and site-based observations and assessments of children to identify problem behaviors and symptoms.
- On-site therapeutic sessions (individual and small group therapy)
- Collaboration with teachers to enhance socio-emotional aspects of the preschool environment
- Referrals to mental health providers for children with acute mental health needs

Exhibit 3.5
Percent of Behavioral Health Services Focused on the Target Child by Recruitment Setting

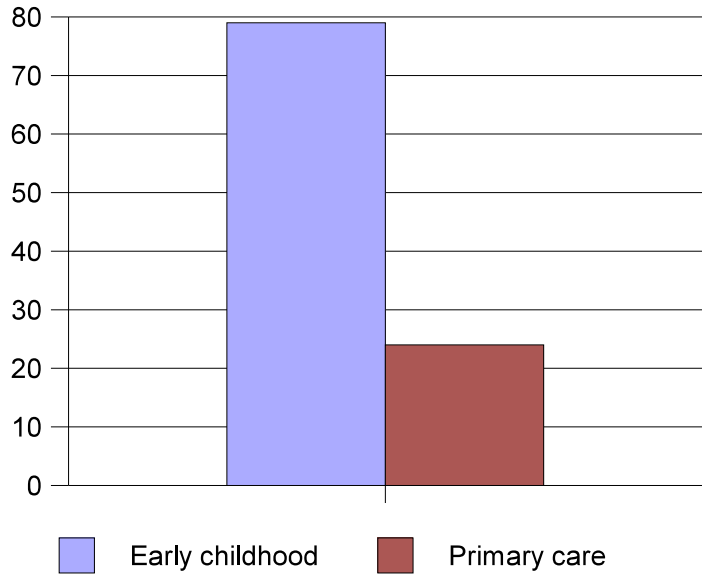


Table 3.7 displays the services offered at each site in the area of child behavioral health. The early childhood sites offered more services in this area than primary care sites because the children were of preschool age, although there was considerable variation in service within the early childhood sites.

Table 3.7
Child Behavioral Health Interventions By Site

Site		Child curriculum	Obser-vations on-site	Developmental assessments	Behavior Management Approaches	Group therapy	Individual Therapy
Early Childhood	1		X		X	X	
	2		X		X	X	X
	3		X		X	X	
	4		X		X	X	X
	5	X	X		X		
	6	X				X	X
Primary Care	8			X			
	10			X			
	11			X			
	12			X			
	13			X			

The SESS EC sites used the classroom as an important place in which to observe and interact with children. In the classroom, SESS providers introduced material or activities designed to teach children basic social skills behaviors and enhance their well-being generally. The activities provided an opportunity for SESS providers to familiarize themselves with children, to observe their behavior in group situations, and to assess and support classroom approaches to problem behaviors. Children who needed further assessments or therapeutic interventions were identified through classroom activities.

Targeted services were then offered children with identified needs. EC sites who had on-site behavioral health services usually offered several types of interventions, including group and individual therapy, and behavioral management techniques developed with the classroom teachers.

Site 3 reflects how these different components fit together. “The entire intervention is designed to be preventive,” according to a site spokesperson. A classroom consultant was in the classroom two hours a week to deliver a curriculum which all in the classroom benefitted from. Additionally, the consultant focused on identifying behavioral difficulties and preventing them from escalating and contributing to more serious behavioral or emotional problems. For children with targeted needs, several strategies were used. One was to develop special approaches with the teacher and host setting personnel to address observed problem behavior. A second strategy was a social skills group, offered in the summer for six weeks the first program year, and more frequently the second year. A third approach was to help refer students with demonstrated needs to appropriate services provided by collaborating agencies.

Summary

Once program models are established, a primary goal of the program stakeholders is to provide appropriate services to individual persons in the service population. Many of the SESS service strategies and interactions were implemented to assure that SESS families would get the services they needed. As a result, threaded throughout the SESS models were continual approaches and efforts to engage clients and support them in getting needed services. The SESS programs considered how to overcome individual, psychological, or cultural factors that inhibited service involvement; systemic barriers directly related to large and, for most families, confusing service bureaucracies; practical barriers associated with service location and schedules; and site-based barriers associated with bringing behavioral health services into different types of service settings. For the most part, all services offered by SESS addressed access and service utilization in a conscious way. Strategies as varied as parent socializing events and referral support had this underlying purposeful approach.

SUMMARY AND DISCUSSION

The SESS collaboration was initiated to support local grantees in designing and implementing a common program concept in varying local settings. Programs were divided between primary care and early childhood settings, an important aspect of those varying contexts that was intended and planned. Within their local contexts, SESS programs have developed interventions that share certain characteristics. The analyses presented in this report focus on the pooled effectiveness of all SESS programs in achieving intended program outcomes. These pooled analyses can be interpreted as testing the shared characteristics of SESS programs, those that define what might be called the SESS approach to service integration. These defining program characteristics are in two major areas.

