A Strategy for Outcome-Based Accountability for School-Based and School-Linked Prevention and Early Intervention Programs

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BAY AREA SOCIAL SERVICES CONSORTIUM

A STRATEGY FOR OUTCOME-BASED ACCOUNTABILITY FOR SCHOOL-BASED AND SCHOOL-LINKED PREVENTION AND EARLY INTERVENTION PROGRAMS

Report Brief

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San Mateo Human Services Agency engages in school-based and school-linked programming designed to promote overall child and family wellness in order to facilitate young children's readiness to enter formal schooling and maintain academic achievement through early elementary school. Although the three programs in Redwood City and Daly City participate in internal evaluation efforts, the County was concerned that its existing evaluation efforts were not sufficient to document effectiveness. For this reason, they commissioned this report in order to develop a comprehensive strategy of outcome-based accountability to be implemented across the programs.

An outcome-based evaluation is a systematic method of collecting and analyzing program data on selected indicators of a program's performance. It is commonly used to inform both policy and practice decisions in order to improve services or the service delivery system. A comprehensive outcome-based program evaluation can confirm anecdotal evidence of a program's success, highlight gaps in service provision, or suggest modifications to current practices. Well designed program evaluations typically are tailored to the goals of specific programs.

The FUTURES project, Daly City Partnership and the Healthy Start Network of Redwood City encompass the bulk of San Mateo County's school-linked or school-based prevention and early intervention services for young children. Services offered by the three programs vary and can include tutoring, counseling, case management, and parent education as well as other services. Each program serves an ethnically diverse, primarily low socio-economic client population, with a large number of English language learners. Despite the variation in program activities, these agencies and community partners work collaboratively toward two primary program goals: kindergarten readiness and third grade literacy. These primary goals are supported

by numerous program activities consistent with three broad objectives:

- stabilizing children's socio-emotional health
- improved academic and social skills for children and parents
- meeting basic needs to promote family stability (i.e. housing, food and parental employment).

The empirical and practice literature identifies numerous variables thought to place a child at-risk of school failure. Some factors are specific to the child, such as behavior and coping skills and academic achievement, while others encompass family factors such as socio-economic status and parent education level. Further, early academic and behavior problems in elementary school are associated with undesirable future outcomes such as involvement with the criminal justice system, teenage pregnancy and substance abuse (West, 1991). Fortunately, the literature also points to prevention and early intervention as crucial to mediating the impact of risk factors in both the short and long-term.

The provision of school-based and school-linked services is a relatively new development in the effort to address the multiple needs of vulnerable children and their families. Little attention, however, has been devoted to documenting the effectiveness of these programs. The need for outcome-based evaluation plans is especially acute. In order to document prevention and early intervention efforts designed to mediate the impact of educational risk factors, program administrators need to implement a uniform and comprehensive evaluation plan.

San Mateo County's interest in unifying evaluation efforts across school-linked family support programs is a noteworthy example of bridging the distance between social services practitioners and educators. Conducting such a cross-site comparison is methodologically difficult and the findings need to be reported with care. Although they share the same common goals, differences between program practices and client populations make it difficult to compare these three programs. The recommendations contained in this report are geared toward supporting the county throughout the evaluation process so that these difficulties can be minimized. Through a commitment to implementing a comprehensive evaluation of the Redwood City and Daly City programs, administrators and program staff can expect to gain valuable insight and information on how to more effectively serve vulnerable families.

Recommended Techniques for Implementing a Comprehensive Evaluation Plan in San Mateo County

Step 1: Assemble an evaluation team to identify program goals and plan evaluation procedures.

The predominant goals identified by San Mateo's Daly City and Redwood City family support programs are kindergarten readiness and third grade literacy. These two primary goals are promoted through services which fall into one of three categories: socio-emotional health, skill-building and family stability/basic needs provision. These three categories should be considered secondary goals because they serve as the mechanisms through which the county is promoting its two primary goals, kindergarten readiness and third grade literacy. Given this, a comprehensive evaluation plan of school-linked prevention services in the county should include outcomes measures of all five of these goals. In order to maximize the success of the evaluation plan, these five program goals should be written in measurable terms.

Step 2: Allocate sufficient time and resources to properly prepare for the evaluation through the development of a support network for the evaluation team and the establishment of communication procedures.

Each of the three programs under consideration involves collaboration with multiple partners and referral sources. Each of these partners needs to be aware of the evaluation effort and their potential role in collecting data or administering assessment tools to clients. Because the two goals that have been identified are educational outcomes, it will be especially important to include caregivers at preschool programs and kindergarten teachers in the evaluation effort. In addition, outreach activities would enhance the county's ability to communicate the purpose and process of the outcome evaluation to stakeholders and secure the support of these key individuals.

Successful implementation of any evaluation plan requires communication between program staff at each site, as well as between program managers and direct service workers (and individuals responsible for data collection and analysis). While each program will be particularly interested in the service outcomes experienced by their clients, it also will be necessary to aggregate the findings across programs in order to determine the county's overall progress toward its primary goals. The merging of data across programs involves establishing a main point of contact for all three programs where data are collected, analyzed and stored on a consistent basis.

Step 3: Develop a rigorous and workable evaluation plan.

To achieve this goal, there are many possible components. One is to utilize culturally sensitive assessment tools. Whenever possible, clients and their families should be served and assessed in the language that is most comfortable for them. Additionally, a comparison group should be included. A non-equivalent comparison group would be composed of children and their families who are not receiving services from the program, but are substantially similar to the clients receiving program services. Without random assignment of subjects to each of the groups, it is impossible to know if the groups are truly equal, but the inclusion of the comparison group can strengthen the design of the evaluation, especially when subjects include young children who mature rapidly.

In order to compare results across programs and measure the county's overall progress toward its goals, it is imperative that each site uses the same assessment tools and administers them at the same time and in the same manner. Depending upon the goal(s) at hand, different measurement tools may be useful. The figure below provides an overview of a suggested evaluation plan for San Mateo's program goals.

Step 4: Collect evaluation information.

An appropriate timeline for data collection should be developed. The timeline should begin with a period of time for staff training on both the purpose and the process of data collection. A uniform protocol regarding when and how the data will be collected in each program will streamline the process and increase the reliability of the results. Also, demographic data should be collected. Categories of data to consider collecting are gender, age, ethnicity, single parent/two parent family, household income, parent

education level, health insurance, and preschool attendance.

Data should be collected at intake and termination to provide important baseline and follow-up information. A pre-test/post-test evaluation should be utilized to measure client outcomes. This approach strengthens the ability of the evaluation to infer that changes in behavior, skills, or knowledge are a result of the intervention and not merely the result of maturation. When young children are involved, multiple assessment tools should be used. The National Educational Goals Panel (NEGP-1998) generally recommends including the following three forms of assessment: (1) social indicators; (2) caretaker assessment; and (3) direct measures.

Step 5: Analyze the evaluation information.

While each program will be particularly interested in the service outcomes experienced by their clients, it also will be necessary to aggregate the findings across programs in order to determine the county's overall progress toward its primary goals. The merging of data across programs involves establishing a main point of contact for all three programs where data are collected and analyzed using one of the common social science statistical software programs, such as SPSS or SAS.

Step 6: Prepare the evaluation report.

Raw data from the evaluation should be compiled and summarized in such a way as to make it accessible to the key stakeholders in program outcomes. These stakeholders may include policy-makers, program managers and direct service workers as well as parents, school administrators, teachers and members of the larger community served by the program or the school with which the program is linked.

Goal	Measurement Tool	Timetable	Administered by:
(1)Kindergarten Readiness	Lollipop Test	Pre-Test: entry into preschool/services. Post-Test: entry into kindergarten.	Preschool teacher (ideally) or kindergarten teacher
	Teacher Survey (to be developed)	Pre-Test: entry into preschool/services. Post-Test: conclusion of preschool/services.	Preschool teacher
	Parent Survey (to be developed)	Pre-Test: entry into preschool/services. Post-Test: conclusion of preschool/services.	Case Manager
(2)Third Grade Literacy	SAT 9	Annually, for second and third graders receiving services.	Second & Third Grade Teacher
	Teacher assigned grade level in reading	Annually, drawn from final report card of each school year for students receiving services..	Kindergarten, First, Second & Third Grade Teacher
(3)Socio-Emotional Health	Behavior Scale (e.g., SCRS)	Pre-Test: at time of referral for services. Post-Test: at termination of services.	Classroom Teacher
(4)Adequate Skill Level	Activity-specific assessment tool (e.g., Power Hour Survey)	Pre-Test: entry into skill-building activity. Post-Test: conclusion of skill-building activity.	Case Manager
(5)Family Stability	Global Assessment Tool (e.g., Department of Economic Opportunity Family Development survey)	Pre-Test: entry into services. Post-Test: termination of services.	Case Manager

Developing a Strategy for Outcome-Based Accountability for Prevention Programs in San Mateo County

The San Mateo County Human Service Agency is committed to providing quality prevention and early intervention services to the county's vulnerable children and their families. San Mateo HSA currently engages in school-based and school-linked programming designed to promote overall child and family wellness in order to facilitate young children's readiness to enter formal schooling and maintain academic achievement through early elementary school. This report focuses on three of these innovative programs, the FUTURES Project of Daly City, the Daly City Partnership and the Healthy Start Network of Redwood City. These services include skill-building activities for children and parents, neighborhood support programs to promote physically and emotionally healthy children and families, and school-based services to encourage optimal child development. The County was concerned, however, that it was not sufficiently documenting the effectiveness of these services. For this reason, this report was commissioned to develop a uniform and comprehensive strategy of outcome-based accountability to be implemented by each of its prevention programs.

An outcome-based evaluation is a systematic method of collecting and analyzing program data on selected indicators of a program's performance. It is commonly used to inform both policy and practice decisions in order to improve the services or service delivery system. A comprehensive outcome-based program evaluation can validate anecdotal evidence of a program's success, highlight gaps in service provision or suggest modifications to current practices. Well-designed program evaluations typically are tailored to the goals of specific programs.

The FUTURES Project, Daly City Partnership and the Healthy Start Network of Redwood City encompass the bulk of San Mateo County's school-linked or school-based prevention and early intervention services for young children. Services offered by the three programs vary and can include tutoring, mental health counseling, case management, and parent education as well as other services. Each program serves an ethnically diverse, primarily low-income client population, with a large number of English language learners. Despite the variation in program activities, these agencies and community partners work collaboratively toward two primary program goals:

- kindergarten readiness
- third grade literacy

These primary goals are supported by numerous program activities that are consistent with three broad objectives, or secondary goals:

- stabilizing children's socio-emotional health
- improving academic and social skills for children and parents
- meeting basic needs to promote family stability (i.e. housing, food and parental employment).

Both the primary and secondary goals were selected carefully from the empirical and practice literature as being particularly supportive of the more complex and long-term process of promoting ultimate school success. While the literature identifies numerous variables that are thought to place a child at-risk of school failure, difficulties transitioning to kindergarten and poor academic achievement in early elementary school have been identified as particularly predictive of future difficulties. It is worth noting here that the risk factors for early difficulties, can be specific to the child, such as behavior and coping skills and academic achievement, or involve family factors such as socio-economic status and parent education level. Fortunately, the

literature also points to prevention and early intervention as crucial to mediating the impact of risk factors in both the short and long-term.

Negative experiences in school, as early as the first grade, have been found to influence educational and socio-emotional health through adolescence. Children with documented behavior problems and low academic achievement in early elementary school are more likely to demonstrate behavior problems, low academic achievement and low achievement motivation as they enter adolescence (Tremblay, et. al., 1992, Roeser, Eccles, & Freeman-Doan, 1999). Moreover, children from the lowest socio-economic sectors are at increased risk of developing school problems such as impaired academic skills and social, emotional and behavior difficulties (Dupper & Poertner, 1997; Schellenberg, 1998).

Several prevention and early intervention activities have been identified as mediating factors in ameliorating the impact of these risk factors on children's outcomes. Gullo & Burton (1992) documented the positive effect of preschool attendance on the academic achievement and school transition of designated "at-risk" children. Preschool programs that have been shown to be particularly effective in preventing subsequent school problems are developmentally appropriate, focus on skill-building, recognize the importance of the child's home environment, involve parents and collaborate with other programs and agencies (Illinois State Board of Education, 1992; Reidinger, 1997).

Not only are these programs effective in the short term, a growing body of literature suggests that there are long-term benefits of prevention and early intervention. For example, Campbell and Ramey (1995) found that a group of children who received intensive preschool treatment continued to score higher on measures of cognitive ability at follow-up ten years later, compared to children who received treatment in elementary school, or received no treatment.

The provision of school-based and school-linked services is a relatively new development in the effort to address the multiple needs of vulnerable children and their families. Little attention, however, has been devoted in the research literature to documenting the effectiveness of these programs. The need for outcome-based evaluation plans is especially acute. In order to document prevention and early intervention efforts designed to mediate the impact of educational risk factors, program administrators need to implement a uniform and comprehensive evaluation plan.

This report was commissioned to provide the San Mateo County Human Service Agency with a blueprint from which they could implement this type of outcome-based accountability evaluation plan. To develop this report, researchers at UC Berkeley became familiar with San Mateo County's programs through a facilitated process of meeting with identified program staff to learn about the programs and their common goals. In addition, the researchers were provided with program descriptions and current assessment instruments. From this starting point, researchers reviewed the relevant literature to describe the theory behind why program services are thought to influence desirable changes in children and their families. From this, it was possible to develop an evaluation plan that could be implemented across the three different programs, the FUTURES project, the Daly City Partnership and the Healthy Start Network of Redwood City.

The first section of the report focuses specifically on the three prevention programs under consideration. The two primary and three secondary goals shared by each program are outlined clearly. In light of these goals, the brief program descriptions that follow are geared towards highlighting the program activities that directly support these goals. As stated earlier, these five program goals are solidly grounded in the empirical and practice literature. This is clearly

shown in the second section of the report, which outlines the theory behind why these activities are thought to promote the outcomes sought by the program goals. The third and final section of the report contains an overview of the purpose and process of conducting a comprehensive outcome evaluation as well as a series of recommendations, which are specific to San Mateo County's efforts. The overview of the evaluation process is included in order to inform the reader about the benefits and limitations of this form of research. From this overview, the appropriateness of this form of evaluation is evident with regard to the three prevention programs under consideration here. The program-specific recommendations, which conclude this report, were developed from the research conducted for each of the previous sections of the report, as well as from additional input from program administrators and staff. This last piece is meant to be a guide, or blueprint, for implementing an evaluation plan which will best serve the County's specific needs.

The FUTURES Project, the Daly City Partnership, and the Healthy Start Network of Redwood City: An Overview of Prevention Programming

Program Goals

San Mateo County demonstrates a strong commitment to supporting its children and families. The county has developed several programs that offer services to stabilize and strengthen vulnerable families. The FUTURES Project, the Daly City Partnership, and the Healthy Start Network of Redwood City are three such programs that offer school-linked interventions centered on promoting educational success for children in the county. The strategy of providing a school-linked safety net for families through multi-agency collaboration is currently being extended county-wide and common goals are being identified. Comprehensive evaluation efforts will help administrators to focus these efforts and funds effectively and efficiently. The provision of school-linked services is congruent with state-wide trends to improve services for vulnerable families.

The long-term goal of each program is to give children the support they need to develop into productive adult citizens. School failure, defined as dropping out prior to receiving a high school diploma or graduating without the necessary basic skills, has been linked to many troubling social problems, such as welfare dependency and an increased involvement in criminal activities and substance abuse (Whiston & Sexton, 1998). Conversely, kindergarten readiness and literacy by the third grade have been identified by program administrators and supported in the literature as predictors of future educational success. For these reasons, San Mateo County agencies and community partners are working collaboratively to support two primary goals:

- kindergarten readiness
- third-grade literacy

These goals are supported by numerous program activities that are consistent with three broad objectives: (1) stabilizing children's socio-emotional health, (2) improved academic and social skills for children and parents, and (3) meeting basic needs to promote family stability (i.e. housing, food and parental employment). Each area affects a child's ability to enter school ready to learn and accomplish the social and academic tasks necessary to achieve literacy by the end of third grade.

Program Practices

The Futures Project of Daly City. The Futures Project, which stands for Families United Together to Ultimately Realize Educational Success, currently operates school-based support centers in nine schools in Daly City. It was established as a proactive program within the Human Services System, which addresses the self-identified needs of the clients served. The FUTURES project focuses on several activities in order to fulfill its main goal of assuring that children served by the program are reading at grade level by the end of the third grade. The program offers services in the following areas: basic needs, medical services, student skill-building, behavior modification, and parent education. Each of these areas represents a number of interventions, which focus on material support, access to needed services, and/or skill building. See Figure 1 for a visual description of services and their relationship to the identified program goals.

The FUTURES project serves families in Daly City, which is a diverse community, both ethnically and economically. Many families are first generation immigrants and 1/4 of school-age children in this geographic area have limited English proficiency, making the need for bilingual and culturally competent services especially relevant. In a typical Daly City school,

50% of the students qualify for free or reduced price lunch and over 1/3 will perform in the lower two quartiles on standardized tests.

The program's Kindergarten Readiness component is offered to all entering children who have not attended preschool or have scored below average on the standardized readiness test used to screen incoming Kindergartners (the Lollipop Test). Currently, the participating schools administer the Lollipop Test to all children when they are registered for Kindergarten. Credentialed teachers and mandatory parent volunteers lead a series of 6-week sessions to help these students make a successful transition to formal schooling.

Figure 1: The FUTURES Program services

		Program Objectives		
		Socio-emotional health	*Skill-Building*	*Family Stability/Basic Needs*
Program Goals	Kindergarten Readiness		Kindergarten Readiness Program.	Pre-natal/Post-natal Care, Case Management
	Literacy by the Third Grade	Psychosocial Evaluation, Short/Long Term Therapy, Group Therapy, Family Therapy, Support Groups, Crisis Intervention	Tutoring, Nutritional Education, Parent & Parenting Education, Classroom presentations & support	Case Management, Food Assistance, Basic Transportation, Child Protection, Physical Examinations, Dental Screening, Nutritional Assessment

Aside from the Kindergarten Readiness program, children are typically referred for services by the classroom teacher or other school staff, but it is possible for a parent to request services. Services are provided to individuals and families on an as-needed basis, determined by the case manager, and the length of service varies from one session to twenty or more sessions. The majority of clients, however, receive services for over 6 months. The FUTURES Program

has a staff of 24 individuals, which include Public Health Nurses, Mental Health Counselors, Child Welfare Social Workers and eligibility counselors with the TANF, MediCal and Food Stamp programs. Funding for this program is provided through a variety of sources which include federal and state monies, County matching funds, the school districts, the City of Daly City, Peninsula Foundation, Cowell Foundation and the Parent Support Project.

The Daly City Partnership. The mission of the Partnership, which was formed in 1995, is to promote collaboration among the health, education and social service providers who are working to support vulnerable children and their families. This collaborative is composed of school districts, child care providers, the City of Daly City, the Chamber of Commerce, San Mateo County Office of Education, Seton Medical Center, San Francisco State University, the Town of Colma, as well as several non-profit agencies operating on the Peninsula on behalf of families with young children.

The prevention and early intervention programs of the Daly City Partnership also provide school-based services in nine schools in Daly City. As illustrated in Figure 2, the Daly City Partnership focuses most of its resources on skill-building activities for children to achieve kindergarten readiness and literacy by the third grade. Program services target families and children up to age nine who are performing below grade level in school. The program's kindergarten readiness sessions are led by credentialed teachers and serve as an introduction for school-based learning to preschool children. The curriculum for this program also includes an early literacy component known as "Raising a Reader." Tutoring and homework assistance programs are conducted on the school site and are staffed by credentialed teachers, instructional aides, as well as community volunteers. Enrichment classes also are offered in such topic areas

as arts and crafts, music, and gymnastics, in order to motivate children to learn outside the classroom.

Figure 2: The Daly City Partnership Program services

		Program Objectives		
		Socio-emotional health	*Skill-Building*	*Family Stability/Basic Needs*
Program Goals	Kindergarten Readiness		kindergarten readiness session,	
	Literacy by the Third Grade	Volunteer program (retired seniors)	Tutoring, homework assistance, enrichment programs (art, music, sports)	

The demographics of the program's client population in Daly City represent a diverse population in terms of language and ethnicity: 34.4% Filipino, 33.06% Latino/a, 10.79% Asian, 10.22% Caucasian, 8.23% African American, 2.51% Pacific Islander, and .70% Native American (CSBA Conference, 1999). Clients usually are identified for the tutoring and homework assistance programs by their classroom teacher if they are performing below grade level. The Kindergarten Readiness program is offered to all preschool aged children with no previous preschool experience, who are scheduled to attend one of the participating elementary schools. The curriculum focuses on the basic skills in literacy and comprehension as well as instilling and/or reinforcing good study habits in the classroom and at home. Academic assistance and enrichment activities are offered on a time-limited basis, but there is no limit to the number of sessions that a child can attend.

Healthy Start Network of Redwood City. The main prevention program for Redwood City is the Healthy Start Network that is implemented in four schools throughout the city. The

network is a 22-member partnership of health, education and social service agencies who operate to support families with young children. These partners include City and County offices, health organizations, school districts and non-profit human service agencies. The Healthy Start Network focuses on several activities in order to enhance children's kindergarten readiness and third-grade literacy. These activities include individual, group, and systems interventions, such as group counseling for parents and children, individual counseling for parents and children, home visits, and community outreach activities focusing on parent organization and involvement with schools. In general, Healthy Start services focus on children aged 0-9 and their families. Services are mostly offered off-site, with some services at the school in conjunction with the on-site health clinics. See Figure 3 for an overview of the services offered by the Healthy Start network.

Children may be referred to the program through the county Child Protective Services, day care centers, teachers, social workers, parents, or any provider that feels that a child might be at-risk for school failure. The client population is reflective of the ethnicity of the neighborhood (73% Latino/a; 18% Caucasian; 5% African American; 4% Asian and Pacific Islander). Over half the client families served are English language learners, with Spanish as their native language.

Once a family is referred, a Family Advocate, who serves as the primary case manager, will meet with them to determine which services are needed and create a service plan. The services outlined in the service plan are provided by a Family Support Team, which consists of professionals, paraprofessionals, community residents, school staff, and student interns. The client and the Family Advocate assess this plan for progress on each stated goal after six to nine months according to a four-point scale (1=No progress; 2=Some progress; 3=Much progress;

4=Met goals.). Although the Center is open for drop-in or one-time assistance, most clients receive services for several months.