- *Shared Operating Principles.* SESS programs share a family-centered philosophy of service; a commitment to individually-tailored services; a holistic and comprehensive orientation to the family's service needs; cultural competence in staff and cultural appropriateness in services and procedures; and a relationship-oriented approach with respect to working with families, to staff interaction and management, and to collaborative relations with other agencies.

- *Core Service Components.* There are four core service components that all SESS programs adhere to. SESS programs 1) manage care coordination through case managers or family advocates, 2) provide services in care givers in the areas of behavioral health (mental health and substance abuse treatment); 3) provide parenting support through parenting classes, support groups, and the provision of basic needs; and 4) child behavioral health services providing preventative classroom-based interventions and one-on-one services to targeted individuals.

The chapter has also documented the variation in ways that programs have adapted to their service and community contexts. Programs implement the shared SESS operating principles in

identifiably different ways depending upon the populations that they are serving. Key variants in programming were identified as follows:

General

- **Recruitment setting.** All SESS families are recruited from either early childhood or primary health care centers. All programs serving families located at early childhood centers recruit the full population of families into the study. Some programs then opt to serve all families and provide prevention services and intervention services as needed. Other programs serve only those families who need more intensive services. Primary care families are recruited almost exclusively based upon a need for services (substance abusers, families under stress, etc.)

- **Risk levels**. SESS families vary widely in terms of their socio-economic and behavioral health backgrounds. While information regarding the risk levels of individuals is provided in Chapter Three, this chapter showed that families participating in SESS who were recruited from primary care settings were for the most part more at risk than families in early childhood settings, reflecting the differences in selection methods between these two recruitment locations.

- **Amount of program contact.** There is significant planned variation in the amount of services that SESS families receive depending upon the specific program model offered at SESS sites. Those who initially recruited SESS families from early childhood centers but then targeted on those families with a clear need for services have less average program contact that early childhood programs where all families received preventative and/or treatment services. Programs that focused services in the home, mainly the primary care sites, had lower average contact with SESS families than programs that provided SESS-based services.

- **Comprehensiveness of Services.** While all programs offered the four core service components (care coordination, adult behavioral health services, parent education and support, and child behavioral health services, some programs offered a more comprehensive package of programming or were more fully implemented than others. These more comprehensive programs tended to offer significant service delivery to both parents and children with programming well integrated into existing services at early childhood centers and/or primary care settings.

Care Coordination

- **Services offered.** Care coordination included a range of services, including assistance with accessing basic services, including housing, health care, legal, child care and transportation. Care coordinators also assisted with fulfilling more acute needs for services by referring families to SESS professionals or external agencies specializing in substance abuse treatment, mental health, and domestic violence services.

- **Staffing.** Care coordination was provided by a case manager or family advocate at all SESS programs, though the emphasis on care coordination was stronger at some sites than others. SESS programs were mixed in terms of the levels of expertise of their care coordinators, with some programs recruiting primarily paraprofessional staff, and others recruiting professional staff. Programs that targeted higher risk families were most likely to have recruited professional care coordinators.

- **Location of services.** SESS services were offered on-site, at home, and at other service agencies. Because the early childhood sites offered a natural setting for service provision, most early childhood programs focused their programming at the host setting; most primary care programs offered services mainly in the home.

Behavioral Health Services for Caregivers

- **Services offered.** Behavioral health services offered to caregivers included mental health counseling, support groups, individual and group therapy, family counseling, financial assistance in obtaining Medicaid-funded services, and crisis counseling. The services offered across sites varied considerably, with some sites mainly providing external referrals, and others focusing predominantly on offering services in this area.

Parenting Classes and Support Services

- **Services offered.** SESS families are offered a variety of parenting education and support classes, ranging from structured parenting education courses to workshops on budgeting, home repair and cooking, to recreation and enrichment activities.

- **Parenting Curriculum.** Most (eight) of the programs offer a parenting curriculum to parents. Curricula range in structure, content and comprehensiveness. Some programs offer minimal parenting classes; for others it is a primary component of the program.

Behavioral Health Services for Children

- **Services offered.** Children served by SESS receive a variety of behavioral health services depending upon the age of the child, their assessed need for services, and the focus of the SESS program. At most primary care sites where most children are infants, the focus of behavioral health services is upon developmental assessments. For preschool-aged children, services vary by site, and include classroom observations, behavioral assessments, group and individual therapy, and teacher training.

- **Staffing.** Programs vary widely in terms of the behavioral health care staff. Some sites have behavioral health care specialists on a very limited basis; others have devoted significant resources to providing full-time behavioral health care specialists to work with children on an ongoing basis.

In sum, this chapter has demonstrated both the common and varying design and implementation elements that characterize the local SESS programs, the program characteristics, and the ways in which the programs delivered services to families in light of local conditions. While SESS programming varies in some important ways, the core principles remain the same. SESS differs from other early childhood programs because it recognizes that the well-being of the child is dependent upon the health of the family overall, and that without a strong, healthy, and well-informed families, children will not be prepared to thrive in school, make positive relationships with peers, or succeed as adults. By beginning in the very early years and working with families and not just the child, SESS offers a unique and important service to high risk families.