Figure 3: The Healthy Start Network of Redwood City Program services

		Program Objectives		
		Socio-emotional health	*Skill-Building*	*Family Stability/Basic Needs*
Program Goals	Kindergarten Readiness	Crisis Intervention Counseling, Family Counseling, Parent Support Groups, Parent Involvement Programs, Home Visits	Kinder-Readiness Program, Home Visits	Family Case Management, Child Protective Services, Welfare-to-Work Services, Health services and referrals, Home Visits
	Literacy by the Third Grade	Crisis Intervention Counseling, Family Counseling, Parent Support Groups, Parent Involvement Programs, Home Visits	Children's Life Skills Groups, Parent education, After school tutoring and homework assistance, After school clubs, Home Visits	Family Case Management, Child Protective Services, Welfare-to-Work Services, Health services and referrals, Home Visits

Factors that Promote Children's Kindergarten Readiness and Third Grade Literacy: A Review of the Literature

The FUTURES project, the Daly City Partnership, and the Healthy Start Network of Redwood City provide a variety of support services to children and families that are designed to nurture children's readiness for kindergarten and third grade literacy. In this section, the existing empirical and practice literature is reviewed to highlight the rationale for how the services provided by these programs are thought to promote the two identified common program goals. School-based support services are a relatively new development in the field of prevention and early intervention for school problems. Consequently, few outcome-based studies have been conducted. Therefore, much of the supporting literature reviewed in this section focuses on what is known about promoting general school success. First, the complex risk factors that make children vulnerable to school difficulties are explored. Then, the factors that have been shown to promote school success by mediating these risk factors are discussed. In conclusion, evidence of the long-term impact of early intervention and prevention programs is reviewed, with special attention paid to California's school-linked services movement. The findings in these three content areas are consistent with the program models and services provided by the three programs under consideration in this report. This suggests that the programs' assertion that their services will promote the two overall goals of kindergarten readiness and third grade literacy has a strong foundation in the available research.

Risk Factors for School Difficulties

A growing body of literature suggests that children's early school success is associated with their later successful transition to adulthood, while children's early academic problems are associated with their maladaptation to adulthood. For example, school failure (i.e. dropping out)

is associated with increased welfare use, lower lifetime income, increased involvement with the criminal justice system, teenage pregnancy and substance abuse (West, 1991). The lasting impact of early school difficulties highlights the importance of school readiness and early academic success, such as third grade literacy, in the long-term school success of vulnerable children. This is also the primary motivation for the establishment of school-based and school-linked programs, which increase access to services and promote early school success.

A range of risk factors has been identified as placing children at-risk for poor educational outcomes (see Figure 4). While some of these factors are child-specific, many come from the family and neighborhood environment in which the child is raised. For this reason, policy-makers and program administrators have recognized that effective interventions to improve educational outcomes need to start early and encompass individual, family and community factors. Comprehensive programs include interventions at the systemic level with families, neighborhoods and schools. Socio-economic status and attendance at a developmentally appropriate preschool emerge from the literature as consistently related to children's kindergarten readiness and achievement of literacy by the third grade.

Figure 4: Overview of Risk Factors for School Difficulties

Study	Risk Factors
Rush & Vitale (1994)	Low academic achievement; Poor behavior and coping skills; Social withdrawal; Low family income; Parenting style; Delayed language development; Retention; Poor school attendance.
Roeser, et. Al. (1999)	Low self-esteem, Poor achievement motivation
Dupper & Poertner (1997); Schellenberg (1998)	Low socio-economic status
Gullo & Burton (1992)	Preschool Attendance; Higher age of school entry

In order to develop a fuller understanding of specific factors associated with children's risk for maladaptive outcomes, Rush and Vitale (1994) surveyed elementary school teachers

regarding their views of the categories of risk that influence students' success in school. A factor analysis of the survey results produced eight factors, which accounted for 52% of the variance and provides a profile of the characteristics of at-risk children. These eight interpretable factors were: (1) low academic achievement, (2) poor behavior and coping skills, (3) social withdrawal, (4) low family income, (5) authoritarian or permissive parenting style, (6) delayed language development, (7) retention, and (8) poor school attendance. These findings are consistent with literature suggesting that children's difficulties in these areas in very early elementary school are related to future long-term educational failure.

A 1978 longitudinal study of 324 French-Canadian first graders from poor and lower-middle class neighborhoods found that early behavior problems, low academic achievement, and troubled peer relationships significantly predicted children's delinquent personality and/or behavior at a 7-year follow up (Tremblay, et.al, 1992). The sample consisted of boys and girls who were initially assessed in the first grade and then subsequently in the fourth grade and at age 14. The purpose of the study was to separate the influences of early disruptive behavior, and poor academic achievement, in early elementary school on predicting later delinquent behavior.

Peer relationships were assessed in the first grade through the Pupil Evaluation Inventory (PEI) which was filled out by the subject as well as his/her peers. The PEI is a 34-item sociometric instrument that covers three distinct areas: disruptive behavior, withdrawn behavior, and likeability. Academic achievement was measured at the 1st and 4th grade level through a review of each student's math and language grades. At follow-up, delinquent behavior was assessed through a 28-item self-report measure constructed by LeBlanc and Frechette (1989), that measures the frequency of certain criminal acts within the previous 12 months (minor theft, major theft, use of drugs, aggression, and vandalism). Delinquent personality was assessed using

the Jesness Inventory, a personality inventory designed to measure attitudes and values associated with a delinquent personality. The causal links between the variables in this study were tested using linear structural equation modeling. Results of the analysis suggested that for boys and girls in the study the presence of both disruptive behavior and poor achievement in early elementary school predicted later delinquent behavior and personality. For boys, however, a statistically significant direct link between disruptive behavior in first grade and delinquency at age 14 was found. For girls, neither factor by itself was sufficient to predict future behavior problems.

Additional longitudinal studies support the finding that difficulties in transitioning to schooling and negative early educational experiences represent a risk factor for future discouraging outcomes (e.g., Roeser, Eccles, & Freedman-Doan, 1999; Stanger, MacDonald, McConaughy, & Achenbach, 1996). In Stanger, et. al. (1996) a sample of 1,103 four to 18 year olds referred for mental health services were assessed six years after the initial referral to determine whether early difficulties were sustained over time or predicted future different, yet related, difficulties. At intake, each child was assessed with the Child Behavior Checklist, which was filled out by his/her parents. These scores were compared at follow-up with standardized assessments filled out by children's teachers, parents, and the child. Using structural equation modeling to test the relationship between intake and follow-up, researchers found that behavior and emotional problems were stable through the developmental stages associated with childhood and early adolescence. In particular, aggressive behaviors, poor peer social skills, attention problems, and withdrawn behaviors had significant long-term effects.

Roeser, et. al. (1999) also found continuity between early academic and mental health difficulties in elementary school and later adjustment problems, specifically looking at the

transition into adolescence. As part of a larger 10-year, longitudinal study, they looked at a subset of the sample (n=184) who were then in the eighth grade, and followed them back to the second grade to differentiate any existing patterns of academic functioning and mental health. The study employed several self-report questionnaires, as well as individual assessments, by the student's primary classroom teacher and existing school records. The self-report measures were designed to capture achievement motivation, cognitive abilities, general mental health, and self-worth.

There were several significant findings as a result of the statistical analyses of the data[1]. Not surprisingly, children who had positive achievement motivation and self-esteem in elementary school were more likely to remain well adjusted academically and socially during the transition to adolescence. Children with multiple problems in early elementary school (e.g., low self-esteem, poor motivation, and poor grades) were more likely to continue to have these issues as they were transitioning into adolescence. Further, the study found that a negative self-perception of competence contributed significantly to the continuation of difficulties for the multi-problem children. The authors noted that these children did not demonstrate significantly lower cognitive abilities (which would indicate low IQ as a factor in poor achievement and achievement motivation). The researchers suggest that poor skills and inappropriate behavior in elementary school, not deficits in intelligence, are likely predictors of future poor school functioning and adjustment to adolescence.

[1] The study employed a person-centered cluster analytic technique to discover patterns of school functioning and mental health between the 2nd and 8th graders. Any differences among the groups in the sample were then investigated through analysis of variance (ANOVA) and Newman-Keuls post-hoc comparisons. To compare patterns between 8th graders and the earlier teacher ratings from elementary school, the study used multivariate analysis of variance techniques (MANOVAs).

Beyond early school problems, characteristics of individual children, their families, schools, and neighborhoods, have been associated with later school failure. For example, Dupper and Poertner (1997) found that 70% of children born into poverty develop school problems such as impaired academic skills and social, emotional, and behavior difficulties, which make it more difficult for them to complete the necessary educational tasks involved in early schooling. Consistent with Dupper and Poertner's work, Schellenberg (1998) devoted attention to the environmental effects of poverty on the academic achievement of students in elementary and middle school. This study was conducted in an economically and ethnically diverse urban school district and used archival data from all K-8 students in the district during two school years (n=21,465 and 22,063 respectively). In each of these two school years, children were grouped according to their eligibility for free or reduced-price lunch (F/R lunch). Neighborhoods in the study were classified according to five economic levels based on the percentage of children in each neighborhood who qualified for free or reduced-price school lunch. The five levels used were extreme poverty (80-100% F/R lunch); concentrated poverty (60=80% F/R lunch); moderate poverty (40-60% F/R lunch); lower poverty (20-40% F/R lunch); and affluent (0-20% F/R lunch).

Students eligible for free lunch scored the lowest, with reduced-price lunch students scoring slightly better and non-eligible students scoring the highest[2]. Further, the analysis demonstrated that all groups showed a decline in achievement on standardized testing as they moved from the most affluent to the poorest neighborhoods. Namely, students from the same socioeconomic status who lived in more affluent neighborhoods scored higher than their

[2] Multiple regression analysis was used to compare the students' scores on district-wide standardized tests of reading and math, with their eligibility status and the economic level of their neighborhood.

counterparts in poorer neighborhoods. This finding suggests the role of concentrated poverty, not just the individual family's socio-economic status, in predicting academic difficulties.

Given the link between school problems and poverty, researchers have begun to explore the specific mechanisms through which poverty may affect children's schooling. Taylor and Wang (1997) suggest a variety of theories including a lack of enrichment in the family, poor nutrition and early health care in poor families, stress caused by struggling to meet basic needs, and low expectations as endemic in multi-generation family poverty. Other research suggests that the negative impact of low socio-economic status on school outcomes can be buffered by early intervention such as attendance in a developmentally appropriate preschool program.

Gullo and Burton (1992) studied a large sample of children (n=4,539) to determine the impact of number of years of preschool, gender, and "at-risk" status on readiness for first grade. Scores on the Cooperative Preschool Inventory defined at-risk status. The sample was drawn from all students who attended pre-first grade classes in a large urban school district. The school system from which the subjects were drawn has the following ethnic representation: 55.3% African American, 30.8% White, 8% Latino/a, 3% Asian, 1.2% American Indian, and 3% other.

The children were divided into three groups depending on the age they entered preschool (three, four or five) and then tested using the Metropolitan Readiness Test (MRT)[3]. The MRT is a standardized test that measures children's readiness for the first grade by assessing their mastery of the skills necessary for first grade reading and math. Boy's mean scores were lower than those of girls, and at-risk students scored lower than not-at-risk students. A similar analysis of both age of entry and at-risk status showed that for children who started school at age three,

[3] Analysis of variance of gender, at-risk status, and age at school entry was performed on the children's composite scores on the MRT. Significant effects were found with regard to all three variables. Newman Keuls post-hoc

at-risk status did not affect their first grade readiness level. For those entering school at age five, however, at-risk students scored significantly lower on the MRT. Since part of school readiness is being familiar with the culture of the school and the way a classroom works, it seems logical that children who get more exposure to preschool are better able to adjust to kindergarten and the early elementary grades.

Promoting School Success

Kindergarten Readiness. Kindergarten readiness is typically understood as a child's capability of learning once he or she enters kindergarten. Although one's capability of learning cannot be measured directly, several authors have offered their own definitions of kindergarten readiness as well as their thoughts on how it is influenced. Klykylo (1985) asserts that a child is ready for kindergarten if he or she can focus his or her attention, cooperate with other children, and accept directions from adults other than their primary caregivers. According to the National Education Goals Panel (NEGP) as cited in Office of Educational Research and Improvement (OERI, 1993), kindergarten readiness needs to be assessed across the following five dimensions:

- Physical well-being and motor development;
- Social and emotional development;
- Approaches toward learning;
- Language usage; and
- Cognition and general knowledge.

These five domains are consistent with the three broad service objectives identified in the programs under consideration in this report: socio-emotional support, skill-building and supporting families in providing for their basic needs. These five dimensions also highlight the variety of interventions that can be used to address risk factors that may inhibit a child's

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analyses were performed on age of school entry and suggested that children who started preschool at age three or four scored higher on the MRT than children who started later.

readiness for school. The OERI suggests that appropriate interventions could include parent education, promoting childhood health and vaccinations, family support, service integration, workplace reform, and enriching communities with parks and libraries. The importance of successful transition to kindergarten has led to a nation-wide emergence of early childhood intervention programs to prepare children for formal schooling. One such prekindergarten program that exemplifies current programmatic efforts to prepare children for school is the Illinois Prekindergarten Program for Children at Risk.

The Illinois program provides preschool education programs for children ages 3 to 5 that are at-risk of academic failure because of their home and community environments. Children are identified for the program through individual screenings. The program seeks to offer individualized services, however the program's readiness activities generally fall into three main categories. First, children are involved in instructional skill building guided by credentialed teachers both in classroom and home-based settings, or in some case a combination of the two locations. The majority of students (about 85%) are served solely in a classroom setting. Next, the program emphasizes and encourages parent participation, which supports children's progress in the program. Along with parent participation, the program also offers parent education components designed to strengthen the parent's role as the child's primary educator. The final emphasis of the program is on promoting collaboration with other programs and agencies in order to maximize use of available resources and avoid service duplication. In this instance, collaborating agencies include health agencies, adult education agencies, and Head Start programs (Illinois State Board of Education, 1992).

The evaluation conducted by the Illinois State Board of Education in 1992 distributed a survey to the students' classroom teacher asking them to rank the children on their academic

achievement in mathematics, reading, language and behavior. Each child was given one of four possible ratings: above average, average, below average or deficient. It found that 74% of children who participated in the preschool program were ranked by their elementary school teachers as above average, or average, in their kindergarten readiness. Upon follow-up, when the children were in the third grade, 75-80% of these children were still ranked by their primary classroom teachers as average, or above average, in academic achievement. Socio-economic status was a significant determinant of readiness and achievement, with only 68% of the children eligible for free or reduced lunch being ranked as average or above average compared to 82% of the children who were not eligible. Children who had two years of preschool attendance were consistently rated higher in readiness and achievement by their classroom teachers than children with only one year of attendance.

Some limitations in the research design of the evaluation of the Illinois program are worth noting but do not entirely discount the demonstrated results of the program. No measurement or evaluation was conducted before the children attended the preschool program, so there is no baseline measurement for their "level of risk" before the intervention with which to compare the results. In addition, this was a statewide evaluation of multiple programs that had differences in eligibility requirements and specific services offered. Further, across the programs, different assessment tools were used to measure kindergarten readiness. In addition, students were ranked by their teachers, not a standardized assessment tool, making the result somewhat subjective. Despite these limitations, the evaluation suggests that the program activities that address the risk factors outlined in the literature may be associated with positive outcomes for students. A more rigorous, uniform evaluation plan would greatly strengthen the conclusions that could be drawn from evaluations of early intervention and prevention programs.

Third Grade Literacy. Research suggests that the same factors that promote kindergarten readiness have desirable effects on children's later literacy. Literacy skills are built starting with verbal and visual communication in the home and continue through informal and formal educational activities. Of particular importance in promoting literacy is enriching the home environments of preschool and school-age children so that all children get a lot of early exposure to print. Academic skill-building interventions build on these early literacy skills and are augmented by their continuation during schooling. The National Research Council (1998) has identified three academic factors as affecting reading achievement: letter naming, phonological awareness, and vocabulary. Outside of academic instruction, these skills are enriched through the quality and quantity of language interactions children have with adults.

Poverty is commonly identified as a risk factor for educational failure, in terms of low reading achievement, from the beginning of formal schooling. Research on literacy learning has explored differences in literacy achievement among children from families within the same socio-economic status. The goal of the research is to target specific characteristics that place poor children at risk for reading problems. The focus of this research primarily has been on investigating the quality of children's home environments and parent-child interactions in order to identify activities or attitudes that support and promote higher achievement in literacy learning.

Several studies have investigated the influence of home environment and child-caretaker interaction on children's literacy. For example, Rush (1999) found that while low socio-economic status is related to lower rates of literacy learning at early ages, significant variation in literacy skills exists within children of the same socio-economic status based on their quality of experiences during early childhood. This study looked at 39 children (and their families) who

were participating in a Head Start classroom program in two urban communities. Participants in the two sites were matched according to child and family demographic information such as ethnicity, parent education level and family size. The children's emerging literacy was assessed through multiple measures and then compared with measures of levels of enrichment in their caregiving environments. The children's school readiness was assessed using the Peabody Picture Vocabulary Test-Revised (PPVT-R), the Expressive One-Word Picture Vocabulary Test (EOWPVT-R), a test of letter-naming fluency, onset recognition fluency and phoneme blending ability. The supportiveness of the caregiving environment was measured through multiple assessment activities. For example, the Stony Family Reading Survey, a short multiple choice instrument, was used as one measure of family literacy activities. This measure was augmented through naturalistic observations of each participating family using the CIRCLE-2 data collection program. CIRCLE-2 is a computerized assessment tool designed according to the child's home environment, specifically focussing on the caregiving environment, the caregivers' behavior, and the child's engagement behavior with people and objects. Each observation was conducted for one hour in children's homes and focused on the ecology of the environment as a whole, the caregiver's behavior in support of literacy, and the child's initiation of literacy learning activities. Results revealed that a higher level of structured play, increased caregiver interaction, and a higher rate of specific literacy-related activities (such as shared book reading) were related to children's higher scores on the early literacy and vocabulary measures.

A limitation of the measures utilized in this study is that they were not normative-referenced, but the researchers note that the students in the sample were representative of preschool children of similar socio-economic status who are not involved with Head Start. Within this sample, variations in literacy levels were shown to co-occur with differences in the

amount of literacy support the child received in their home environment. An additional limitation is the small amount of time spent on each observation. A richer picture of family life could potentially lend more meaning to the study's findings.

Rush's (1999) findings are consistent with the work of Swick and Lovingood (1981). Based on a sample of 119 kindergartners, these researchers conducted structured interviews of mothers to determine the amount of literacy support in children's home environments, as well as the mothers' level of education. Interview results were compared to children's scores on the Metropolitan Reading Test (MRT), a well-respected school readiness and reading readiness tool. A significant positive relationship was found between home support and reading readiness. In addition, mother's education level was positively associated with both home support and children's reading readiness. It should be noted that this study found no relationship between children's socio-economic status and reading readiness, however, children's general coping skills were related to higher scores on the MRT.

An evaluation of the Even Start Family Literacy program identifies comprehensive approaches to early intervention that are considered promising. The Even Start program is a kindergarten readiness and reading achievement program. It was instituted in 1989 nationwide and serves as a model for a comprehensive approach to intervening with children, parents, and children's environments to promote academic success. The three main goals of Even Start are (1) to help parents become full partners in their children's education, (2) to assist children in reaching their full potential as learners, and (3) to provide literacy training for participating parents. In order to meet these goals, Even Start provides early childhood education, adult literacy and/or basic education, and parenting education. Parents who are willing to participate in each of these activities can enroll their children aged seven and younger in the Even Start

program (Reidinger, 1997). The Even Start curriculum is based on the theory that a child's transition to kindergarten is influenced by their home environment, prekindergarten programs attended, and the degree of continuity between the prekindergarten and kindergarten environments. The program reports success in its approach at partnering with families in a comprehensive, supportive and flexible manner. According to Reidinger (1997), this approach has helped families to feel important, respected, supported, and hopeful.

A process evaluation of the Even Start program was conducted by Reidinger in 1997. The evaluation focused on descriptive data that highlighted the implementation process and service strategies which the program staff, parents, and teachers thought were successful in promoting school and reading readiness in the children served. Descriptive data were collected from all Even Start projects operating in the 1993-1994 program year and qualitative data were gathered through site visits to five of these projects. The data collected is limited due to the variation in approaches used at different project sites. Conclusions drawn from the site visits can safely be applied only to those five sites. Despite these limitations, the evaluation identified the importance of intensive work with the parents, as well as the importance of communication between parents, preschool teachers, and kindergarten teachers as children transition to formal schooling. Additional factors thought to influence children's school readiness included parents literacy and education level, violence and/or deprivation in the home, limited access to quality childcare, socio-emotional health of the primary caregiver(s), and the attitude of school administrators and teachers. Parent involvement in the program was thought to be affected less by the motivation of individual parents than by the attitude and openness of the kindergarten teacher.

The process evaluation offers insights into potential challenges that may be encountered by program staff. The primary difficulties involved influencing home environments and encouraging greater levels of parent involvement. Many factors in the home environment are outside of the scope of the service providers, such as socio-economic status, violence, and drugs and alcohol.

The importance of the home environment in supporting early literacy learning also highlights the greater difficulty faced by bilingual/monolingual children who use a language other than English in their homes. Not hearing English in the home, they will need extra support to become literate in English. It is also important to support their literacy in their native language, which implies the importance of employing bilingual service providers.

Impact of Early Intervention/Prevention Programs

Beyond children's kindergarten readiness and third grade literacy, an emerging body of literature suggests that there are long-term benefits of early intervention. For example, Campbell & Ramey (1994) and Campbell, et al. (1998) conducted a longitudinal study of preschool treatment with randomized assignment of children in the sample to the Abecederian intensive early education treatment program. These studies measured children's cognitive development and academic achievement at ages 12 and 15, respectively, to determine if the effects of early intervention persisted. The study design was particularly rigorous in that it utilized three cohorts: two treatment groups (preschool treatment, and early elementary treatment) and an untreated comparison group. All children were from low-income families referred by the county social services department and were assessed from birth with regard to cognitive/developmental progress of the child, psychosocial assessments of parents, and evaluation of the home environment. Due to space limitations, each of the cohorts was limited to 28 children. The

preschool treatment consisted of a developmentally appropriate educational intervention offered through full-day year-round specialized day care and was designed to support the children's cognitive development. The school-age treatment focused on increasing parental involvement in their children's education through a series of intensive home visits by a home/school resource teacher (HST). The HST provided parents with materials and training in how to support their children's cognitive development, as well as advocating for the parents in the school and community to meet their basic needs.

The preschool treatment and control groups were assessed with a developmentally appropriate standardized measure of intelligence such as the Bayley Scales of Infant Development (0-24 months), the Stanford-Binet Intelligence Scale Form LM at 24 and 36 months, and the McCarthy Scales of Children's Abilities at 42 and 54 months. At every point after 18 months, the treatment group scored higher on these measures of cognitive development. The school-age treatment and control groups were assessed again with a developmentally appropriate measure of intelligence, the Wechsler Preschool and Primary Scale of Intelligence at age 5, and the Wechsler Intelligence Scale for Children-Revised (WISC-R) for children six and older. In addition, academic achievement was measured through a standardized measure, the Woodcock-Johnson Psycho-Educational Battery Part 2: Tests of Academic Achievement (WJ), and teachers filled out the Classroom Behavior Inventory (CBI), which is designed to measure children's ability to adapt to their learning environments. Results indicated that preschool treatment resulted in significantly higher scores on both the intelligence tests and the academic achievement measures, and these students experienced fewer grade retentions in the first three years of formal schooling. In addition, for those who received treatment in preschool, the results were stronger than for either the school-age treatment group or the control group.

The children were followed-up when they were 12 and 15 years old (Campbell & Ramey, 1995, and Campbell, et. al., 1998, respectively) and blind assessments were conducted (examiners were unaware of the child's previous treatment history). At the time of the first follow-up at age 12, none of the students had received services for four years. The study found that the earlier treatment results (of higher scores on intelligence test and higher achievement on standardized tests of mathematics and reading) were maintained. Since the children were just beginning to enter adolescence, another follow-up was conducted when the children reached 15 years of age. At this follow-up, the WISC-R and WJ were again used to assess cognitive development and academic achievement. Data on school progress, such as the incidence of referral for special education and retention, were also collected

Significant results were found in terms of higher cognitive development and academic achievement for students who participated in the preschool treatment program compared to the school-age treatment group and control group, even through mid-adolescence[4]. In addition, both the treatment groups were less likely to have been retained or referred for special education services. A noteworthy aspect of these results is that the majority of the sample consisted of African American children, who generally are disproportionately assigned at-risk status. The results of this study lend weight to the importance, and long-range impact, of early intervention services on future achievement.

California's School-Linked Services Movement

The provision of school-linked and school-based services in California is a relatively new phenomenon so empirical evaluation of these programs is generally lacking. SRI International has, however, conducted several outcome and qualitative evaluations of California's Healthy

Start school-linked services. A review of their preliminary findings illustrates the scope of evaluation activities needed in San Mateo County.

One year after implementation, Wagner, et al., (1994) completed a preliminary process and outcomes evaluation of the state's Healthy Start efforts. Because recipients of Healthy Start grants are given discretion in how funds are used, there was a great deal of variability between the programs evaluated in this study in terms of the target client population, mode of service delivery and primary process and outcome goals. A total of 66 different program sites were examined, which included a variety of age ranges, ethnic background and socio-economic status. Although Healthy Start grants were made available to all schools, 44.6% served children in elementary school or lower grades, compared to 19.4% working predominantly with children 13-18 years old. In the overall sample, 37% of participants were classified as limited English proficient (LEP) and 48% were receiving AFDC. The client population consisted of a majority of Latino families (55.8%), followed by White clients (21.0%), and African American (12.7%) and Asian (10.5%) clients.

Given the variation in program services, the study focused on four separate process components and seven outcome variables. The outcome variables included basic needs, employment, health and wellness, individual emotional health, family functioning, youth behaviors and educational performance. These seven variables can be roughly combined into the two overall goals and three sub-objectives outlined in this report: kindergarten readiness, third grade literacy, socio-emotional health, skill-building, and basic needs provision.

Data for these outcomes variables were collected at intake and termination from three primary sources: the intake/follow-up forms, self-administered questionnaires and school

[4] The data were analyzed using general linear models, such as analysis of variance (ANOVA), to determine if there

records. Researchers noted that the intake/follow-up forms used at the different sites were not uniform and therefore were not composed of structured identical questions, which increases the chance of error in the results. The sources of data, however, were deemed to be similar enough by researchers for inclusion in the study design.

In terms of assisting families in meeting their basic needs, statistically significant reductions in need were reported for food, clothing, eviction, transportation and childcare, but not for employment status. In terms of health and wellness, the program reported an increase in use of prevention services, but did not include an actual evaluation of health status of clients or their families. Through the use of self-report measures, analyses revealed significant improvements in individual mental health. For example, reported symptoms of depression (feeling sad for more than three days) were down six percentage points ($p<.01$). No changes were found in either overall family functioning or youth behaviors. Surprisingly, the study reported statistically significant changes in educational outcomes after only six months of operation. The average GPA of clients increased from 2.08 to 2.15 ($p<.05$), a small but reliable increase. Interestingly, children with the lowest grades showed better than average improvement and program sites with an explicit focus on educational outcomes showed greater improvements in GPA than sites with other primary goals. These results should be reported cautiously due to the threat to internal validity present in this type of study design.

Wagner, Newman and Golan (1996) repeated their evaluation to follow-up on the preliminary outcomes found after the first year of operation. This follow-up study focused on the same process and outcomes variables of their prior study. It used multiple statistical tools to evaluate the data, including cross-tabulations, t-tests and multivariate analysis to separate the

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was a long-term effect of early treatment on cognitive development and academic achievement.

effects of multiple interrelated variables. Results revealed statistically significant reduction in household need (housing, food, clothing, etc.) among the program's clients and improvements in employment status were also improved. In terms of access to healthcare, statistically significant increases in access to preventive health care continued from the earlier results. Reductions in reported mental health concerns also continued from the first evaluation, although they did not significantly improve from the initial follow-up. With regard to educational outcomes, students continued to show small, but statistically significant improvements in overall GPA. In addition, multivariate analysis was used to investigate the effects of several interrelated independent variables on these results. Through this analysis, it was found that younger children, and children with the lowest grades, showed the greatest improvement in overall academic achievement.

In sum, these two initial evaluations of the Healthy Start network report cautiously optimistic results for school-based and school-linked prevention services. They also highlight some of the methodological difficulties in creating and implementing uniform outcomes based accountability evaluations. The scope of these prevention programs is quite broad in terms of the services that are offered, the primary goals the program is seeking to attain, and the target client populations they are designed to serve. This flexibility allows local education agencies to design programs that fit the needs of their specific community, but make cross program comparisons difficult.

The crisis facing the nation's schools and the importance of prevention and early intervention is clearly delineated in the practice literature and acknowledged by professionals. San Mateo County is developing promising solutions to this crisis with their three school-linked service programs. Their interest in assessing the outcome-based accountability of these

programs is pioneering considering the general lack of empirical research in this area. Currently, support for the efficacy of these programs must be inferred from the existing literature concerning school readiness and literacy learning. San Mateo County's evaluation efforts will contribute significantly to the empirical research in this area. The remaining section of this report will outline how this evaluation will be carried out. First, it provides an overview of outcome-based research to provide readers with sufficient understanding of the general evaluation process to consider the county-specific recommendations made in the final portion of the report.

Overview of the Program Evaluation Process

Program managers and staff routinely conduct informal assessments of their programs through inquiries about their program's effectiveness. Areas of concern often center around client benefit, client satisfaction, and the adequacy of staff training and skills. Typically, managers evaluate their programs in order to identify ways the program or service delivery system could be improved. Evaluation research is a systematic method used to discover whether or not informal assessments are supported by empirical evidence. This is accomplished by collecting and analyzing data on specific indicators of a program's performance. These indicators are chosen by their relationship to the program's identified goals and should be supported in the literature (Administration on Children, Youth and Families, 1996). When assessments are conducted rigorously, the evaluation is said to have good validity, which means that the indicators chosen for measurement actually represent the goal they are meant to represent. Another hallmark of high quality research is reliability. Reliability refers to obtaining similar results if the evaluation was conducted multiple times, or by multiple individuals.

In general, there are two types of program evaluation that agencies may conduct to assess the effectiveness of their programs and services. The first, and more rigorous, is called 'in-depth, ad-hoc evaluation'. With this type of evaluation, agencies are able to identify the impact of their services as well as the cause of their outcomes. Unfortunately, in-depth, ad-hoc evaluations involve an intense time commitment and are usually conducted at high costs to agencies. The second type of program evaluation is commonly referred to as 'regular outcomes measurement'. With this approach, agencies are able to track program outcomes on a regular basis. The benefit of this type of evaluation is that it can provide timely feedback to workers and managers and can offer insight on how to make programmatic improvements. It does not,

however, provide information on which program activities or policies caused particular outcomes. Despite this limitation, regular outcome measurement is the type of evaluation research that is most often used in human services due to its cost efficiency (Mullen & Magnabosco, 1997). Regardless of which type of evaluation is used, the assessment process can help program administrators and policymakers identify and implement necessary improvements. Thus, evaluation research may be considered an essential component of human service programs, social policy changes, and public administration movements (Rossi & Freeman, 1985).

Regular outcomes measurement evaluation focuses on a program's stated objectives. Typically, two types of program objectives may be identified: program implementation objectives and participant outcome objectives. Program implementation objectives refer to the planned activities of a specific program, how the activities will be implemented, and who is intended as the consumer. They include the services or training that will be implemented, the characteristics of the participant population, the number of people expected to be reached, the staffing arrangements and training, and the strategies for recruiting program participants. Evaluating program implementation objectives is often referred to as a process evaluation (Administration on Children, Youth and Families, 1996).

Participant outcome objectives describe what is expected to happen to participants as a result of a specific program, with the term "participants" referring to agencies, communities, and organizations as well as individuals. Participant outcomes objectives typically aim at changing participants' knowledge, attitudes, behaviors, or awareness. Evaluating a program's success in attaining its expectations for participants is often called an outcomes evaluation (Administration on Children, Youth and Families, 1996).

Evaluation benefits and limitations

An outcome evaluation can highlight various mechanisms of a program's operations. It can validate the hard work that has been invested toward accomplishing a program's purpose and it can demonstrate how a program is achieving its intended goals and desired results. Thus, the clients, the agency, and the community will be better informed about the effectiveness of a program.

An outcome evaluation also may highlight gaps in certain areas of practice or management. A lack of associated outcomes to that of the goals of a program might be discovered. Uncovering this discrepancy in a program is very important as program administrators then have the opportunity to change their mode of practice in order to reach agency goals. In addition, offering a program to clients that is not effective may be harmful, unethical, and a waste of resources. An outcome evaluation also may uncover the use of inappropriate tools to measure outcomes. Thus, a program might be effective, but unable to demonstrate its effectiveness because of poor measurement tools.

Another possible finding of an outcome evaluation is that the program is not flawed in its implementation or administration, but the program is disoriented in its design. A design problem needs to be uncovered quickly so that a program may be restructured. This is another important reason why program evaluations need to be part of a program from its inception. Program evaluations may be designed to answer an array of questions about a specific program's design, implementation, administration, and/or effectiveness. Thus, evaluations can be used to guide new programs or to fine-tune established programs (Administration on Children, Youth and Families, 1996).

A program evaluation, in itself, is not intended to change the course or success of a program. Evaluation research provides an opportunity for ongoing assessment and feedback. If program managers desire a change in a program, they must implement program changes. Managers who change program practices mid-course should consult with the evaluation specialist as any changes to programs will affect the ways the process and outcome objectives may be assessed. Indeed, too many changes to a program too soon may sacrifice the ability of the program to demonstrate any program outcomes in a systematic manner.

In addition, evaluation needs to be conducted early in a program and in an ongoing manner. A program evaluation can give suggestions regarding how an agency can attempt to remedy a specific problem. However, the agency will need to secure the financial, technical, political, and human resource commitments that might be needed in order to implement evaluation recommendations (Mullen & Magnabosco, 1997).

Conducting an effective evaluation

In order for an outcome evaluation to be an accurate representation of the operations of a specific program, agency involvement is essential. The agency's role involves supplying data to the evaluation researcher and direct contact with the researcher for full descriptions of program goals, objectives, and outcomes. An agency's investment and participation in the evaluation will benefit the agency with a better understanding of it's own functioning. Thus, it is in an agency's best interest to guide, participate in, and learn from an outcome evaluation.

Evaluation research requires a structured and consistent method of collecting and analyzing information about a program. Following the guidelines outlined below will help to ensure that the evaluation is conducted in a systematic manner (Administration on Children, Youth and Families, 1996):

Step 1: Assemble an evaluation team. Planning and executing an evaluation should be a team effort. Even if an outside evaluator or consultant is hired to help, members of the staff of the agency should be partners in the evaluation effort.

Step 2: Allocate time and resources to properly prepare for the evaluation. This planning phase includes deciding what to evaluate, building a program model, stating objectives in measurable terms, and identifying the context for the evaluation. Program evaluation activities should be incorporated throughout a program starting when a program begins in order to measure progress toward program goals and address insufficient progress early. Evaluation should not begin when a program is near its end because opportunities will have been missed to collect important baseline data and because it is often too late to apply the lessons that the evaluation offers.

Step 3: Develop a comprehensive and realistic evaluation plan. An evaluation plan is a blueprint or a map for an evaluation. It details the design and the methods that will be used to conduct the evaluation and analyze the findings. The evaluation plan ensures that appropriate data can be gathered to document a program's efficacy. Evaluation activities should not be implemented until an evaluation plan has been completed and approved by the evaluation team.

Step 4: Collect evaluation information. Once an evaluation plan is completed, it is appropriate to begin collecting the specified data.

Step 5: Analyze the evaluation information. After evaluation information is collected, it must be organized in a way that allows it to be analyzed. Data analysis should be conducted at various times during the course of the evaluation to allow agency staff to obtain ongoing feedback about the program. This feedback may strengthen confidence in the agency's activities or identify areas where changes may be needed.

Step 6: Prepare the evaluation report. The evaluation report should be a comprehensive document that describes the program and provides results of the data analysis. The report also should include an interpretation of the results for understanding program effectiveness with regard to the program's goals.

For the next several pages, this six-step process will be applied to the specific evaluation needs of San Mateo County, with special attention paid to implementation and utilization issues.

Recommended Techniques for Implementing a Comprehensive Evaluation Plan in San Mateo County

In the previous section, a framework for developing and implementing a comprehensive outcome-based program evaluation was outlined. In this section, this framework is applied to the specific prevention programs operated as a part of San Mateo County's prevention services to vulnerable children and their families.

Step 1: Assemble an evaluation team to identify program goals and plan evaluation procedures

San Mateo County already has begun this part of the evaluation process by commissioning this report outlining the steps necessary to implement and utilize an outcome-based evaluation. Whether this plan is implemented internally or externally (or a combination of the two), it is important that it remain a team effort throughout the process so that necessary decisions and modifications are made with input from all key stakeholders. Staff commitment to this effort will greatly enhance both the process and the outcome of the evaluation plan. Ideally, this team should consist of county personnel, program administrators and direct practice representatives, in addition to the primary researcher(s) who is coordinating the evaluation effort. The coordinating role for implementation of the evaluation plan can be done internally, within the San Mateo HSA, or externally, by contracting with an independent research group. There are pros and cons with each approach that should be considered when the evaluation team makes this decision.

When considering how to conduct the evaluation plan, the evaluation team should consider the impact of their choice on staff time, program resources, and the ultimate goal of the evaluation effort. An independent research group brings their expertise to the project. Therefore, this approach would likely require less of a time commitment from County and

program staff. It should be considered, however, that this approach would be more costly and would still require the county to play a coordinating role to facilitate the research process.

If the county's goal for this evaluation effort is to implement an on-going evaluation that can document effectiveness on an annual, or multi-year basis, coordinating internally may be a more practical choice. While start-up for this endeavor may require more staff time and energy, routine implementation should not be problematic and can be incorporated smoothly into ongoing program operations. The data collection procedures suggested in this section are designed to easily be incorporated in the daily running of each program, but it will be important to give the programs time to implement the selected data collection tools. Additionally, the HSA will need time to develop a centralized location within the county to collect, analyze and report the data from each program. Once these mechanisms are in place, the evaluation can be repeated each year with little additional work for the County or the prevention programs.

Whether the evaluation is implemented internally or externally, the first step is to establish the program goals to be measured. The predominant goals that already have been identified by San Mateo's family support programs are kindergarten readiness and third grade literacy. The services provided in support of these goals fall into three categories: stabilizing socio-emotional health, skill-building and family stability/basic needs provision. These three categories of service are common secondary program goals because it is through these services that kindergarten readiness and third grade literacy are promoted. Therefore, these outcomes should be measured as part of a comprehensive evaluation plan of school-linked prevention services in the county. In order to maximize the success of the evaluation plan, program goals should be written in measurable terms. See Figure 5 for an overview of the recommended

evaluation plan and program goals. For an evaluation of San Mateo's school-linked family support programs, consider the following measurable program goals:

> Kindergarten Readiness: As a result of the program's kindergarten readiness activities, students will possess sufficient academic knowledge and skills before they begin formal schooling. This outcome will be demonstrated by a minimum score of _____ on the Lollipop Test of School Readiness. Students will also be socially ready to start kindergarten as demonstrated by a minimum score of _____ on a survey filled out by the child's parent/guardian, and a minimum score of _____ on a survey filled out by the child's teacher.
>
> Third Grade Literacy: As a result of academic skill-building activities such as tutoring and enrichment classes, students with a demonstrated deficit in academic achievement in kindergarten through second grade will achieve third grade literacy. This outcome will be demonstrated by a minimum score of _____ on the SAT 9 and their primary classroom teacher will rate the child at grade level in literacy skills.
>
> Socio-Emotional Health: Students will demonstrate sufficient ability to participate in classroom activities and complete educational tasks, without undue impairment from mental health issues, as demonstrated by a minimum score of _____ on the chosen assessment tool for the socio-emotional health of children (such as the SCRS).
>
> Skill-building activities: Students will be proficient in the subject matter of the intervention as a result of program activities as demonstrated by a minimum score of _____ on the selected activity-specific assessment tool.
>
> Basic Needs: Client families will attain an adequate level of material stability through case management and provision of services and referrals as demonstrated by a score of _____ or above on the Department of Economic Opportunity Scale. Families will demonstrate an adequate level of interpersonal family functioning as demonstrated by a minimum score of _____ on the scale selected.

The outcome levels, or standards, which are adopted for these five outcome measurements, will come from a variety of sources and need to be specific to the populations being served by the three programs. For example, scoring information regarding the Lollipop test is available and may be used to set a uniform standard that children should attain before entering Kindergarten. But, for measures of socio-emotional health, the instrument might need to be administered to a random sample of students from the general school population in order to

get an average score to compare with the students receiving services. In addition, for third grade literacy, student scores on the SAT 9 could be compared to the school average. Each of these decisions must be made jointly by the programs and reflect realistic expectations of progress from baseline measurements.

Figure 5: Outcomes Measurement Tools by Program Goals

Goal	Measurement Tool	Timetable	Administered by:
(1) Kindergarten Readiness	Lollipop Test*	Pre-Test: entry into preschool/services. Post-Test: entry into Kindergarten.	Preschool teacher
	Intake Assessment (background variables)	Pre-Test: entry into preschool/services. Post-Test: conclusion of preschool/services.	Case Manager
	Parent/Teacher Survey (to be developed)	Pre-Test: entry into preschool/services. Post-Test: conclusion of preschool/services.	Case Manager
(2) Third Grade Literacy	SAT 9*	Annually, for second and third graders receiving services.	Second & Third Grade Teacher
	Teacher assigned grade level in reading*	Annually, drawn from final report card of each school year for students receiving services..	Kindergarten, First, Second & Third Grade Teacher
(3) Socio-Emotional Health	Behavior Scale* (e.g., SCRS)	Pre-Test: at time of referral for services. Post-Test: at termination of services.	Classroom Teacher
(4) Adequate Skill Level	Activity-specific assessment tool* (e.g., Power Hour Survey)	Pre-Test: entry into skill-building activity. Post-Test: conclusion of skill-building activity.	Case Manager
(5) Family Stability	Global Assessment Tool* (e.g., Department of Economic Opportunity Family Development Scale)	Pre-Test: entry into services. Post-Test: termination of services.	Case Manager

*An assessment tool for this outcome is currently being used by at least one program site.

Step 2: Allocate sufficient time and resources to properly prepare for the evaluation through the development of a support network for the evaluation team and the establishment of communication procedures

Each of the three programs under consideration involves collaboration with multiple partners and referral sources. Each of these partners needs to be aware of the evaluation effort and their potential role in collecting data or administering assessment tools to clients. Because the two goals that have been identified are educational outcomes, it will be especially important to include caregivers at preschool programs and kindergarten teachers in the evaluation effort. In addition, outreach activities would enhance the county's ability to communicate the purpose and process of the outcome evaluation to stakeholders and secure the support of these key individuals.

Successful implementation of any evaluation plan requires communication between program staff at each site, as well as between program managers and direct service workers (and individuals responsible for data collection and analysis). While each program will be particularly interested in the service outcomes experienced by its clients, it will be necessary to aggregate the findings across programs in order to determine the county's overall progress toward its primary goals. The merging of data across programs involves establishing a main point of contact for all three programs where data are collected, analyzed, and stored on a consistent basis. (Refer to Step 1 for discussion of external v. internal coordination of the evaluation plan.)

Step 3: Develop an evaluation plan which is rigorous and workable

As was discussed earlier, there are some methodological difficulties associated with cross-site evaluations. These difficulties represent significant threats to the internal and external validity of the results. In order to strengthen the validity of the study, the following four

principles should be kept in mind when implementing any evaluation plan: the use of culturally sensitive assessment tools and procedures, the inclusion of a comparison group, the use of multiple forms of assessment with young children, and the use of uniform assessment tools across program sites.

Utilize culturally sensitive assessment tools and procedures. Whenever possible, clients and their families should be served and assessed in the language that is most comfortable for them. The measurements attained in this manner will more accurately reflect the true abilities of the clients, and will not be skewed as a result of a language barrier.

Include a comparison group. Rigorous outcome evaluations typically include randomly assigned experimental and control groups. Because this outcome evaluation plan is meant to be integrated into the daily operation of these three targeted programs, this most rigorous design may not he feasible. With enough clients eligible for inclusion in the sample, it may be possible to randomly or systematically select cases for inclusion in the experimental group. This type of selection technique helps to reduce potential bias in the sample. Often, however, programs need to include all clients receiving services in order to have a large enough sample to conduct statistically reliable analysis.

An additional method of improving the evaluation design is to collect data for a non-equivalent, or comparison, group to provide a comparison to the children receiving services. The non-equivalent group would be composed of children and their families who are not receiving services from the program, but who are substantially similar to the clients receiving program services. It would be important that those included in the comparison group be similar in such areas as gender, age, ethnicity, socio-economic status, academic functioning, and family composition, among other variables. The same data would be collected for this group as for the

experimental group and the results would be compared. Without random assignment of subjects to each of the groups, it is impossible to know if the groups are truly equal, but the inclusion of the comparison group can strengthen the design of the evaluation, especially when subjects include young children who mature rapidly. If changes are found in the treatment group and not in the comparison group, more confidence may be afforded to the conclusion that the services influenced the change and results were not just the result of maturation or some other intervening variable.

Use multiple assessment tools with young children. The first eight years of life offer several assessment challenges to program evaluators. Children in this stage develop rapidly and sporadically in terms of their physical, motor and linguistic abilities. Additionally, their development is highly influenced by environmental factors such as home environment, parenting style, and the setting in which the assessment is conducted. For these reasons, assessments of very young children need to include multiple measures. The National Educational Goals Panel (NEGP-1998) generally recommends including the following three forms of assessment when evaluating very young children: (1) social indicators; (2) caretaker assessment of child; and (3) direct measures. This global assessment approach tends to result in more valid and reliable results concerning children's skills.

In the context of measuring children's abilities, social indicators refer to the level of learning support experienced in their daily home and school lives. Home factors included in this measure could include household income, parent education level, family size, and immunization record. School factors could include the number of years of preschool attendance as well as participation in additional services. Direct measures, such as standardized tests, are efficient in terms of administration time and resources needed, and are quite useful when attempting to

make comparisons between groups of children or mark progress in a particular area. With regard to assessing young children, however, they are insufficient as sole instrumentation. Any point-in-time measurement is suspect because of the variability in performance which is considered normal for this age range of children. Although the NEGP concedes that direct measures can be used with children as young as three, they caution that results are considered more reliable after the age of five. Standardized quantitative tests should be augmented with background variables like the ones mentioned that describe the context in which the children are being raised, as well as the assessment of parents and teachers who interact with children on a daily basis. These background variables could be incorporated into the intake assessment already conducted by each program and the teacher evaluation could be included in the referral procedures. Researchers could then conduct a chart review to collect this data.

Utilize uniform assessment tools across all programs. In order to compare results across programs and measure the county's overall progress toward its goals, it is imperative that each site use the same assessment tools and administer them at the same time and in the same manner. This procedure will enable evaluators to draw more reliable conclusions about the programs as a whole, as well as to highlight similarities and differences among the programs. The following measures for each of the county's goals are consistent with the recommendations outlined in this report and meet high quality standards of validity and reliability for the assessment of young children. See the Appendix for copies of the recommended assessment tool described below.

With regard to *kindergarten readiness*, a comprehensive evaluation of a child's readiness for formal school would involve three distinct assessment tools: (1) a direct measure; (2); an assessment by the parent/primary caretaker; and (3) an assessment by the preschool teacher.

The Lollipop test is a standardized direct measure of school readiness already in use in Daly City. The test is individually administered and consists of four subscales: (1) identification of colors and shapes, and copying shapes; (2) picture description, position and spatial recognition; (3) identification of numbers, and counting; and (4) identification of letters and writing. Another commonly used measure is the Metropolitan Readiness Test, which is designed to measure readiness for first grade. In one longitudinal study, Chew and Morris (1989) measured the long-term predictive validity of the Lollipop Test and the Metropolitan Readiness Test. Each measure was administered at the end of kindergarten to a sample of 246 children. When the children reached fifth grade, their scores on the Lollipop Test were correlated with their performance on the Stanford Achievement Test (SAT 9) and teacher assigned grade level in math and reading at the end of the year. Both measures significantly predicted children's later achievement. The Lollipop Test, however, was a slightly stronger predictor of later achievement than the MRT and takes approximately 1/5 the time to administer, making it the more efficient instrument.

Because it is already familiar to program staff, it is relatively easy to administer, and it has strong documented predictive value of later academic achievement, the Lollipop Test should be adopted by all three of San Mateo's programs. It should be administered to children when they enter preschool (by the preschool teacher) or to preschool-age children when they enter services (by the case manager) if they are not currently enrolled in a preschool. Ideally, this test would be administered at the beginning of the school year to all preschool children and then again at the beginning of kindergarten. Administering the test to all children, not just those receiving services, produces a non-equivalent comparison group.

To augment children's performance on the Lollipop Test, a comprehensive assessment of kindergarten readiness could include measures completed by children's primary caretakers as well as preschool teachers. These measures ideally should include assessments of children's readiness socially, emotionally, physically and cognitively. The Daly City Partnership is currently using one such measure, which is filled out by the child's parents/primary caretaker. An additional guide to school readiness decisions, which was developed by Smith and Strick (1997), has been included in Appendix. While no standardized test with demonstrated reliability and validity exists, this checklist illustrates the kinds of areas of children's development that need to be considered when determining school readiness. Whichever measurement tool is chosen by the County, all three programs should use it.

For the goal of *third grade literacy*, a comprehensive assessment of children's reading level in the third grade should include two measures: (1) a norm-referenced standardized test; and (2) a teacher assigned grade level in reading at the end of the year.

The Stanford Achievement Test, or SAT 9, is a norm-referenced standardized achievement test adopted state-wide in California as the measure by which schools are held accountable for children's education. The test is administered annually to all students from 2nd-12th grades and requires an investment in time and resources for each school to administer. Because of the documented validity and reliability of this test, as well as its widespread use, it is reasonable to use in San Mateo as a test of children's general reading and writing ability. The scores of students receiving services should be collected from their 2nd and 3rd grade years. These scores can be compared to the overall average performance rating for the school for comparison. Testing children in 2nd and 3rd grades also will capture any measurable improvement over the course of the year of service.

Because the SAT 9 is not administered to children in kindergarten or first grade, teacher assigned grade level in reading can be used as a proxy in charting the literacy progress of children receiving services. Once standardized testing is available, teacher assessments of grade level can still be used to provide a more complete picture of children's literacy achievement with regard to their grade level.

With regard to *socio-emotional health*, conducting a complete psychological battery for each child receiving services would be prohibitive to the county in terms of time and money. Instead, it is recommended that an indirect measure of the children's socio-emotional health, completed by parents or teachers, may be used. It is common for the socio-emotional health of young children to be operationalized in terms of behavior, and in this case, classroom behavior could be measured by a survey completed by the classroom teacher. The Healthy Start Network currently uses a Child Rating Scale filled out by the teacher or Family Advocate to measure the child's classroom behavior and emotional health (see Appendix).

An additional standardized measurement with tested validity and reliability, the Self-Control Rating Scale (SCRS), is included in the Appendix. The SCRS is a 33-item survey which rates children's behavior on a 7-point Likert scale, and is designed to measure children's ability to monitor their behavior as opposed to acting impulsively. The survey is constructed so that lower ratings represent "more desirable" behaviors, while higher ratings signify "less desirable" behaviors. In pilot studies conducted by Fisher and Corcoran (1994), the measure demonstrated high reliability ratings and good construct validity with other measures of children's ability to exhibit self-control.

A limitation of operationalizing socio-emotional health in this way is that it only measures one type of behavior (acting out), and may not capture behavior changes in children

who may be emotionally withdrawn. The strength of this definition, however, is that it captures behavior problems which are more likely to be reported by teachers as disrupting the learning environment in the classroom. The behavior rating should be completed by the primary classroom teacher at the beginning and end of each school year in which children are receiving county services.

In order to measure the result of *skill-building activities*, an assessment tool would need to be developed which would capture the skills and/or knowledge that the client is supposed to gain from participation in the activity. This tool would be administered at the beginning and end of the activity. An example of this type of assessment instrument is the Power Hour Survey utilized by the FUTURES project to measure changes in student attitude, social skills, and behavior in school after participation in the Power Hour Classes.

With regard to the global assessment of basic needs, two distinct measurements should take place. The first would capture the ability of the program to assist client families in providing for their basic material needs (housing, employment, food, transportation, etc.). The second would be a measurement of the health of the interpersonal family functioning or the levels of support that exists for, and between, family members. As noted in the literature review, the level at which a child is supported educationally in the home has a profound influence on their self-conception as a learner and their literacy development.

The Healthy Start Network is already using a standardized measurement of basic needs outcomes which includes assessment of six specific standards: housing, food and clothing, transportation, finances, employment and children left without supervision. This measure from the Department of Economic Opportunity is called the Family Development Report and should

be adopted by all programs, to be completed at intake and termination of services. This assessment tool has been included in the Appendix.

The Healthy Start Network also uses a measurement of family functioning, the CBLA Family Assessment Form Guide (see Appendix) to assess the overall health of the family's environment and the quality of their supportive interactions. Although information on the reliability and validity of this measure was not available for this report, the measure appears comprehensive and uses a five point scale, where one represents the most desirable family functioning and five represents the least desirable family functioning. It also appears that completion of this scale would be useful in developing treatment plans for client services.

A variety of standardized scales are available in the literature for use in measuring family functioning. Several involve extensive observation in the child's home environment, which may not be feasible in the context of this evaluation effort. One self-report measure is worth including here because it specifically measures the ability of the home environment to support children's intellectual and academic achievement. The Henderson Environmental Learning Process Scale (HELPS) is a 5-point, 55 item Likert-type instrument with high interrator reliability (see Appendix). Subscales of the measure include educational expectations, level of stimulation in the environment, parents as teachers, presence of a variety of educational and occupational role models and the type of reinforcement experience in the home with regard to academics.

Step 4: Collect evaluation information.

Develop an appropriate timeline for data collection. As stated earlier, this plan is meant to be integrated into the daily operation of the program. A realistic timeline would need to begin with a period of time for staff training on both the purpose and the process of the data collection.

A uniform protocol regarding when and how the data will be collected in each program will streamline the process and increase the reliability of the results. Assuming that the County plans for this to be an ongoing evaluation, data would need to be collected, analyzed and reported annually to track effectiveness of prevention services provided through the three programs.

Collect Demographic Data. Basic demographic information that describes program participants can be used to analyze evaluation results. Categories of data to consider collecting are gender, age, ethnicity, single parent/two parent family, household income, parent education level, health insurance, and preschool attendance. These items of data may be easily assessed through client intake files. In analyzing the data, one might find that children participating in kindergarten readiness activities through one program are scoring higher on the standardized test of academic readiness than children participating in another program activities. Or perhaps it is observed that across all programs, families with the lowest socio-economic status are consistently scoring lowest on all measures, indicating a need for more intensive services. While the evaluation does not tell why this is, it does contain information about the trend, which can direct information sharing and program modifications designed to address this discrepancy.

Collect data at intake and termination. Uniform intake and termination forms filled out by the primary service provider in conjunction with the client family will provide important baseline and follow-up information for the purposes of the evaluation.

Utilize a pre-test/post-test evaluation to measure client outcomes. In order to document children's progress in a particular area, it is necessary to take a baseline measurement when they are referred for services and later administer the same measurement at termination. This approach combined with the inclusion of a comparison group strengthens the ability of the

evaluation to infer that changes in behavior, skills, or knowledge are a result of the intervention and not merely the result of maturation.

Step 5: Analyze the evaluation information. Data from an outcome evaluation are entered into one of the commonly used social science statistical software programs, such as SPSS or SAS, for analysis. From a review of the results of this statistical analysis, the findings of the study can be interpreted and reported.

Step 6: Prepare the evaluation report.

Present findings to all stakeholders. Raw data from the evaluation should be compiled and summarized in such a way as to make it accessible to the key stakeholders in program outcomes. These stakeholders may include policy-makers, program managers and direct service workers as well as parents, school administrators, teachers and members of the larger community served by the program or the school with which the program is linked. Establishing the mechanisms through which evaluation results will be disseminated to these key stakeholders will be the responsibility of the evaluation team. These decisions should be made early in the evaluation process so that the results can be utilized most effectively by program administrators, policymakers and practitioners.

Challenges in Implementation

There are certain challenges inherent to implementing any comprehensive evaluation plan. In this section potential barriers to evaluation are highlighted so that solutions may be sought early in order to facilitate an effective evaluation. The county can expect to face barriers in the implementation of this evaluation plan, as well as barriers in relation to interpreting the results. With regard to implementation issues, special attention will need to be given to staff preparation, access to preschool programs and preschool children in order to collect data, and

ensure culturally competent assessment practices. When interpreting the findings, the county will need to be aware of reliability and validity issues in relation to the assessment tools used, and be cautious regarding drawing conclusions from the results of the statistical analysis. Outcome evaluations are able to illustrate association but may not be able to determine causal relationships. Despite these very real barriers, the County should feel confident that their evaluations efforts can be successful and the results will provide a useful guide to both program administrators and practitioners.

Whenever a new evaluation effort is implemented, concerns may be raised by direct service staff as well as program management. Practitioners often are concerned about the amount of time evaluation efforts will take and the impact on their workload. In addition, they may express concerns regarding how to accurately capture client progress and how evaluation information will be used. Program managers may be concerned about definitions of "success" in relation to program goals and outcomes, and the ability of the evaluation plan to provide useful information from which to make programmatic decisions. By spending time at the beginning of the evaluation's implementation to educate staff regarding the purpose, process, and importance of outcome evaluations, many of these concerns can be addressed. In addition, establishing a procedure for feedback with regard to the evaluation effort can provide ongoing support to the staff who are involved in data collection and assessment on a regular basis. The evaluation team will be crucial in involving managers and practitioners in the decision-making process and responding to concerns as they arise.

A second implementation issue is getting access to the children that the program wishes to serve and assess, before they enter a formal system, such as the education system. In order for this effort to be highly successful, each program must align themselves with the preschool

programs in the county in order to identify students at-risk in time to get a baseline measurement and provide the appropriate prevention and intervention services. Even more difficult than collaborating with the county's many preschool programs, is the issue of reaching out to children who are not attending preschool. It is these children that the literature suggests are at-risk of poor academic achievement in early elementary school, making their identification even more important.

Cultural issues also will require special attention in this evaluation effort. The literature identified English language learners as vulnerable to low academic achievement in early elementary school. Assessment procedures and tools should be administered in the language most comfortable to the client whenever possible. Many agencies face a shortage of bilingual staff and translation services, making this a hardship. Every effort should be made in this area in order to provide for a more accurate assessment of the skills and functioning level of these client families.

With regard to interpreting the results, it is important to reiterate here what an outcome evaluation can and cannot tell about a program. First, the results of an outcome evaluation are dependent on the quality of the assessment tools that are chosen, specifically their reliability and validity. If chosen carefully, and uniformly administered across program sites, the instruments indeed measure what we want them to. For example, we want to feel confident that the assessment tool we have chosen accurately tells us how proficient a given child is in his/her reading ability. Whenever possible, an instrument with proven validity and reliability has been recommended. In other instances, it is recommended that existing tools be tested prior to formal adoption and distribution.

Although each of the challenges described are real, they will generally be faced during the start-up portion of implementing the evaluation plan. Once the plan is fully integrated into program operations, it should be able to run smoothly, with minimal modifications on an annual basis. San Mateo's interest in unifying evaluation efforts across school-linked family support programs provides a unique bridge to foster communication between social services practitioners and school-based educators, through the accurate and knowledgeable involvement of a program evaluation. The information gained from a comprehensive evaluation of the Redwood City and Daly City programs will provide administrators and program staff with important findings needed to effectively serve these vulnerable families.

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Appendix

School Readiness Checklist

Is Your Child Ready for School?

If your child can do many of the tasks on this checklist before beginning kindergarten, he or she is well on the way toward school success. The remaining skills need to be developed during the Kindergarten year in order to promote success in the first grade.

- ❑ Sings the alphabet song
- ❑ Recognizes and names alphabet letters
- ❑ Identifies words that rhyme; adds a rhyming word where appropriate in a story
- ❑ Identifies whether dictated words begin with the same or different sounds
- ❑ Claps to the number of syllables heard in a word
- ❑ Recognizes and names common colors, objects and body parts
- ❑ Tells full name, address, telephone number and birthday
- ❑ Comprehends age-appropriate vocabulary and stories
- ❑ Recites familiar nursery rhyme
- ❑ Completes sequences (e.g., breakfast, lunch, _____; yesterday, today, _____)
- ❑ Completes analogies (e.g., in daytime it is light, at night it is _____; birds fly, fish _____)
- ❑ Can respond to various question forms, such as how many, which, where, whom, what, why, what if
- ❑ Expresses opposite relationships ("How are a spoon and a glass different?")
- ❑ Tells simple stories that contain several characters interacting
- ❑ Follows two-and three-step simple directions, such as "Put on your boots, get your jacket, and get in the car"
- ❑ Succeeds at simple concentration-type games requiring matching pictures form memory
- ❑ Recognizes name in writing
- ❑ Prints his or her name
- ❑ Recognizes some common signs or labels by their shapes (McDonald's, Coca-Cola)
- ❑ Sorts and names objects by category: food, clothing, animals
- ❑ Recites and recognizes numbers up to ten
- ❑ Counts groups of objects, to ten or more
- ❑ Matches equal sets of objects, such as three triangles being the same amount as three circles
- ❑ Points to positions in a series: beginning, middle, end; first, second, last
- ❑ Recognizes and names common shapes such as circles, squares and triangles
- ❑ Copies designs: circle, cross, square, X, triangle
- ❑ Copies letters and simple words
- ❑ Draws recognizable house, person, tree
- ❑ Cuts out picture fairly close to edge
- ❑ Dresses self fairly independently
- ❑ Ties shoes
- ❑ Uses fork and spoon appropriately; cuts soft food with knife
- ❑ Usually finishes age-appropriate activities (such as a puzzle, listening to a short story, making an object out of clay) rather than abandoning activities in the middle
- ❑ Develops friendships and plays cooperatively with other children

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CBLA Family Assessment Form Guide

I. ENVIRONMENT

A. Physical Environment

1. CLEANLINESS/ORDERLINESS — OUTSIDE HOME

Refers to litter, garbage, feces, vermin, clutter and odors around exterior of home. Assesses health hazards, physical neglect issues, and impact of physical environment.

1 above average; feels like a place you want to visit

2 adequate; clean; orderly; no health hazards; feels comfortable

3 borderline; mild odors; lots of litter; lots of clutter around yard and house; looks junky; feels like you want to pick up and organize

4 always smelly; wet and dry litter and garbage; potential health hazards; feels quite uncomfortable

5 intolerable odors; overflowing trash bins/barrels; rotting food; attracting flies; definite health hazards; not a place you want to visit or be

2. CLEANLINESS/ORDERLINESS — INSIDE HOME

Refers to litter, garbage, cleanliness, feces, vermin, clutter and odors in home. Does not refer to cleanliness of people in home. Assesses health hazards, physical neglect issues, and impact of physical environment.

1 above average; very clean; inviting; pleasant place to be

2 adequate; clean and basically neat

3 borderline; lots of clutter, trash, full garbage bags; noticeable but tolerable odor; disorderly; generally not clean; could be improved with a couple of hours of work; occasional roach problem

4 food particles on floors, tables, chairs; dirty diapers laying around; consistent odors; stained furniture, grease and grime on walls; cobwebs; potential health hazard; roaches; feels very uncomfortable

5 feces (animal or human) on floor; rotting food; overflowing garbage; intolerable odors causing difficult breathing; filthy in all areas; multiple vermin; urine-soaked furniture; sticky floors; hesitance about entering or sitting down

3. SAFETY — OUTSIDE HOME

Refers to condition of building's exterior in terms of danger, thoughtfulness as regards to safety precautions and organization. Assesses environmental stressors.

1 above average; extra safety precaution provided

2 adequate; some basic safety precautions taken; no problem

3 generally disorganized exterior; cracks in walls; cracked windows; trash bins, old freezers, etc. carelessly placed

4 many broken windows in child's reach; rotting floors and walls

5 extremely dangerous; holes through walls; missing steps; broken glass in hallways and play areas; many windows broken; dangerous junk all around, i.e., rusting metal, sharp tools, matches

4. SAFETY — INSIDE HOME

Refers to condition of building's interior in terms of danger, functioning and safety of plumbing, electricity and gas; thoughtfulness as regards to safety precautions and household organization. Assesses environmental stressors.

1 above average safety precautions taken; poisons and medications locked; outlets plugged; plans for emergency situations

2 no danger to child(ren); minor cracks in floors, walls, windows; poisons and medications out of reach but not locked; most precautions taken

3 one broken window out of child's reach; mold or wet spots on walls; poisons and medications out of sight but within reach of child(ren); overloaded outlets; plumbing problems; few precautions taken

4 many broken windows in child's reach; rotting floors or walls; poisons and medications visible and accessible; broken glass on floor; no hot water; wires frayed; no screens on 2nd floor windows for toddlers; generally not safe

5 extremely dangerous; holes in walls; no or non-functioning plumbing; no electricity; many hazards within reach; guns; hunting knives; street drugs; open medication bottles

5. APPROPRIATE PLAY AREA/THINGS — OUTSIDE HOME

Refers to adequacy and safety of play area; number and condition of playthings; age appropriateness or developmental appropriateness of playthings.

1 planned outside play area with swings, etc.
2 unfenced grassy area; safe
3 small; only concrete; littered with hazards
4 only play area is parking lot, driveway, or street
5 no place to play; no access to park, school yard or recreation center

6. APPROPRIATE PLAY AREA/THINGS — INSIDE HOME

Refers to adequacy and safety of play area; number and condition of playthings; age appropriateness or developmental appropriateness of playthings.

1 lots of age appropriate learning toys in very good condition
2 some age appropriate toys for each child
3 only broken toys available; secondhand toys; no age appropriate toys; only about one toy for each child
4 no toys; only household and found items
5 nothing to play with; or inappropriate/potentially dangerous items used as toys

7. ADEQUATE FURNITURE

Refers to amount of furniture and whether or not it meets the needs of the family; also refers to condition of the furniture.

1 above average; all new or in excellent condition
2 adequate furniture for family needs; functional
3 sparse furnishings; furniture is old and dirty; overcrowded with furniture
4 child(ren) sharing beds; parent and child sharing bed; sleeping on couches, or sleeping on floor; missing furniture but may have luxuries; no furniture in some rooms; broken nonfunctional furniture
5 missing necessities; nothing to sit on; one bed for whole family

I. ENVIRONMENT

B. Family Finances

1. FINANCIAL STRESS

Refers to degree of financial stress experienced by family regardless of income. Contributing factors might include unemployment, high debts, inadequate income (AFDC), minimum wage, etc.

1 no stress; money not an issue; enough money to meet responsibilities and spend on leisure activities; no employment worries
2 minor stress; manageable debts; some limitations on luxuries but not on necessities
3 consistent worry; just making ends meet; living on AFDC; income equals debts/bills; minimum wage job; working poor
4 very stressful; frequently running out of money; unmanageable debts; unable to stay current on bills/debts; employment worries; suffering emotionally due to stress
5 extremely stressful resulting in emotional and/or physical health problems; creating significant conflicts in relationships; seems hopeless; no light at the end of the tunnel

2. FINANCIAL MANAGEMENT

Refers to ability to plan, budget, organize, and spend money wisely and responsibly.

1 above average; good at bargain hunting; plans in a way that gets best value for money
2 manageable debts; planned use of money
3 no plan for use of money; occasional impulse buying; doesn't deprive child of necessities but problem if there were an emergency
4 in debt over their heads; irresponsible spending; buys luxuries rather than necessities; no budget; loses money
5 without necessities; frequently broke; betting or gambling

3. FINANCIAL PROBLEMS DUE TO WELFARE SYSTEM/CHILD SUPPORT

Refers to financial problems that result from errors, delays, etc. in welfare system that are out of client's control.

1 not financially dependent on welfare system or child support
2 isolated problems that are quickly resolved or no problems
3 regular problems with eligibility worker or ex-spouse
4 irregular or late AFDC, Medi-Cal or food stamps; child support sporadic
5 severe problems; little hope of resolution; causes extreme financial difficulties for family; canceled aid; not eligible; other parent provides no child support

I. ENVIRONMENT

C. Social Supports

1. EXTENDED FAMILY SUPPORT

Refers to emotional, social, and concrete help provided by family. Also assesses positive or negative nature of the relationship(s).

1 family is positive influence and lives nearby
2 family is positive influence but lives far away.
3 minimal support; a few or one relative(s) nearby; emotional support but no concrete help
4 no extended family or no follow through on commitments
5 negative influence or effect by extended family involvement; more trouble than help

2. SUPPORT FROM FRIENDS AND NEIGHBORS, AND COMMUNITY INVOLVEMENT

Refers to involvement in society and community.

1 positive and present; active in community; regularly attends church or community functions
2 friends supportive but not near; some church and/or community involvement
3 one friend; talk, but no concrete help; goes to community resources in crisis
4 no friends; very limited social/community contact such as going to church on holidays
5 extremely isolated; negative impact or involvement; leaves home for necessities only

3. AVAILABLE CHILD CARE

Refers to availability, affordability, and adequacy of child care. NOTE: If caregiver says, "I never leave my child," question why: Past problems? Current resources?

1 available and affordable; relative or other person willingly provides good care
2 some difficulty finding and affording, but has adequate resources
3 caregiver not always available as needed; baby-sitter/relative/friend does it but complains; available and not affordable or affordable but not available
4 able to make arrangements with inconsistent, unreliable, or inappropriate people; can arrange in emergency; may have to leave child(ren) with stranger
5 none; no family, no friends, no neighbors, no child care, no money for it

4. CHILD(REN) HAVE OPPORTUNITY FOR PEER/SOCIAL CONTACTS OTHER THAN SCHOOL/SIBLINGS

Refers to parents' involvement in planning for, providing, and/or making possible peer contact for child(ren). Assesses isolation of child(ren). For school age children, assesses social contacts after school or on weekends. Rate item separately for children under 5 years old and those over 5 if applicable. Circle NA as appropriate.

Under 5 years old

1 regular planned contact for social interactions
2 some contact for short periods of time
3 limited, *e.g.*, one day a week sees cousins or friends, Saturday play group
4 very limited, *e.g.*, child care during church
5 no peer contact

Over 5 years old

1 regular contact and availability for social interactions
2 some contact for short periods of time
3 limited, *e.g.*, one day a week
4 very limited, *e.g.*, child care during church
5 no peer contact after school or on weekends

5. AVAILABILITY OF TRANSPORTATION

Refers to availability or access to a car, bus, or rides.

1 has car or regular access to car; no problem with transportation
2 has monthly bus pass; shares a car
3 convenient bus stop; can arrange ride as needed
4 no nearby bus stop; can't afford bus often; difficulty getting a ride
5 transportation unavailable

6. ABILITY TO MAINTAIN LONG-TERM RELATIONSHIPS

Rate caregivers 1 and caregivers 2 separately. Refers to quality, length and emotional support of adult-to-adult relationships including friends and partners (not of family origin).

1 lots of friends; no problem maintaining emotionally supportive relationship with occasional normal conflict but no enmeshment

2 has long-term friendship but no current intimate relationship or only intimate relationship and no long-term friendship but several social friends

3 a long-term conflictive relationship or multiple short-term partners; one close friend; few social friends

4 sporadic relationships within the past 1 1/2 years; one long-term conflictive relationship with no outside friends

5 no past or current intimate relationships; no personal friendships

II. CAREGIVER(S)

A. Caregiver(s) History

1. STABILITY/ADEQUACY OF CAREGIVER'S OWN PARENTING

Refers to stability, consistency/continuity and emotional adequacy of caregiver's own upbringing.

1 self worth and individualization emotionally supported and fostered; extremely consistent and stable caretaking

2 some instability but not enough to cause problems; adequate emotional support and nurturing

3 limited nurturing; traumatic loss of contact with one parent; physically or emotionally remote parenting; tenuous connection; somewhat conflictual parental relationship

4 little or no nurturing; changing parental figures; long-term parental absence; chronically tumultuous relationship

5 mainly raised in foster home(s) or institution(s)

2. CHILDHOOD HISTORY OF PHYSICAL ABUSE/CORPORAL PUNISHMENT

Refers to use of corporal punishment, severity, and physical abuse.

1 none

2 occasional spanking, not the routine method of punishment

3 spanking was regular method of discipline; occasional incidences of excessive corporal punishment

4 routine excessive corporal punishment; physical abuse; hit with fist or objects

5 life-threatening physical abuse; hospitalization

3. CHILDHOOD HISTORY OF SEXUAL ABUSE

Refers to degree of sexual abuse and present effect on person.

1 parents proactively taught self-protection skills

2 no exposure to inappropriate sexuality

3 some minor inappropriate exposure to sexuality, *i.e.*, uncle attempting to fondle

4 incidences of exposure to sexual activity (fondling, flashing, oral sex) causing confusion and/or problem; no physical force or threat involved

5 one or more traumatic events, *i.e.*, rape, incest, sodomy, oral copulation, chronic long-term sexual abuse; physical force or threat involved

4. HISTORY OF SUBSTANCE ABUSE

Refers to use and abuse of alcohol and/or drugs.

1 none; never used anything

2 social, recreational use or experimentation; no resulting social/emotional problems

3 frequent pattern of abuse resulting in social/emotional problems; recovering in or out of a program

4 routine use, *i.e.*, every weekend or daily use

5 chronic addiction; daily use over time; can't live without it

5. HISTORY OF AGGRESSIVE ACTS AS AN ADULT

Refers to severity of physically violent acts toward people or property. Assesses propensity toward violence.

1 history of appropriate assertiveness; no history of verbal assaults

2 no aggressive/violent acts

3 tantrum-like behavior which may have resulted in minimal property damage, but not directed at people; no child abuse; throwing objects; verbally threatening

4 history of property damage; fighting with peers; physically threatening; pushing, shoving, shaking people

5 beating of people, causing injury or serious property damage (i.e. arson)

6. HISTORY OF BEING AN ADULT VICTIM

Refers to being victimized as an adult either emotionally or physically.

1 never a victim

2 isolated incident, *e.g.*, mugged, robbed by a stranger

3 moderate verbal abuse as in hurtful teasing or name calling; constant put downs by spouse or family member; some pushing or shoving in relationships

4 chronic verbal or emotional abuse; isolated serious incidents of physical abuse, i.e., violent rape or domestic violence; regularly physically threatened, pushed and/or shoved in relationship; pattern of serious incidents of physical domestic violence causing injury

5 chronic, consistent victim; puts self in life-threatening situations and/or exploitative relationships; allows self to be used as a prostitute, drug runner, etc.; domestic violence resulting in hospitalization; multiple rapes

7. OCCUPATIONAL HISTORY

Refers to...

1 has career; history of promotions and upward movement in field

2 long-term full-time employment

3 long-term part-time employment; some pattern or consistency in types of jobs; intermittent employment; frequent unemployed periods

4 irregular jobs; seasonal jobs; disabled; unable to hold job for more than six months; work doing anything to survive

5 chronic unemployment

II. CAREGIVER(S)

B. Personal Characteristics

1. LEARNING ABILITY/STYLE

Refers to ability to understand instructions, directions, ideas, etc. Assesses motivation to learn.

1 above average; quickly catches on to complex and/or abstract ideas; has ability to anticipate consequences; able to learn through any means

2 average; generally understands; minimal repetition/ explanation needed for complex and/or abstract idea; able to learn from a variety of means

3 a little slow to comprehend; understands simple concepts; problems with abstract ideas; concrete thinking

4 mildly to moderately retarded; difficulty in understanding simple concepts; moderate to major learning disabilities

5 thought disorder; severely retarded; minimal comprehension; severe learning disability

2. COOPERATION

Refers to degree of cooperation measured by actions and statements. First Rating is to be completed during initial assessment. Second Rating will reflect cooperation during treatment.

1 actively seeking help; provides information with minimal questioning; brings examples of problems; open to new ideas about solutions

2 willingly cooperates in answering questions; gives additional information; keeps appointments; punctual; calls to reschedule if necessary; tries suggested ideas

3 some reluctance or hesitancy; needs to be pushed or prodded to give information; passively cooperates; doesn't call if late or to cancel

4 participates only to follow court order; comes late; answers questions only "yes" or "no"; gives excuses; minimizes problems a lot; refuses to answer some questions

5 no cooperation; refuses to answer most questions; attitude leads to questionable honesty of responses

3. EMOTIONAL STABILITY (MOOD SWINGS)

Refers to consistency and range of moods or emotions, appropriateness of emotions and/or behavior, speed of reaction. Assesses whether emotions or emotional behavior interfere with daily functioning.

1 emotionally stable

2 occasionally moody with minimal consequences; unaware of feelings; some restricted range

3 moderately moody; significantly limited in emotional range; some inappropriateness in emotional responses; short-tempered; confused circular thinking; mild manic features

4 extreme moodiness; unpredictable; frequent inappropriateness that often interferes with functioning

5 grossly inappropriate emotional reaction to situation; interferes consistently with daily life; no stability

4. DEPRESSION

Refers to degree of depression and its interference with functioning. Assess through affect, appearance of self and home, level of activity as well as verbal statements.

1 not depressed

2 periods of mild depressions; "feeling blue," but functioning adequately; no impact on child(ren)

3 frequently depressed but functioning without treatment; past suicidal thoughts; "tired" all the time

4 seriously depressed but functioning minimally; recent suicidal thoughts; past suicidal attempts

5 chronic, long-term depression; treated psychiatrically; current suicide attempts; using medication; unable to function currently

5. AGGRESSION/ANGER

Refers to current expressions of aggression and anger.

1 above average ability to be assertive; exercises healthy way of releasing aggressive feelings or anger

2 adequate; generally appropriate expression of aggression (i.e., sports, gardening, hobbies, exercise) and anger (*i.e.*, controlled verbal expression not causing physical or emotional harm); occasional verbal barb or slammed door

3 passive aggressive withholding behaviors; yelling a lot at child(ren); using foul language to excess around child(ren); minimal property damage (*i.e.*, kicking a door)

4 verbally explosive; ranting and raving at child(ren); pattern of provocative statements or behaviors; no injury-causing physical abuse, but harsh (*i.e.*, pushing, pulling, grabbing); more serious property damage, *i.e.*, punching holes in walls; denies any angry feelings at all

5 violent; threatening with some injury-causing physical aggression, not necessarily life-threatening; threatening abandonment; emotional cruelty when angry; holding a grudge against child; consistent, regular violent acts toward people and property causing major damage and injury requiring hospitalization or resulting in death or permanent disability

6. PARANOIA/ABILITY TO TRUST

Refers to degree of paranoia or ability to trust.

1 no paranoia; generally tends to trust with appropriate and realistic limits

2 a little cautious; overly trusting on occasion

3 guarded; has difficulty trusting; questions staff's need to know certain basic things; tends to trust and divulge too quickly, causes some problems

4 suspicious; extreme difficulty trusting; hesitant to reveal any information; overly trusting of strangers; suspiciousness or over trustfulness causes major problem(s) for person or family

5 extreme paranoia; client feels everyone is against him/her without basis in reality; interferes with functioning; inappropriate and dangerous trusting of strangers that threatens person's/child's welfare

7. CURRENT SUBSTANCE USE

Refers to current use and abuse of alcohol and/or drugs.

1 no use

2 social, recreational use or experimentation; no interference with daily functioning

3 frequent use; 2-3 times a week; some interference in functioning; or recovering in or out of a program

4 daily, habitual use and abuse; significant interference in ability to function

5 chronic addiction; unable to function without drugs or alcohol

8. PASSIVITY/HELPLESSNESS/ DEPENDENCY

Refers to emotional dependence on someone as well as ability to make daily decisions, write checks, buy food, fulfill job expectations, etc.

1 functions independently for daily living needs; appropriate emotional independence

2 minor areas of dependence, i.e., insurance, major purchases; requires some extra emotional support at times of crisis

3 relies on others for routine help; some emotional dependence; does not like being alone; prefers to be in company of others and seeks vigorously a companion; uses child(ren) for companionship

4 minimal independent functioning; cannot live alone; needs help with money management, buying food; uses child(ren) for emotional support; easily exploited

5 unable to function independently; cannot survive without outside help; requires help with all daily activities; totally emotionally dependent on other(s); stays in relationships at whatever cost to self or child(ren); no independent decision making; pattern of exploitative threatening relationship(s) or living situation(s)

9. IMPULSE CONTROL

Refers to ability to tolerate frustration or control destructive acts.

1 has ability to delay gratification of needs; high level of frustration tolerance

2 sometimes frustrated or irritated when tired but does not act out frustration

3 generally "short-fused" or "high-strung"; inconsistent impulse control; binge eating, drinking, or shopping; slaps child(ren) with hand; yells and screams a lot

4 very "short fused"; verbal rages; throws things; often out of control

5 inadequate impulse control; fights; steals; substance abuse; suicide attempts; hurts self and others; limited ability to care for child(ren)

10. PRACTICAL JUDGMENT/PROBLEM SOLVING AND COPING SKILLS

Refers to ability to develop options and make appropriate decisions/choices, in areas such as child care, discipline, money management, personal relationships; ability to cope with daily stress. Also assesses awareness of own abilities and limitations.

1 uses excellent judgment; able to develop and build options; pro-active approach to problem solving; has a variety of appropriate coping techniques; aware of and able to compensate for own limitations; excellent insight

2 generally good ability to problem solve and cope with stress; some ability to anticipate and develop options in advance; knows and works around own limitations; some insight

3 difficulty seeing options; makes good choices in some areas but not in others; reactive approach to problem solving; some difficulty in acknowledging limitations; little insight

4 poor judgment in many minor areas or one major area, *i.e.*, leaves child with alcoholic friend; very limited ideas on problem solving and coping; difficulty seeing options even with help; no insight

5 grossly inappropriate judgment; unable to develop options to solve problems; unable to cope with daily stress; denial of limitations

11. MEETS EMOTIONAL NEEDS OF SELF/CHILD

Refers to healthy balance between meeting own needs and child's needs.

1 maintains healthy balance

2 some imbalance at times; marital relationship sometimes gets lost in family and child(ren) needs; child(ren) needs occasionally secondary to parents, but causes no harm

3 frequently meeting own needs first with some emotional consequence but no physical consequence to child(ren), *i.e.*, mom rushes child(ren) so she can see boyfriend; uses child(ren) to avoid being alone; uses child(ren) for emotional support

4 pattern of meeting own needs first with potential endangerment, *i.e.*, leaves latency age child(ren) in charge of toddler; refuses to acknowledge special needs child to that child's detriment; overly self-sacrificing, "My whole life is these children", "I do everything for them", "I am nothing without them"

5 meets own needs at expense of child's emotional, physical or medical welfare; child is currently suffering due to this

12. SELF ESTEEM

Refers to current feelings about self.

1 able to make positive self comments; likes self

2 tends to be self-critical but can take positive feedback

3 low self esteem; difficulty taking positive feedback

4 consistently self-deprecating; cannot identify positives in self

5 no self esteem; self hatred

II. CAREGIVER(S)

C. Child-Rearing Ability

1. UNDERSTANDS CHILD DEVELOPMENT

Refers to all areas of development including physical, emotional, cognitive and social.

1 above average understanding of child(ren); well read in most areas

2 adequate knowledge in all four areas leading to realistic expectations

3 some weakness in areas; needs education; some but inadequate understanding; some erroneous beliefs leading to parental frustration over normal childhood behavior

4 limited understanding; high risk for emotional and/or physical abuse or neglect; sees problems that are not there; has inappropriate expectations

5 little or no appropriate knowledge or understanding of normal child development which may have resulted in some type of abuse or neglect

2. SCHEDULE FOR CHILD(REN)

Refers to all areas including bedtime, meals, naps, homework, baths, etc.

1 individualized and consistent schedule for child(ren) that is age appropriate

2 reasonably consistent, flexible and age appropriate

3 has some schedule; some rigidity or some inconsistency; only some areas are scheduled

4 minimal scheduling or consistency; overly rigid

5 no schedule; no consistency; extreme rigidity

3. PROVIDES BASIC MEDICAL/PHYSICAL CARE

Refers to provision of food, clothing, shelter, grooming and bathing. Also assesses whether child receives well baby care, follow through on treatment and return visits, and provision of good home care for health problems.

1 high quality care; preventive health care plan including dental as well as medical care; shots current; child is well groomed; nutritionally planned meals

2 adequate physical care; parent reacts appropriately to symptoms of illness; regularly scheduled checkups

3 occasional problems; areas with mild problems; areas of inadequacy but not health endangering; overreacts to minor illnesses; inadequate home health care practices; child(ren) often sick; only go to doctor when sick

4 generally inadequate; poor nutrition; poorly groomed and dirty; no shots; waits too long to go to doctor when child is sick; no follow through on treatment; child has not been to doctor recently (recently refers to past six months if child is less than one year and past 12 months if child is over one year)

5 child's health is endangered; extremely inadequate care, *e.g.*, food, clothing, home; malnutrition; inappropriate clothing for weather; child is not receiving needed medical care; failure to thrive

4. USE OF PHYSICAL DISCIPLINE

Refers to use, frequency, and severity of corporal punishment. Assess for age and vulnerability of child and potential for harm.

1 not used at all

2 infrequent swats with hand, but believes physical discipline inappropriate

3 occasional; shaking of older child

4 regular spanking; use of belts, shoes, etc.; shaking of toddler

5 regular and severe corporal punishment; explosive and out of control; shaking of infant

5. APPROPRIATENESS OF DISCIPLINARY METHODS

Refers to a planned approach appropriate to the age of the child; caregiver is in emotional control; punishment fits offense; child learns through discipline.

1 well thought out, age-appropriate, non-punitive educational approach; uses positive reinforcement as part of regular routine

2 generally has appropriate plan; parent in control; nonabusive; generally uses positive reinforcement

3 some inappropriate expectations, *i.e.*, three-year-old has to sit in corner for 15 minutes; some potential for emotional harm; tendency to focus on negative side; "serves you right" attitude

4 unplanned punitive approach; only reacts emotionally; inappropriate to age; name calling; emotionally abusive; isolates child from family; overreaction to offense; potential for physical harm; rarely sees positives in child

5 past or current severe emotional and/or physical abuse or no discipline at all

6. CONSISTENCY OF DISCIPLINE

Refers to predictability; child feels secure about parent's response. Does misbehavior get corrected each time it occurs and in a similar manner?

1 well thought out consistent plan; not impacted by parent's mood

2 generally consistent and predictable response to offense; appropriate to age and situation; occasionally impacted by parent's mood

3 some consistency, but very dependent on parental mood (more consistent than not); sometimes inappropriate for age or situation

4 mostly inconsistent; unpredictable; overly rigid; little flexibility related to age or situation

5 no consistency; no flexibility related to age or situation

7. CHOOSES APPROPRIATE SUBSTITUTE CAREGIVERS

Refers to caregiver's thinking about planning for safe child care. Keep in mind age appropriateness and need of child. If no money, resources or adequate child care available, indicate N/A and make note in comments as to what problem is, so it can be addressed.

1 parent very careful and conscious; checks things out; makes sure child is comfortable with caregiver

2 generally adequate; concerns not necessarily nonexistent but does not create risk

3 pattern of questionable decisions; leaves young child(ren) with inappropriate young caregivers, *i.e.*, 8 or 9-year-old children; leaves child(ren) at home alone for periods with a neighbor watching but essentially unsupervised

4 leaves child(ren) in chaotic child care situations; physical care all right but emotional deprivation or cruelty; potentially dangerous but not life threatening; left with casual acquaintances; relies on known drug or alcohol users as caregivers

5 no thinking about or planning for child care; child(ren) in imminent danger; left with strangers or known child abusers; left totally alone with no supervision or anyone watching over; left with person currently under the influence of drugs or alcohol

III. FAMILY INTERACTIONS (OBSERVED OR INFERRED)

A. Caregiver to Child(ren)

1. PROVIDES ENRICHING/LEARNING EXPERIENCES FOR CHILD(REN)

Refers to parent's investment in child's social and academic growth and development.

1 teaches with enjoyment; plans reading time, carefully selects experiences; plans outings, *i.e.*, park, museum; avid involvement with school; appropriately helps to attain expected developmental tasks, *i.e.*, walking, talking, self-care skills

2 reads to child frequently, as time allows; monitors what child(ren) watches on TV; occasionally planned learning activity; checks homework; talks to teacher

3 lets kids watch any program on TV, although may verbally disapprove; interacts with school only at school's request; rarely reads to child(ren); allows child to develop without interfering; some pushing for unrealistic achievement, *i.e.*, child must read before starting school

4 little interest in child learning and development; avoids school contact; child on own; excessive pressure to achieve

5 frustrates and rejects child's need for learning; keeps child(ren) at home to meet own needs; interferes with child's attempts to achieve normal developmental tasks (i.e. keeps child in crib 90% of the time, holds excessively, only talks baby talk); pressures child to perform/achieve to degree that child develops emotional or physical problems

2. BONDING STYLE TO CHILD(REN)

Refers to emotional investment and attachment of the caregiver to the child(ren).

1 balanced; encourages appropriate independence; loves warmly; attentive; responds appropriately to needs; reads child's cues correctly; sense of connectedness

2 adequate emotional involvement and support; occasional difficulty allowing independence/differences; reads cues correctly most of the time; occasional delay in response

3 frustrated or intrusive; some ambivalence; passive; responds to physical and/or social needs inconsistently; some difficulty reading child's cues; some enmeshment

4 little emotional investment; irritable; over-identifying; misinterprets cues most of time; frequently does not respond or responds inappropriately; minimal response to child's approach/attachment to other people; a lot of enmeshment

5 resentful; rejecting; detached; promotes child's attachment to other people rather than self; child endangered by nonresponsiveness or inappropriate responses; totally enmeshed

3. ABILITY AND TIME FOR CHILD(REN)'S PLAY

Refers to parent's understanding of the value of play and creating or allowing it.

1 sets aside special time; plays in enriching way with child(ren); encourages playfulness and spontaneity

2 understands importance of play; sets up play situation; makes helpful suggestions regarding play activities; plays with children occasionally as time allows

3 rarely plays with child but allows child(ren) to play; sees little importance in play; some dampening of spontaneity

4 ignores child's need for play; makes no provisions for space or time; doesn't play with child(ren); puts restrictions on play; puts down spontaneity; feels child(ren) should be working or studying rather than playing

5 resents need for play; parentified child; thwarts playfulness and spontaneity in child; "I never got to play, all he/she ever does is play"; doesn't want or allow child(ren) to play

4. ATTITUDE EXPRESSED ABOUT CHILD(REN)/PARENTAL ROLE

Refers to verbal or nonverbal cues about enjoyment of the child(ren) and parenting. Assesses degree to which caregiver accepts child as he/she is without projecting either positive or negative attitudes about or onto the child.

1 happy to be a parent; sees humor in role; accepting; warm; loving; positive

2 accepts parental role; can verbalize some enjoyment; generally positive; some complaints about children

3 "children are a lot of work"; more work than pleasure; mostly views child as responsibility; limited moments of enjoyment in parenting; some indifference; some irritation and resentment; inconsistent; attitude depends on parental mood

4 fatigued; talks of own problems; tied down feelings; no pleasure; ambivalent; predominantly irritated and resentful; mostly negative

5 child interferes in life; resents responsibility of parenting and parenting tasks and conveys this to child; detached and indifferent; rejecting; hatred; denigrating

5. TAKES APPROPRIATE AUTHORITY ROLE

Refers to parent's ability to convey appropriate authority without being overly demanding or rigid. Also assesses parent's ability to exert authority.

1 thoughtfully allocates appropriate authority to child; willing and able to negotiate on privileges and consequences appropriate to child(ren)'s age and situation; parent knows how and when to set and hold limits and is able to take a stand comfortably

2 adequate authority; sometimes allows child inappropriate decisions; occasional power struggle; can hold limits when necessary; generally consistent

3 shares inappropriately with child; child mostly sets own rules; parent exhibits ambivalence about authority; generally indecisive about rules, consequences, privileges; some rigidity in parenting style

4 frequent role reversal; constant power struggles; parent unable to say no or allow child any decision-making power; rigidly holds to rules regardless of situation

5 complete role reversal; child takes on parenting role; completely rigid parenting; allows no flexibility or negotiability; abdicates responsibility

6. DEALS WITH SIBLING INTERACTIONS

Refers to parent's ability to cope with sibling conflicts and structure positive interaction. *Mark N/A if no siblings.*

1 sensitive; teaches problem solving and sharing; appreciates individual differences

2 limits fighting; encourages sharing and verbal conflict resolution

3 apathetic; leaves to own devices; tends to ignore sibling interaction both positive and negative

4 favors one; allows one to rule; compares negatively

5 rejects one; fosters rivalry; scapegoats one child

7. QUALITY AND EFFECTIVENESS OF COMMUNICATION

Refers to parent's ability not only to make own desires known but to foster child's understanding and communication abilities.

1 praises appropriately; language expresses love and enriches; open two-way verbal communication without fear

2 adequate; difficulty verbalizing in some areas (sex; deep feelings); no emotional abuse; sometimes doesn't really listen to child

3 gives brief answers; daily business oriented, *i.e.*, hi, bye, dinner is ready, go to bed; not enriching; does not give child clear or adequate feedback; gives some mixed messages

4 short with child; irritable; little verbal interaction; frequently harsh; yelling; irritated tone of voice; allows no feedback; pattern of double-bind messages

5 shouts; angry; absence of verbal communication; harmful verbal abuse; personalized negative remarks, *i.e.*, "You are only a problem to me," "I hate your guts"

III. FAMILY INTERACTIONS

B. Child(ren) to Caregivers

1. QUALITY AND EFFECTIVENESS OF COMMUNICATION

Refers to the child's verbal or non-verbal ability to communicate needs and feelings to caregiver. Also assesses quality of warmth and respect conveyed through verbal and non-verbal communication.

1 spontaneous verbal communication or physical affection; reflects positive respectful attitude; child feels understood and has clear understanding of parental expectations, desires and feelings

2 child(ren) can generally understand and communicate feelings and needs; occasional instances of feeling misunderstood or confused by parental messages

3 child(ren) generally understand communication from caregiver(s) but unable to communicate own feelings and needs to caregiver(s); reflects attempts at positive communication, but somewhat cautious; hesitant in initiation and response; gives only brief answers

4 extremely limited; frequently ignores or verbally provokes; disrespectful; frightened or withdrawn; does not share ideas, feelings or needs with caregiver(s)

5 constant fighting, provoking, or active avoidance

2. COOPERATION/FOLLOWS RULES AND DIRECTIONS

Refers to degree to which child follows rules and directions. How easily does he/she cooperate?

1 cooperative; follows rules; does chores

2 mostly cooperative; needs verbal reminding

3 50/50; inconsistent cooperation; "does it in his/her own time"; needs firm limits to follow directions

4 oppositional; indifferent; mostly uncooperative

5 totally uncooperative; refuses to follow rules or do chores; impossible to live with

3. BONDING TO CAREGIVER

Refers to child's emotional investment and attachment to caregiver(s). Note to whom the child seems most bonded and the qualities of the attachment. These qualities are seen in the body language, facial expressions, tone of voice, content communications, visual contact, physical closeness or distance and amount of time spent with the caregiver and depends on the developmental stage of the child.

1 a balanced, warm, easy, reciprocal interaction appropriate for age; child exerts appropriate independence/shyness

2 adequate bonding with occasional tensions or anxieties; occasional differences over amount of independence allowed

3 signs of ambivalence, anxiety or hostility in child toward caregiver; child may be overly friendly with strangers

4 bland affect; little emotional investment or confidence in caregiver's response; frequent anger towards the caregiver; needy of affection from strangers

5 no signs of a relationship with the caregiver or enmeshed with the caregiver; a consistently hostile, rejecting and provocative stance toward the caregiver or excessive fearfulness of the caregiver

III. FAMILY INTERACTIONS

C. Caregiver-to-Caregiver

1. CONJOINT PROBLEM SOLVING ABILITY

Refers to the ability of caregivers to listen, develop options and compromise. (Rate ability of couple, not each caregiver.)

1 able to negotiate and communicate; encourage each other to have and express own opinions

2 mild problem in developing options; listening

3 weak communication skills; able to problem solve daily living issues, *i.e.*, shop, home chores, but difficulty solving bigger issues, *i.e.*, children, relatives

4 rarely able to problem solve together; decision-making discussions become arguments

5 no compromise or negotiation; do not discuss problems

2. SUPPORTIVE

Refers to emotional support and degree to which caregivers can count on each other. (Rate each caregiver separately.)

1 supportive

2 mostly supportive; minor disagreement in one area

3 inconsistent support; unpredictable

4 frequently unreliable; irresponsible; often lets partner down; frequently does not backup partner

5 does not follow through on agreements; totally unreliable; extremely critical of each other; insults partner in public; ridicule each other

3. PARTNERS' ATTITUDE TOWARD EACH OTHER

Refers to overall feelings partners seem to have about each other. (Rate each caregiver separately.)

1 respectful; positive; admiring; loving

2 minor areas of irritation, but generally positive attitudes

3 some indifference; irritated; patronizing

4 condescending; resentful; angry; disrespectful; fearful; ambivalent

5 excessively fearful; terrified; hostile; hateful; rejecting; totally indifferent

4. MANNER OF DEALING WITH CONFLICTS/STRESS

Refers to way in which couple handles conflicts. (Rate ability of couple, not each caregiver.)

1 talk over problems; effective handling of stress

2 discuss major differences; deal with minor issues independently

3 major conflicts ignored; able to resolve minor differences

4 constant arguing; physical expression like slapping, shoving, slamming doors, breaking dishes

5 domestic violence; substance abuse; abandonment; harmful to health and safety of self and others

5. ABILITY TO COMMUNICATE (VERBALLY AND NONVERBALLY)

Refers to ability to listen to the other and express own opinion. (Rate each caregiver separately.)

1 open communication; frequent sharing of feelings and experiences

2 difficulty communicating on some issues

3 daily life/business oriented; no quality conversation; isolated

4 very poor communication; lots of misunderstanding; misreading of other's cues

5 no communication; no ability to listen or express opinions

6. BALANCE OF POWER

Refers to healthy interdependence; how dependent is one on the other. (Rate couple, not each caregiver.)

1 healthy balance; each takes lead; shares decision making

2 minor imbalance; not endangering to children or adults; one tends to dominate but not rigid; "traditional roles" accepted by both caregivers, *i.e.*, culturally accepted male dominance

3 moderate imbalance leading to difficulty in problem solving and conflict resolution

4 major dangerous imbalance; high risk for domestic violence; emotionally harmful; one extremely domineering

5 severe imbalance; detrimental to physical well-being of children or adults; one adult squelches other

Department of Economic Opportunity, Family Development Report Basic Needs Outcomes

FORM C
BASIC NEEDS OUTCOMES

PURPOSE

Form C is designed to capture the extent to which families who were case managed or intensively served by your program are meeting more of their basic needs after involvement in Healthy Start. This is done by comparing the status of families when they became involved in Healthy Start with their status at follow-up.

If you have opted to report on the Basic Needs Outcome Cluster, you will need to report on the following outcome indicators for families case managed by your program:

- Housing
- Food and clothing
- Transportation
- Finances
- Employment
- Children left without supervision.

WHO COLLECTS AND WHEN

At intake into Healthy Start and every 6 months after intake, you will need to meet with case-managed families to determine their current basic needs status.

- Baseline = Status on basic needs category at time of intake into Healthy Start program.
- Follow-up = Status on basic needs category reported at time of most recent follow-up.

Only data from case-managed families for whom you have complete information (both baseline and follow-up data) for at least one outcome indicator (e.g., shelter scores) should be reported. In other words, if no follow-up data can be collected (e.g., family moved away), then do not include the family on this form.

Use as many sheets as necessary to include all the families being case managed or intensively served.

WAYS IN WHICH DATA CAN BE COLLECTED

We ask that you use scales developed by the Department of Economic Opportunity, *Family Development Report* (DEO-410-FDR), to measure basic needs status. You may adopt the use of this entire form or use its scales in your own locally developed forms. Please note that sites which have Community Block Grants already collect these data. More information about and copies of this assessment can be obtained from:

Department of Economic Opportunity
700 North 10th Street, Room 258
Sacramento, CA 95814
(916) 322-2940
(916) 327-3154 fax

To collect data on children left without supervision, a question regarding child care will need to be added to either the *Family Development Report* or your own locally developed intake and follow-up forms.

ITEM INSTRUCTIONS

Site Name	Indicate the name of your Healthy Start site.
Site ID#	Indicate the identification number given to your grant application.
School Year	Write the school year to which the data refers (e.g., 1995-1996).
Grant Year	Circle on the form the year of grant funding to which the data refers: Pre = Pre Healthy Start operational grant year 1 = First year of Healthy Start operational grant 2 = Second year of Healthy Start operational grant 3 = Third year of Healthy Start operational grant
1. Family number (1 through X or ID#)	Number each row that indicates a unique family's data. For example, a site with 25 families would list 1, 2, 3...25. If it is easier for your site, you can list family/mother's ID number.
2. Date of intake	Date on which the family (usually mother or father) was first seen by Healthy Start program staff.
3. Shelter scores	For each case-managed family, indicate their score at intake and for every six-month follow-up on the following *Family Development Shelter Scale*: 5 *Thriving* - lives in housing of choice; spends less than 25% of income for rent or mortgage; owns or has long-term occupancy. 4 *Safe/Self-sufficient* - lives in or has access to adequate housing; spends less than 33% of income for rent or mortgage; safe and secure in home and neighborhood; tenancy is secure for more than one year. 3 *Stable* - spends less than 50% of income on rent or mortgage; tenancy is secure for at least one year; housing is not hazardous, unhealthy, overcrowded; space is appropriate to family size and composition. 2 *At risk* - lives in temporary or transitional housing and is not certain where next shelter is to be found; lives in unsafe or deteriorating housing; spends more than 60% of income on housing; housing is overcrowded for family size. 1 *In crisis* - lives in dangerous conditions, homeless or on the verge of homelessness.

4. Food and clothing scores	For each case-managed family, indicate their score at intake and for every six-month follow-up on the following *Family Development Food and Clothing Scale*: 5 *Thriving* - has sufficient healthful food of choice; everyone in the family eats a nutritious diet at well-scheduled meals; has clean, durable clothing appropriate to full range of individual and family activities. 4 *Safe/Self-sufficient* - always has resources to provide sufficient food for all family members; family has regular meal times; has clean, appropriate clothing for all critical activities such as school or work. 3 *Stable* - has sufficient resources to obtain food most of the time and can use community resources to supplement food resources if needed; generally healthy attitude toward food; has adequate food preparation appliances and equipment; meals have some elements of balance and are sometimes scheduled; clothing is clean and appropriate most of the time. 2 *At risk* - inadequate resources to obtain food for family; meals lack quality, important nutrients; inappropriate use of food for emotional rather than nutritional ends; erratic, undependable meal times; insufficient utensils, appliances for meal preparation; clothing is ill-fitting, inadequate, or inappropriate for school or work. 1 *In crisis* - serious lack of resources to obtain food, hunger is common; diagnosis or evidence of malnutrition; severe eating disorder; no one is preparing meals; lack of adequate clothing for warmth and comfort, may seriously impede necessary activity.
5. Transportation scores	For each case-managed family, indicate their score at intake and for every six-month follow-up on the following *Family Development Transportation and Mobility Scale*: 5 *Thriving* - has current driver's license; auto is fully insured with comprehensive coverage; has choice of transportation; able to repair vehicle when needed; vehicle is safe. 4 *Safe/Self-sufficient* - has license; has basic insurance coverage; has fair driving and accident record; has and maintains own vehicle. 3 *Stable* - generally has access to some form of safe transportation when needed; has driver's license and basic insurance.

	2 *At risk* - is driving without license or without insurance, or both; has unpaid parking tickets; does not have safe or reliable transportation or means to obtain it. 1 *In crisis* - has revoked or suspended license; not insurable; no access to transportation for basic needs; no money to obtain transportation; incarcerated for traffic violations.
6. Finances scores	For each case-managed family, indicate their score at intake and for every six-month follow-up on the following *Family Development Finance Scale*: 5 *Thriving* - sufficient earned income to allow family choices for nonessential purchases; able to save 10% of income; established relationship with financial institution; expects continued income at current level or better for at least next year. 4 *Safe/Self-sufficient* - sufficient income to meet basic family needs; plans and sticks to monthly budget; saves when possible; able to obtain secured credit; pays bills on time; delay purchases to handle debt load; anticipates continuation of income level for next six months. 3 *Stable* - minimally adequate income without regard to source; plans monthly budget; no savings; able to obtain limited secured credit; generally pays bills on time; aware of and use appropriate resources for help; no foreseen major decrease of family income. 2 *At risk* - occasionally unable to meet basic needs; spontaneous, inappropriate spending; no savings; unable to obtain credit; limited knowledge of and access to resources for help; unpaid bills, overwhelming debt load. 1 *In crisis* - no money; cannot meet basic needs; no knowledge of available resources for help.
7. Adult employment scores	For each case-managed family, indicate their score at intake and for every six-month follow-up on the following *Family Development Adult Employment Scale*: 5 *Thriving* - constant development of new transferable skills; employed by secure business offering comprehensive benefit package; has made steady advancement in career of choice; has solid job search and retention skills; has and can afford high-quality child-care/child-development services. 4 *Safe/Self-sufficient* - has attained marketable skills; employed by secure company offering some benefits or always knows where next employment is to be found; has employment with potential for advancement; has job retention skills; has and can afford appropriate child care.

	3 *Stable* - considering learning more marketable skills; has seasonal or temporary employment with inadequate hours, benefits, and/or stability; has limited advancement potential; has understanding of job skills; can search for job with assistance; has access to publicly funded or subsidized child care; working in field of choice. 2 *At risk* - minimum job skills; inadequate employment and/or no benefits; not sure where to find next job; no advancement potential; no career plans; disciplinary or performance problems at work; few job search or retention skills; has inadequate child care. 1 *In crisis* - unemployed; no leads for next job; no positive work history; no interest in employment; no child care available to support employment or training.
8. Number of children without adult or appropriate teenage supervision	This indicator *does not* appear on the *Family Development Report Form*. Find out from parents how many children age 9 or under they have who are left without adult or appropriate teenage supervision both at intake and for each follow-up assessment.
Sums	Sum scores in each of the columns. Include only families with both baseline and follow-up data.
Number of families with complete data	Report the number of families with both baseline and follow-up data for each of the outcomes. This number will be the denominator when calculating means.
Means	To calculate means, take the score for each column and divide it by the total number of families for whom you have complete information (i.e., both baseline and follow-up scores for that outcome). If you subtract the follow-up mean from the intake mean, you will determine the approximate average increase or decrease in families' abilities to meet their shelter, food and clothing, transportation, finance, employment, and child care needs.
Optional Basic Needs Indicator	
Family mobility	Include the following or a similar question on your case closure or exit form. Was this case closed because the family moved away from the community? Yes No Report case closures on the Family Mobility page of this form. Sum the number of cases closed and the number of closures due to moving. **Proportion:** Divide the sum of "yes" responses by the total number of cases that were closed during this school year.

Lollipop Test: A Diagnostic Screening Test of School Readiness-Revised

ADMINISTRATION AND SCORING BOOKLET

for

THE LOLLIPOP TEST:

A DIAGNOSTIC SCREENING TEST OF SCHOOL READINESS-REVISED

By Alex L. Chew, Ed.D.

		1st Testing	2nd Testing
Name _____	Present Date	_____ Year Month Day	_____ Year Month Day
Nationality _____ Sex____			
School _____	Birth Date	_____ Year Month Day	_____ Year Month Day
Months in Kindergarten _____			
Examiner_____	Child's Age	_____ Years Months	_____ Years Months

SUMMARY OF CHILD'S PERFORMANCE

Test	Possible Score	Child's Score 1st Testing	Child's Score 2nd Testing
1. Identification of colors and shapes, and copying shapes	17		
2. Picture description, position, and spatial recognition	17		
3. Identification of numbers, and counting	17		
4. Identification of letters and writing	18		
(Totals)	69		

1st Testing; 2nd Testing. This test may be administered twice (at the beginning and end of the kindergarten year) as a pre- and post-test, or may be administered once depending on the diagnostic and planning needs of the school.

Interpretation of Scores. See the last page of this booklet and the **Developmental and Interpretive Manual** for interpretative guidelines and suggested score ranges.

GENERAL TEST DIRECTIONS

An Individual Test. This is an individually administered screening test of school readiness, and, as such, is not for group administration.

Setting and Materials. The testing should be conducted in a quiet area as free from visual and auditory distractions as possible. A small table is best utilized for the test materials, which consist of this combination **Administration and Scoring Booklet** and the set of seven **Stimulus Cards.** The only other materials needed are several pencils and an unruled sheet of plain white paper.

(Continued on last page of booklet.)

Revised 1992

TEST 1

IDENTIFICATION OF COLORS AND SHAPES, AND COPYING SHAPES

Instructions: Place Stimulus Cards in front of child and turn to **Stimulus Card 1** and say: "Look this is a picture of lollipops. Look they are all different colors."

Scoring: Score one point for each correct response.

Test Instructions	Child's Score 1st Testing	2nd Testing
1. Say: "Show me the **red** lollipop." (Note: If child does not respond point to the red lollipop and say: "This is the red lollipop," but give no further help on this section.)	_____	_____
2. Say: "Show me the **green** lollipop."	_____	_____
3. Say: "Show me the **orange** lollipop."	_____	_____
4. Point to the **blue** lollipop and ask: "What color is this lollipop?"	_____	_____
5. Point to the **brown** lollipop and ask: "What color is this lollipop?"	_____	_____
6. Point to the **yellow** lollipop and ask: "What color is this lollipop?"	_____	_____
Turn to **Stimulus Card 2** and say: Look at all these different shapes."		
7. Say: "Show me the **circle**." (Note: If child does not respond point to the circle and say: "This is the circle," but give no further help on this section.)	_____	_____
8. Say: "Show me the **rectangle**."	_____	_____
9. Say: "Show me the **cross**."	_____	_____
10. Point to the **triangle** and ask: "What shape is this?"	_____	_____
11. Point to the **square** and ask: "What shape is this?"	_____	_____

Test 1 continued on next page.

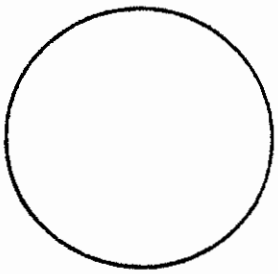
Test 1, Continued (1st Testing)

Use this page for 1st Testing and opposite side for 2nd Testing

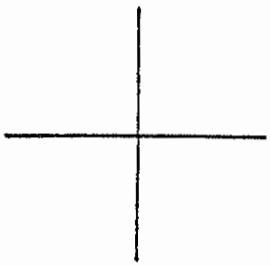
Instructions: Place a pencil on the table in front of the child and ask: "See this circle (point to the circle)? Draw a circle just like this one. Draw it here (point to the space next to the circle)."
If child is not successful on first attempt, give another trial.
Note below with which hand the child draws.

Follow above directions with the cross and then the square.

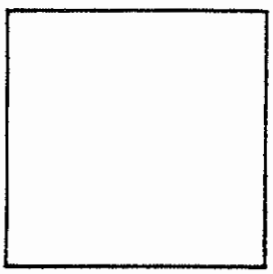
Scoring: Score two points if child is successful on either attempt.



Score _____



Score _____



Score _____

Examiner should check the appropriate descriptor:

Child held pencil with left hand _____

Child held pencil with right hand _____

Child held pencil with both hands _____

Child alternated use of hands _____

Note: If examiner is not sure of scoring for above figures, see back page of this booklet.

Total Possible Score 17

Child's Total Score: 1st Testing _____

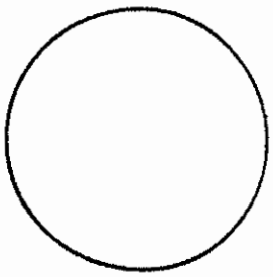
Test 1, Continued (2nd Testing)

Use this page for 2nd Testing

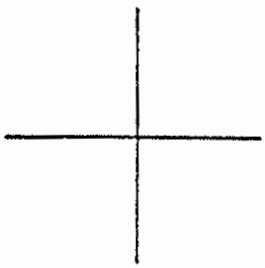
Instructions: Place a pencil on the table in front of the child and ask: "See this circle (point to the circle)? Draw a circle just like this one. Draw it here (point to the space next to the circle)."
If child is not successful on first attempt, give another trial.
Note below with which hand the child draws.

Follow above directions with the cross and then the square.

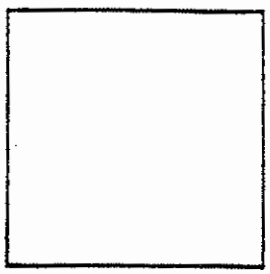
Scoring: Score two points if child is successful on either attempt.



Score _____



Score _____



Score _____

Examiner should check the appropriate descriptor:

Child held pencil with left hand _____

Child held pencil with right hand _____

Child held pencil with both hands _____

Child alternated use of hands _____

Note: If examiner is not sure of scoring for above figures, see back page of this booklet.

Total Possible Score 17

Child's Total Score: 2nd Testing _____

TEST 2

PICTURE DESCRIPTION, POSITION, AND SPATIAL RECOGNITION

structions: Turn to **Stimulus Card 3** and say:
"Look at this picture."

:oring: Score one point for each correct response unless otherwise noted.

Instructions		Child's Score 1st Testing	2nd Testing
. Say: "Tell me all about this picture." (Note: If child does not respond, say: "What's happening in this picture?")	(Maximum Score: 5)	_____	_____
Probing: To improve child's answer, one probe is allowed. Ask: "Can you tell me more about the picture?"			
Scoring: If child identified "kitties" or "cats," score 1 point. If child says "mama cat and kitties," score 2 points. Score 1 additional point (up to a maximum of 5) for each additional concept the child mentions, e.g., "kitty hungry," "bowl empty," "that kitty climbing on mama's back," "kitty playing with ball," etc.			
2. Say: "Show me (point to) the kitty that is on **top**."		_____	_____
3. Say: "Show me the kitty that is **inside** something."		_____	_____
4. Say: "Show me the kitty that is on the **left** side."	(2 points)	_____	_____
5. Say: "Show me the kitty that is **underneath**."	(2 points)	_____	_____
Turn to **Stimulus Card 4** and say: "See these lollipops? They are all red, aren't they?"			
6. Say: "Show me which is the **biggest**."		_____	_____
7. Say: "Show me which is the **smallest**."		_____	_____
8. Ask: "Which one is **first**?"		_____	_____
9. Ask: "Which one is **last**?"		_____	_____
0. Ask: "Which one is in the **middle**?"	(2 points)	_____	_____
otal Possible Score 17	**Child's Total Score**	_____	_____

TEST 3

IDENTIFICATION OF NUMBERS, AND COUNTING

Instructions: Turn to **Stimulus Card 5** and say:
"Look at this page of numbers."

Scoring: Score one point for each correct response unless otherwise noted.

Instructions		Child's Score 1st Testing	2nd Testing
1. Say: "Show me the number 5." (Note: If child does not respond, point to the number 5 and say: "This is the 5, but give no further help on this section.)		_____	_____
2. Say: "Show me the 4."		_____	_____
3. Say: "Show me the 7."		_____	_____
4. Say: "Show me the 9."		_____	_____
5. Point to number 3 and ask: "What number is this?"		_____	_____
6. Point to number 6 and ask: "What number is this?"		_____	_____
7. Point to number 2 and ask: "What Number is this?"		_____	_____
8. Point to number 8 and ask: "What number is this?"		_____	_____
9. Say: "Tell me how old you are." (Note: If child does not know, ask him to hold up how many fingers old he is and then ask him to count his fingers. Child must verbally tell his age.)		_____	_____
Turn to **Stimulus Card 6** and say: "Look at all the lollipops on this page."			
10. Point to box A and say: "Count the red lollipops in this box for me." (If necessary, add: "Count out loud for me.")		_____	_____
11. Point to box B and say: "Count the yellow lollipops in this box for me."		_____	_____
12. Point again to box B and ask: "If we added one more yellow lollipop, how many would we have?"	(2 points)	_____	_____
13. Point to box C and say: "Count the green lollipops in this box for me."	(2 points)	_____	_____
14. Point to box D and say: "Count the orange lollipops in this box for me."	(2 points)	_____	_____
Total Possible Score 17	**Child's Total Score**	_____	_____

TEST 4

IDENTIFICATION OF LETTERS, AND WRITING

Instructions: Turn to **Stimulus Card 7** and say:
"Look at all the letters on this page."

Scoring: Score one point for each correct response.
See special scoring instructions for item 14.

Instructions	Child's Score 1st Testing	2nd Testing
1. Say: "Show me the letter **B**." (Note: If child does not respond, point to the letter **B** and say: "This is the letter **B**, but give no further help on this section of the test.)	_____	_____
2. Say: "Show me the letter **L**."	_____	_____
3. Say: "Show me the letter **C**."	_____	_____
4. Say: "Show me the letter **P**."	_____	_____
5. Say: "Show me the letter **F**."	_____	_____
6. Point to the letter **M** and ask: "What letter is this?"	_____	_____
7. Point to the letter **E** and ask: "What letter is this?"	_____	_____
8. Point to the letter **S** and ask: "What letter is this?"	_____	_____
9. Point to the letter **D** and ask: "What letter is this?"	_____	_____
10. Point to the letter **H** and ask: "What letter is this?"	_____	_____
Remove **Stimulus Card 7** from the child's view.		
11. Ask: "Can you write the letter **A** for me?"	_____	_____
Place a sheet of unruled, plain white paper in front of the child and say: "Write the letter **A** on this page for me."		
12. Repeat the above directions for the letter **B**.	_____	_____
13. Repeat the above directions for the letter **C**.	_____	_____
14. Ask: "Can you write (print) your name?"	_____	_____
Using the same sheet of paper, say: "Write your name on this page for me." (Scoring: One point for each of the first two letters. Five points for complete name, if recognizable.)		
Total Possible Score 18	**Child's Total Score** _____	_____

;ENERAL TEST DIRECTIONS, Continued

st Testing; 2nd Testing. This scoring booklet has been designed to allow the recording of two sets of scores. he test may be administered at the beginning and end of the kindergarten year, as a pre- and post-test, or administered nce depending on the unique needs of the school system.

ıdministration. The test is especially recommended for use at the beginning and end of the kindergarten year as pre- and post-test. Used in this manner the test can assist in diagnosing individual student deficits, plan for remedial ıstruction and evaluate student progress at the end of the kindergarten year. However, the flexibility of the test .llows for a number of administration options: (1) at the beginning and end of kindergarten, as a pre- and post-test; 2) at the beginning of kindergarten as a diagnostic and instructional planning aid; (3) at the end of kindergarten ır pre-first grade; or (4) at the beginning of first grade in order to facilitate academic and/or remedial planning for ıdividual students.

łow to Begin. If the child is not familiar with the examiner, it is essential to establish rapport. Be informal and tell he child that he is going to look at some pictures with you, or, depending on the child's maturity, that the two of ·ou are going to do some schoolwork together. Since the first Stimulus Card is an illustration of lollipops, it may ıelp to establish rapport by showing the child an actual lollipop and telling him that he can have it to take back to :lass (or home) when your work is over.

Responses and Scoring. Each response that the child gives should be accepted. Mistakes should be quickly passed)ver without acknowledging them as wrong answers. Do not supply the child with correct answers when he is wrong. Throughout the testing procedure, offer the child encouragement (without giving clues to the answers). When ıecessary, questions may be repeated as they are contained in this booklet. Should the child experience considerable difficulty on one section of the test, it is permissable to move on to another section. Then, return later to complete he difficult one. Scoring instructions are given at the beginning of each section, and at other appropriate points hroughout the booklet.

nterpretation of Scores. Regardless of when this test is administered, the primary purposes for testing are the same: (1) to assist the school in identifying those children who will need additional instruction in readiness activities :o obtain maximum benefit from their kindergarten and/or first grade experience, (2) to help identify those children who may have special learning and/or adjustment problems and who may need additional individual psychoeducational evaluation, (3) to assist the school in planning their overall instructional objectives and to individual instruction, and '4) in the case of pre- and post-testing, to determine the progress made by individual students during the instruc-:ional period. It is not the purpose of this screening test to exclude any child from school entry or to determine that ne or she is not "ready" for school. Individual schools and school systems are urged to establish their own local score ranges representing average, above average and below average readiness. However, the child's total score is not as diagnostically useful as the identification of specifiable and teachable units of information and skills that comprise the child's deficit area(s) and require remediation strategies. See the **Developmental and Interpretive Manual for the Lollipop Test** for a discussion on establishing local norms and for additional information on the interpretation of scores.

Scoring Criteria for Copying Shapes

Circle. The circle need not be completely round, but should not contain any angles. A flattened or broadened circle is scored as correct. Circles not completely closed, or in which closures slightly overlap, are also scored as correct.

Cross. The lines need not be perpendicular to each other and may resemble a large X instead of a cross. However, the two lines must clearly intersect each other at their approximate midpoint.

Square. The main criteria is that the corner angles be formed correctly. "Ears" or rounded corners are not acceptable. However, the lines that form any right angle may intersect slightly and extend beyond the figure. The figure may not be more than half again as long as it is wide.

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STIMULUS CARDS

for

THE LOLLIPOP TEST:

A DIAGNOSTIC SCREENING TEST OF SCHOOL READINESS

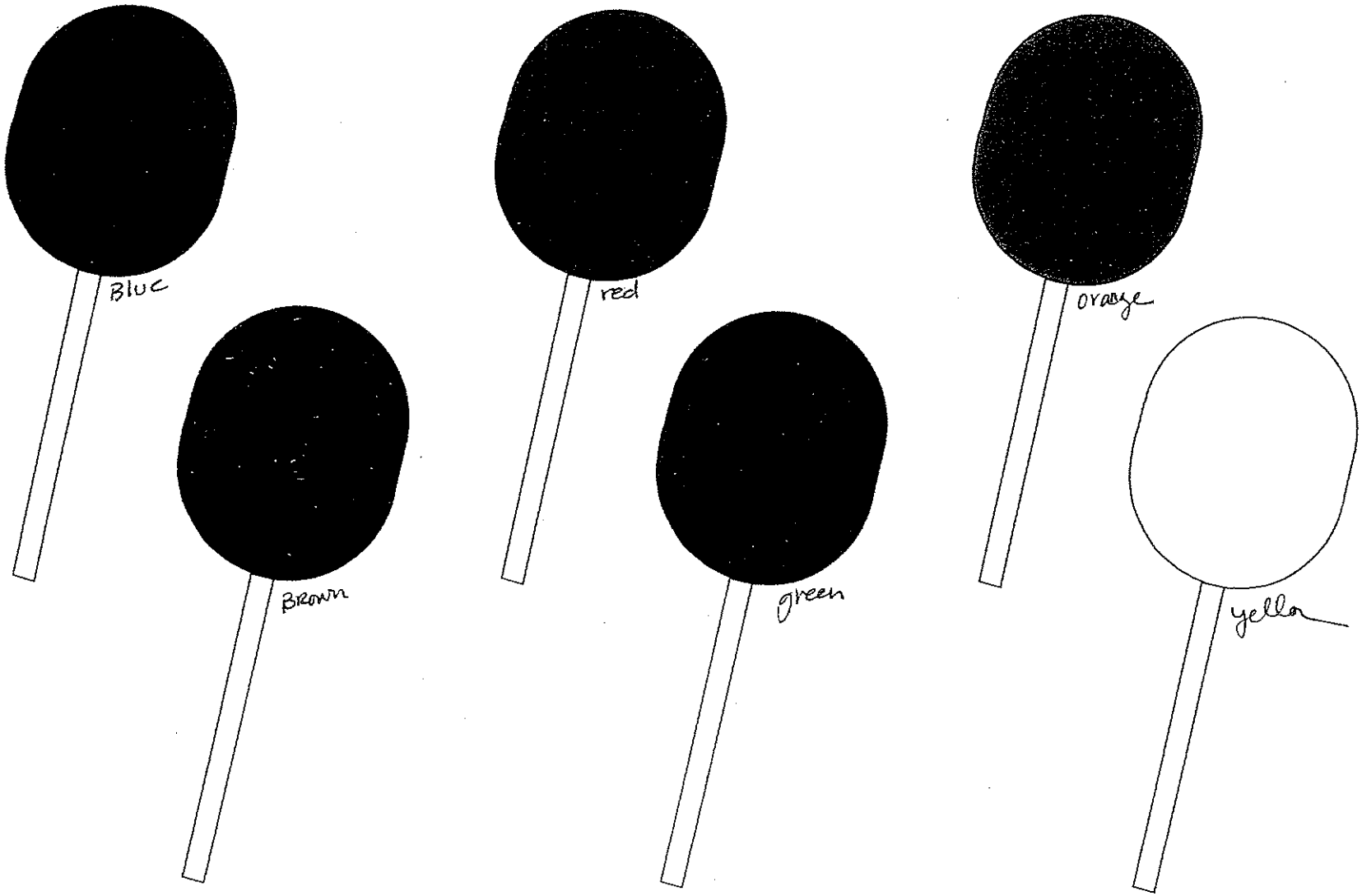
by

Alex L. Chew, Ed.D.

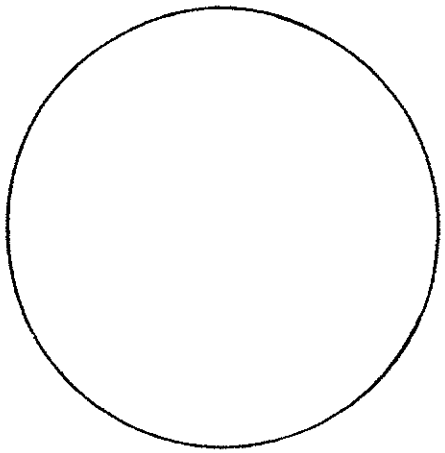
Stimulus Cards are used with the **Administration and Scoring Manual**. See manual for complete directions.

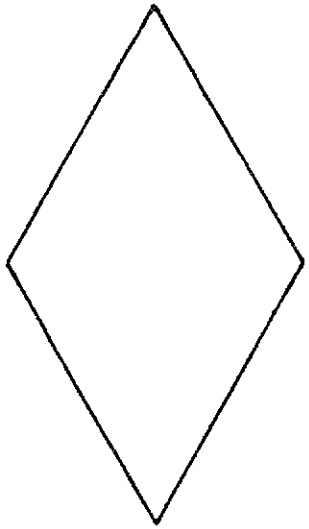
Contents:

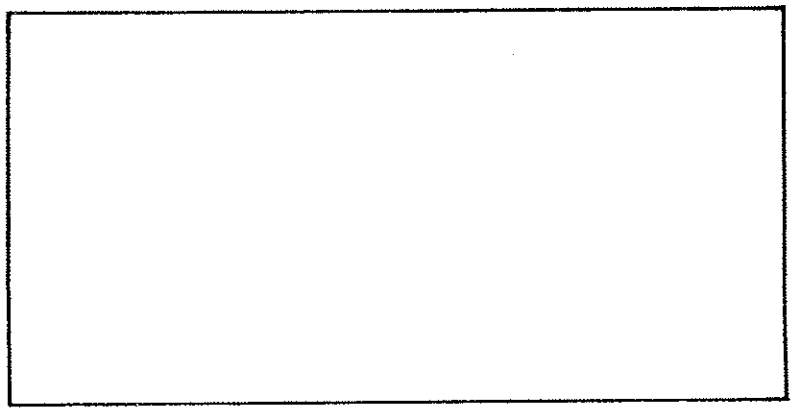
Stimulus Card 1: Identification of Colors

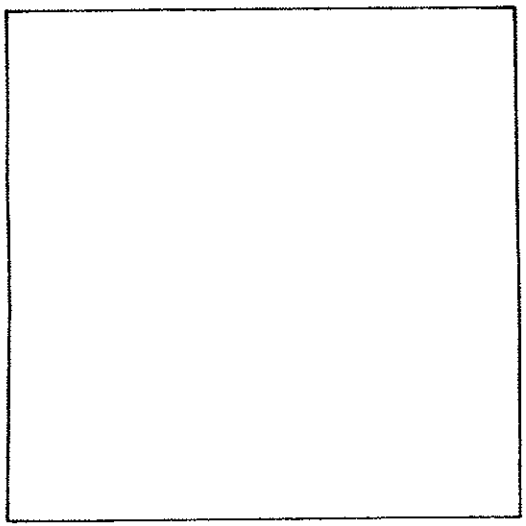


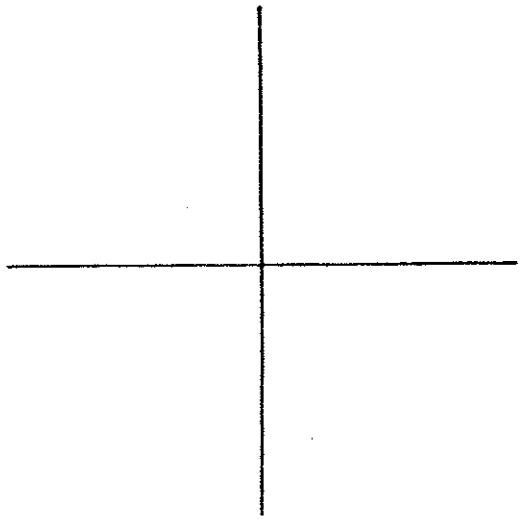
Stimulus Card 2: Identification of Shapes

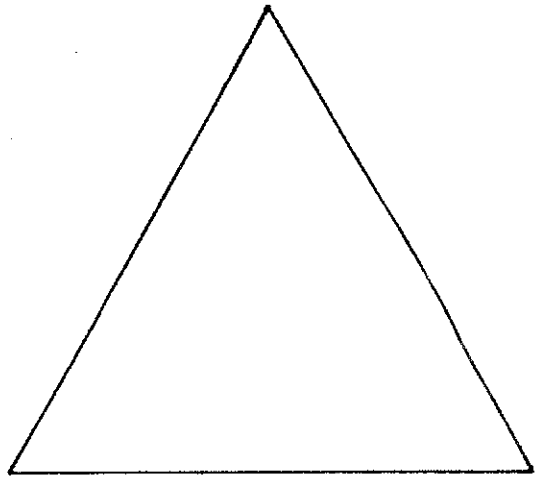




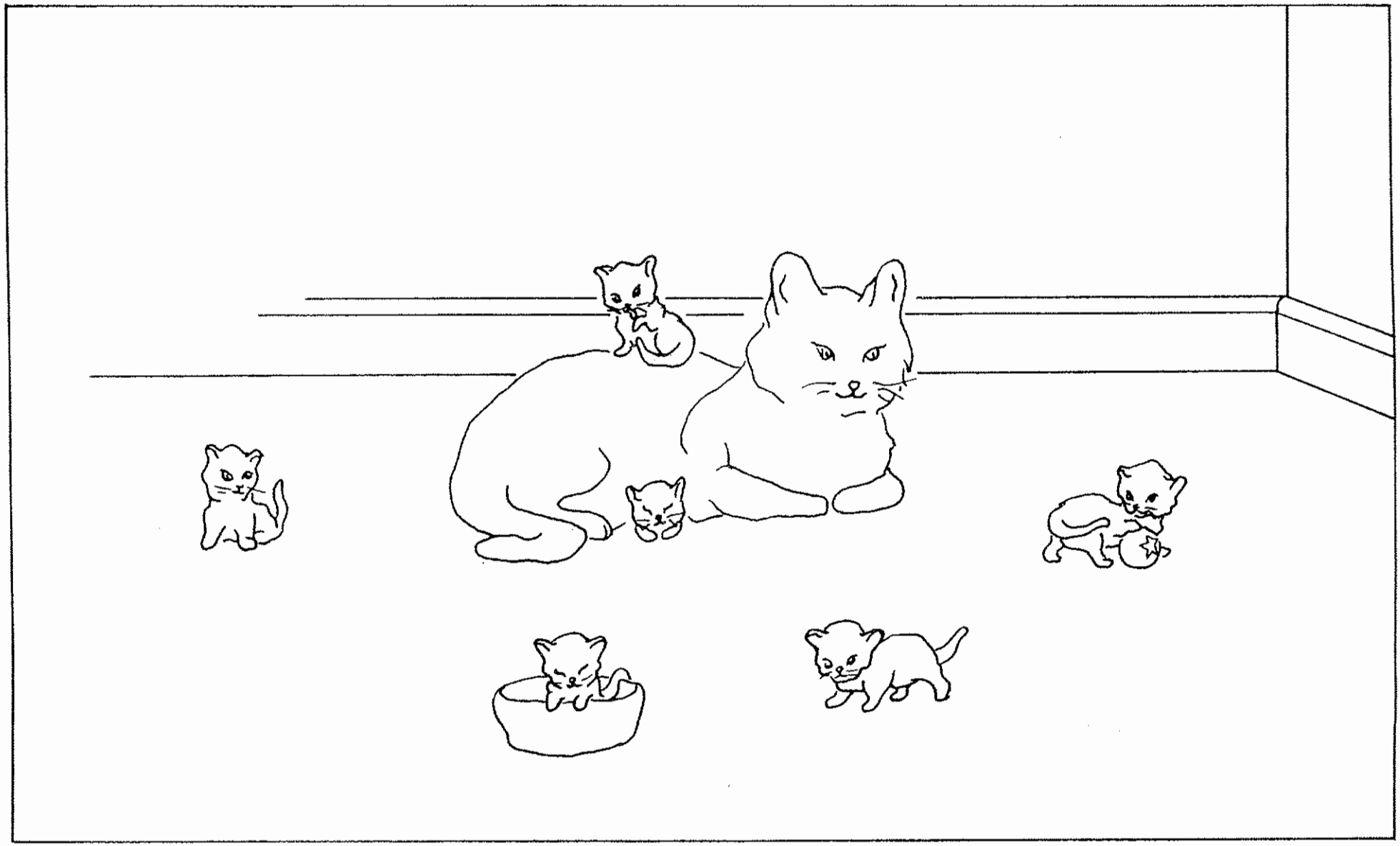




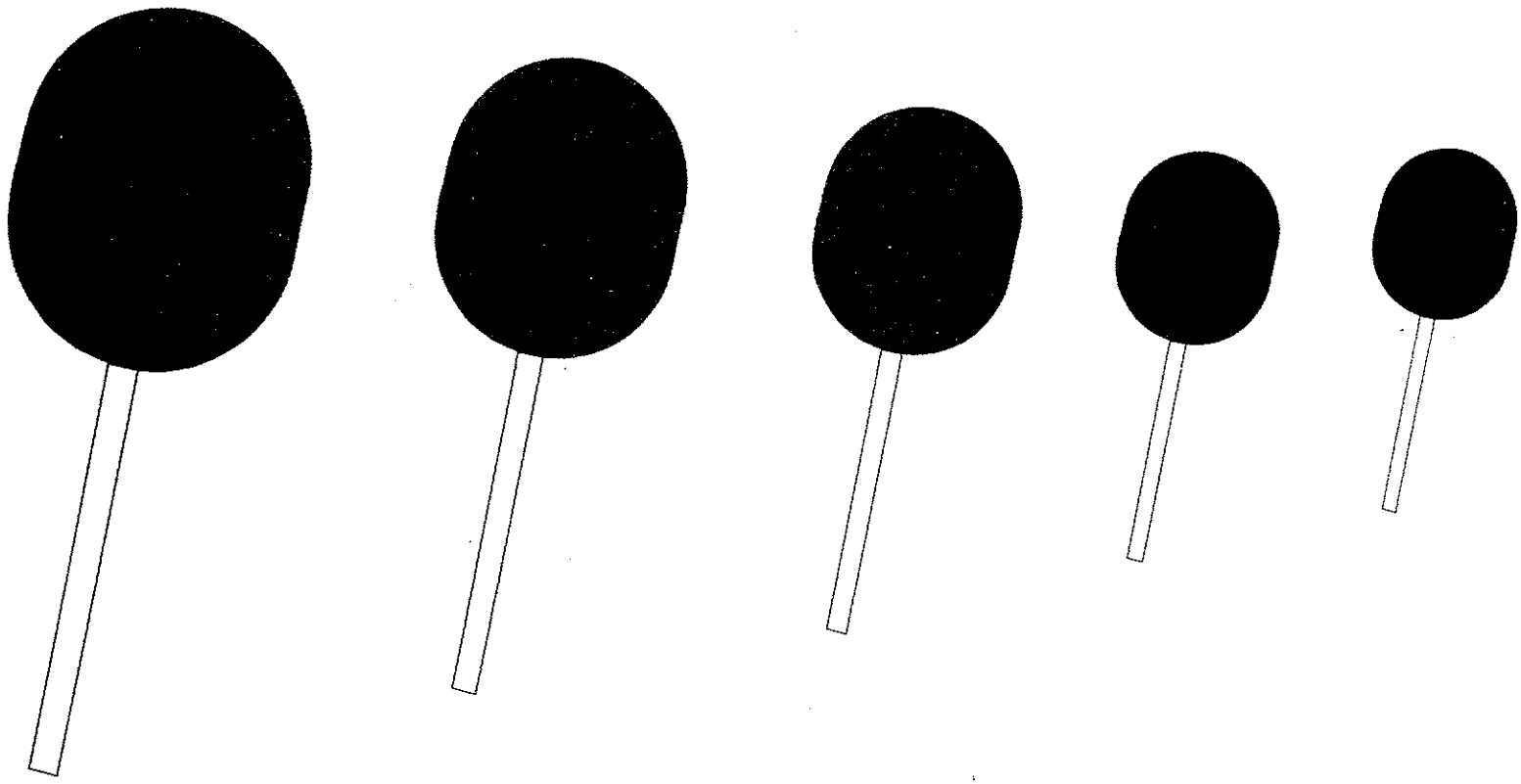




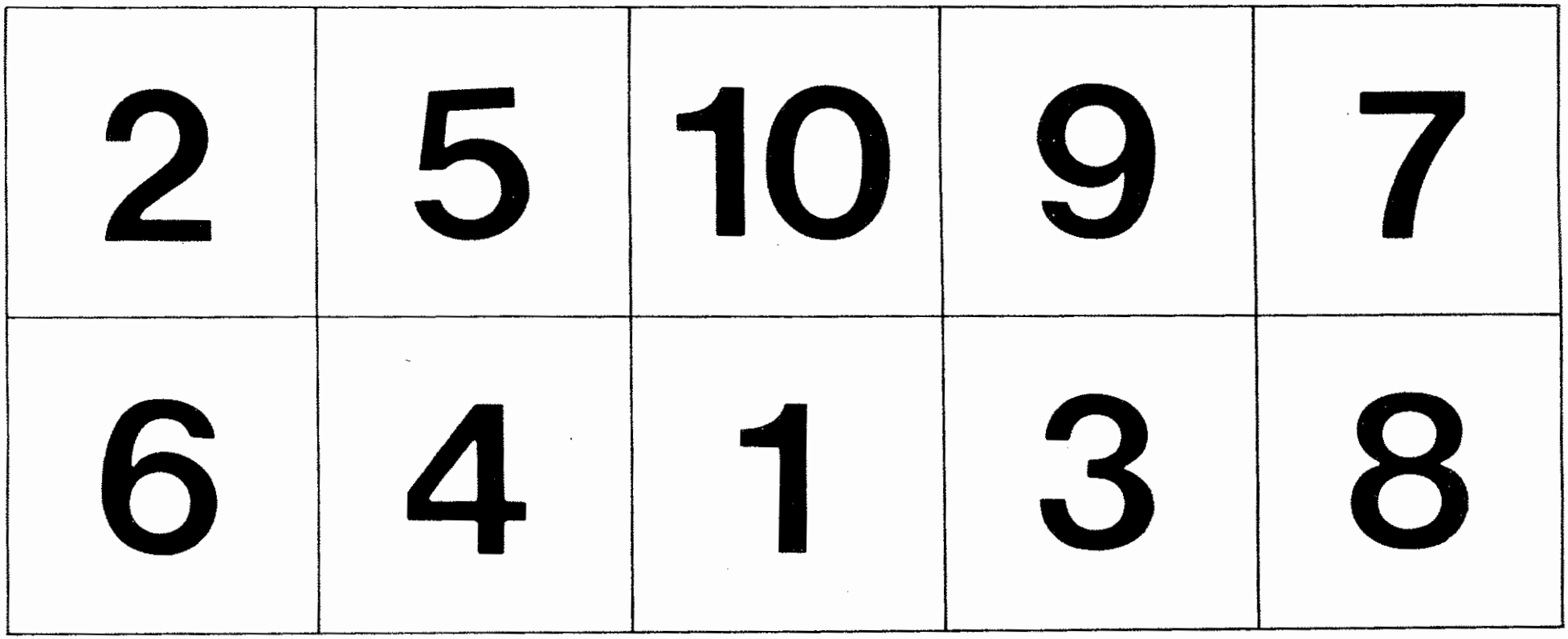
Stimulus Card 3: Picture Description & Position



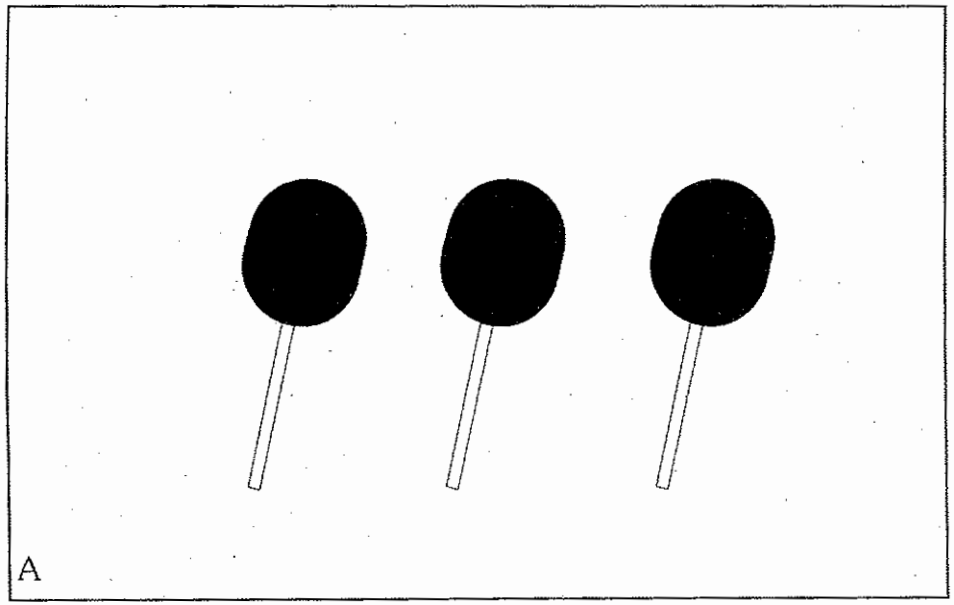
Stimulus Card 4: Spatial Recognition

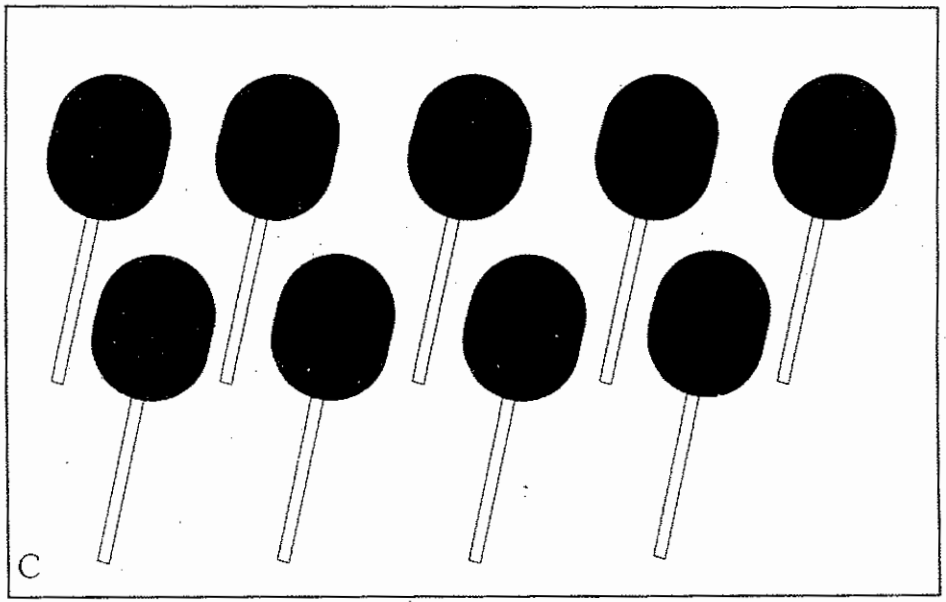


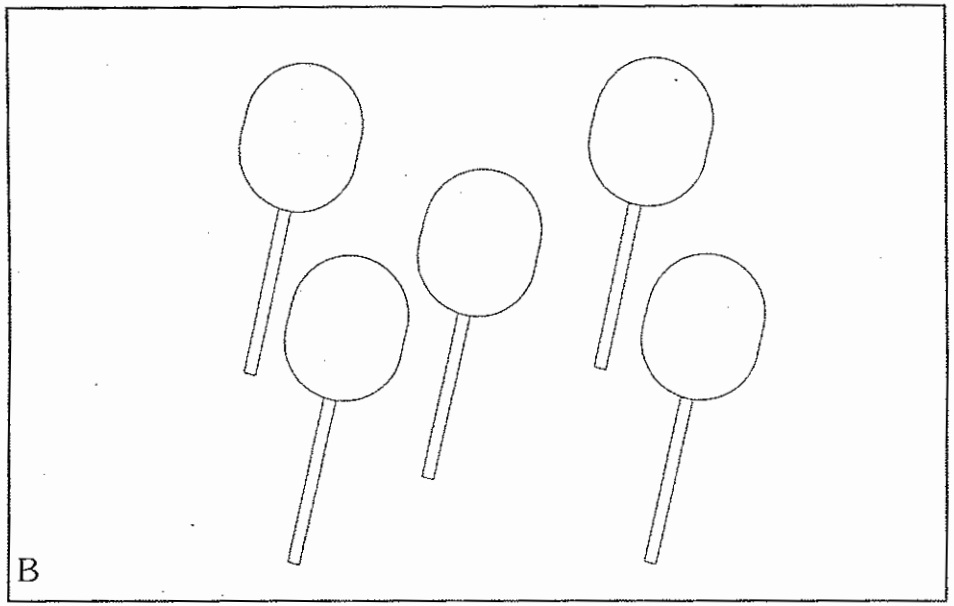
Stimulus Card 5: Identification of Numbers

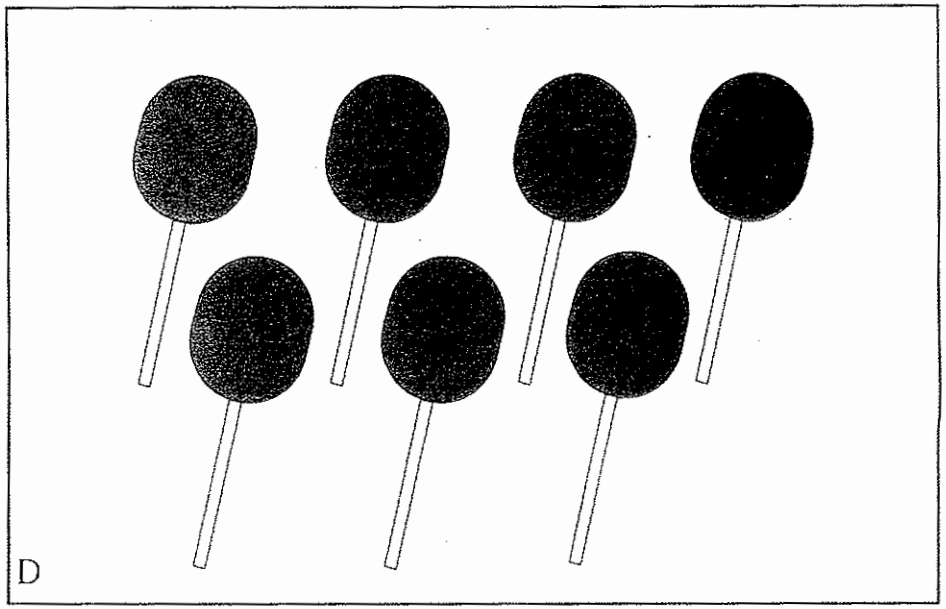


Stimulus Card 6: Counting

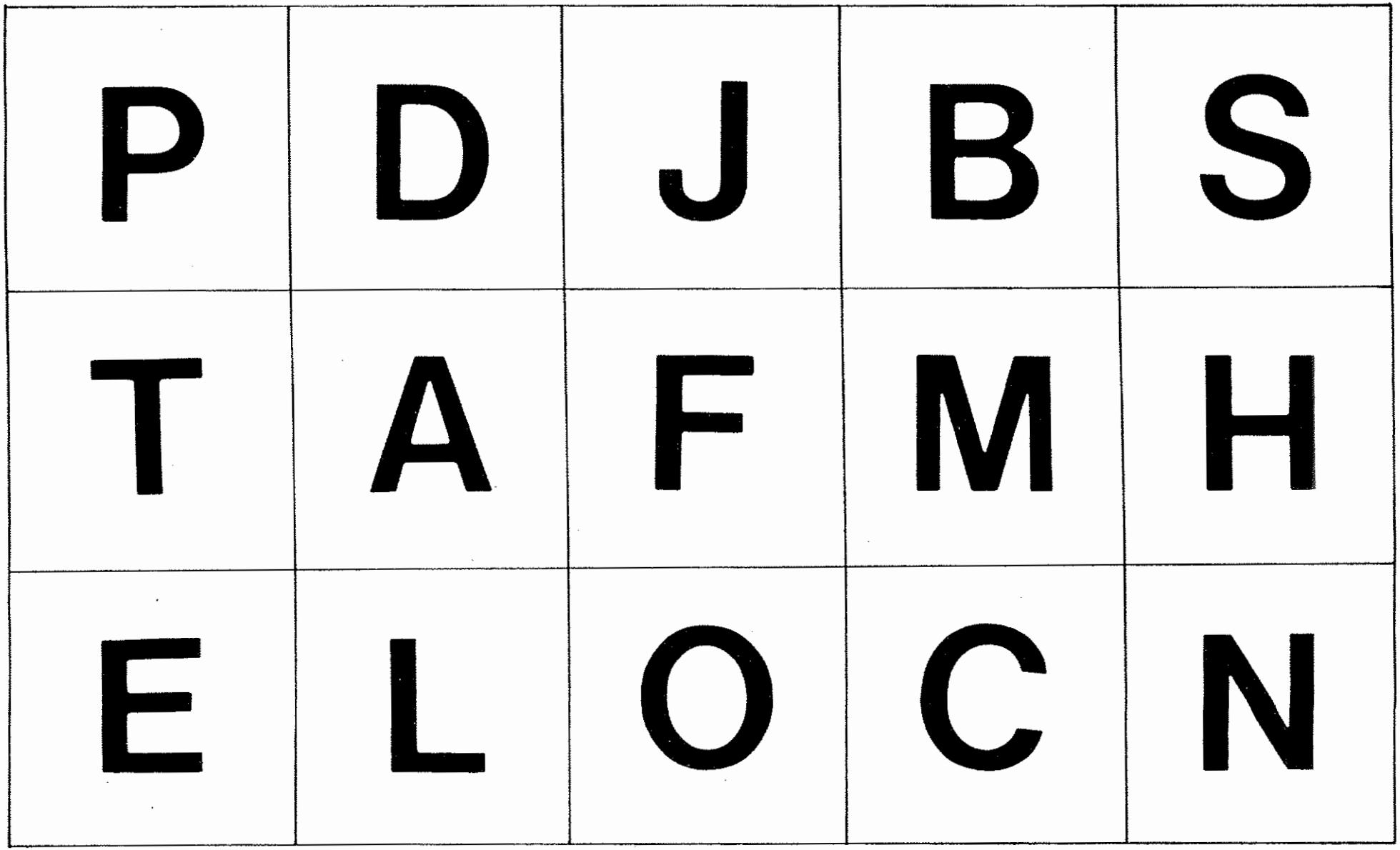








Stimulus Card 7: Identification of Letters



Parent Survey of Kindergarten Readiness

Parent Information about child entering Kindergarten

Please rate your child's ability on the following :

Not at all — Very Well

Boy or Girl

1. Can count to twenty	1	2	3	4	5	Don't know
2. Recognizes letters of alphabet	1	2	3	4	5	Don't know
3. Knows First and last name	1	2	3	4	5	Don't know
4. Knows address and telephone number	1	2	3	4	5	Don't know
5. Can sit and listen to a story for 15 minutes	1	2	3	4	5	Don't know
6. Recognizes the eight basic color: Blue , Red, Green, Yellow, Purple, Brown, Orange, Black	1	2	3	4	5	Don't know
7. Recognizes four shapes: square, triangle, circle, and rectangle	1	2	3	4	5	Don't know
8. Can put on own jacket	1	2	3	4	5	Don't know
9. Is able to use toilet by himself	1	2	3	4	5	Don't know
10. Can hop and skip	1	2	3	4	5	Don't know
11. Can follow 2 oral directions	1	2	3	4	5	Don't know
12. Share with others	1	2	3	4	5	Don't know
13. Plays with other children	1	2	3	4	5	Don't know
15. Uses crayon and pencil	1	2	3	4	5	Don't know
16. Attended preschool	Yes	No	Don't	Know		

Lollipop Test: A Diagnostic Screening Test of School Readiness-Revised

Teacher/Family Advocate: Child Rating Scale

Teacher\Family Advocate - Child Rating Scale

Initial Final
circle one

Child's Name _____ Date _____

Teacher/Family Advocate _____ School _____ SEX: M F

Please rate this child on the following items by circling the number which corresponds to this scale:

		Never	Occasionally	Moderately	Frequently	Always
1.	Disruptive in class	1	2	3	4	5
2.	Completes work	1	2	3	4	5
3.	Accepts things not going his/her way	1	2	3	4	5
4.	Withdrawn	1	2	3	4	5
5.	Defends own view under group pressure	1	2	3	4	5
6.	Underachieving; not working to ability	1	2	3	4	5
7.	Has many friends	1	2	3	4	5
8.	Ignores teasing	1	2	3	4	5
9.	Fidgety, difficulty sitting still	1	2	3	4	5
10.	Shy timid	1	2	3	4	5
11.	Poor work habits	1	2	3	4	5
12.	Comfortable as leader	1	2	3	4	5
13.	Anxious, worried	1	2	3	4	5
14.	Disturbs others while they are working	1	2	3	4	5
15.	Well organized	1	2	3	4	5
16.	Is friendly toward peers	1	2	3	4	5
17.	Accepts imposed limits	1	2	3	4	5
18.	Poor concentration, limited attention span	1	2	3	4	5
19.	Participates in class discussions	1	2	3	4	5
20.	Constantly seeks attention	1	2	3	4	5
21.	Nervous, frightened, tense	1	2	3	4	5
22.	Functions well, even with distractions	1	2	3	4	5
23.	Makes friends easily	1	2	3	4	5
24.	Difficulty following directions	1	2	3	4	5
25.	Copes well with failure	1	2	3	4	5
26.	Overly aggressive to peers (fights)	1	2	3	4	5
27.	Expresses ideas willingly	1	2	3	4	5
28.	Works well without adult support	1	2	3	4	5
29.	Is able to express feelings	1	2	3	4	5
30.	Poorly motivated to achieve	1	2	3	4	5
31.	Classmates wish to sit near this child	1	2	3	4	5
32.	Tolerates frustration	1	2	3	4	5
33.	Defiant, obstinate, stubborn	1	2	3	4	5
34.	Unhappy, depressed, sad	1	2	3	4	5
35.	Questions rules that seem unfair/unclear	1	2	3	4	5
36.	A self-starter	1	2	3	4	5
37.	Well liked by classmates	1	2	3	4	5
38.	Learning academic subjects (e.g. reading, math, etc.)	1	2	3	4	5

over

Acting Out

_____ Raw Score

_____ %ile

Shy-Anxious

_____ Raw Score

_____ %ile

Learning Skills

_____ Raw Score

_____ %ile

Frustration Tolerance/
Behavioral Limits

_____ Raw Score

_____ %ile

Assertive Social Skills

_____ Raw Score

_____ %ile

Task-Orientation/
Educational Performance

_____ Raw Score

_____ %ile

Peer Sociability

_____ Raw Score

_____ %ile

Self-Control Rating Scale

Self-Control Rating Scale (SCRS)

Please rate this child according to the descriptions below by circling the appropriate number. The underlined 4 in the center of each row represents where the average child would fall on this item. Please do not hesitate to use the entire range or possible ratings.

1. When the child promises to do something, can you count on him/her to do it? 1 2 3 4 5 6 7
2. Does the child butt into games or activities even when he/she hasn't been invited? 1 2 3 4 5 6 7
3. Can the child deliberately calm down when he/she is excited or all wound up? 1 2 3 4 5 6 7
4. Is the quality of the child's work all about the same or does it vary a lot? 1 2 3 4 5 6 7
5. Does the child work for long-range goals? 1 2 3 4 5 6 7
6. When the child asks a question, does he/she wait for an answer, or jump to something else before waiting for an answer? 1 2 3 4 5 6 7
7. Does the child interrupt inappropriately in conversations with peers, or wait his/her turn to speak? 1 2 3 4 5 6 7
8. Does the child stick to what he/she is doing until he/she is finished with it? 1 2 3 4 5 6 7
9. Does the child follow the instructions of responsible adults? 1 2 3 4 5 6 7
10. Does the child have to have everything right away? 1 2 3 4 5 6 7
11. When the child has to wait in line, does he/she do so patiently? 1 2 3 4 5 6 7
12. Does the child sit still? 1 2 3 4 5 6 7
13. Can the child follow suggestions of others in group projects, or does he/she insist on imposing his/her own ideas? 1 2 3 4 5 6 7
14. Does the child have to be reminded several times to do something before he/she does it? 1 2 3 4 5 6 7
15. When reprimanded, does the child answer back inappropriately? 1 2 3 4 5 6 7
16. Is the child accident prone? 1 2 3 4 5 6 7
17. Does the child neglect or forget regular chores or tasks? 1 2 3 4 5 6 7
18. Are there days when the child seems incapable of settling down to work? 1 2 3 4 5 6 7
19. Would the child more likely grab a smaller toy today or wait for a larger toy tomorrow, if given the choice? 1 2 3 4 5 6 7
20. Does the child grab for the belongings of others? 1 2 3 4 5 6 7
21. Does the child bother others when they're trying to do things? 1 2 3 4 5 6 7
22. Does the child break basic rules? 1 2 3 4 5 6 7
23. Does the child watch where he/she is going? 1 2 3 4 5 6 7
24. In answering questions, does the child give one thoughtful answer, or blurt out several answers all at once? 1 2 3 4 5 6 7
25. Is the child easily distracted from his/her work? 1 2 3 4 5 6 7
26. Would you describe this child more as careful or careless? 1 2 3 4 5 6 7
27. Does the child play well with peers (follow rules, waits turn, cooperates)? 1 2 3 4 5 6 7
28. Does the child jump from activity to activity rather than sticking to one thing at a time? 1 2 3 4 5 6 7
29. If a task is at first too difficult for the child, will he/she get frustrated and quit, or first seek help with the problem? 1 2 3 4 5 6 7
30. Does the child think before he/she acts? 1 2 3 4 5 6 7
31. Does the child think before he/she acts? 1 2 3 4 5 6 7
32. If the child paid more attention to his/her work, do you think he/she would do much better than at present? 1 2 3 4 5 6 7
33. Does the child do too many things at once? 1 2 3 4 5 6 7

Henderson Environmental Learning Process Scale (HELPS)

Henderson Environmental Learning Process Scale (HELPS)

Avail: NAPS-3

Variables Measured: Elements of the home environment that influence intellectual or academic achievement.

Type of Instrument: Self-report questionnaire

Instrument Description: The HELPS is a 5-point, 55-item Likert-type instrument designed to assess home environments of children and the extent to which those environments facilitate intellectual and academic achievement. The inventory was designed to be administered during interviews with parents of school-aged children. The interviewer is instructed to sit next to the respondent, reading each question and the available responses, while the participant follows along. Populations investigated with the HELPS are often not well educated. Reading of items is included in order to avoid embarrassing parents whose reading skills are suspect. The scale was designed to be administered by trained research or clinical assistants. Although not indicated by the authors, following slight modifications, paper-and-pencil administration should also be possible. Items are in the form of questions, with each response indicated on an appropriate continuum (e.g., *good/poor, excellent/failing, almost every day/very seldom*). Items are scored 1-5, with higher numbers indicating greater experience within that context, contact with learning situations, and so on. The HELPS score is the sum of scores of all times. Areas investigated by this scale include educational aspiration, range of stimuli available within the environment, guidance or teaching provided by parents, variability of adult educational and occupational role models, and the structure of reinforcement within the home to encourage intellectual/academic performance.

Sample Items:

(A) How often do you take (CHILD) along when you go shopping?
(B) How often do you talk to (CHILD) about things he/she has seen on TV?
(C) How often does (CHILD) see you reading something?

Comments: Cronbach's alpha, estimated from use of the HELPS with several samples, is reported to range from .71 to .85. The scale has been modified and used in various forms, with varying numbers of items and identified factors. The senior author indicates that users should modify the instrument according to the age of the sample and intellectual resources that are available within the community (museum, art gallery, zoo, and so on).

References:

Henderson, R.W., Bergan, J.R., & Hurt, M., Jr. (1972). Development and validation of the Henderson Environmental Learning Process Scale. Journal of Social Psychology, 88, 185-196.

Mink, I.T., & Nihira, K. (1986). Family lifestyles and child behaviors: A study of direction of effects. Developmental Psychology, 22, 610-616.

Nihira, K., Mink, I.T., & Meyers, C.E. (1985). Home environment and development of slow-learning adolescents: Reciprocal relations. Developmental Psychology, 21, 784-794.

Valencia, R.R., Henderson, R.W., & Rankin, R. J. (1985). Family status, family constellation, and home environment variables as predictors of cognitive performance of Mexican American children. Journal of Educational Psychology, 77, 323-331.