Assessment of Developmental Supports for At-Risk Children and their Families:

A Special Study for Help Me Grow-Alameda County

Draft Version
Acknowledgements

This project was funded by First 5 Alameda County and produced by Applied Survey Research.

A special thanks to our contributors:

Focus group participants

- Help Me Grow Family Navigator and Care Coordinator Staff
  - Carmen Hernandez, BANANAS
  - Cam-Mi La, Larene Paré, and Sonia Waters, Family Resource Network
  - Beatriz Dominguez, Laura Otero, Rachel Rivera and YC Wong, First 5 Alameda County
- Alameda County Home Visiting Program staff:
  - Rebecca Alvarado, Marguerite MacKenzie, and Nancy Roth, Alameda County Public Health Department
  - Morgan Bonar, Through the Looking Glass
  - Peggy Buscher, Special Start, Children’s Hospital Oakland
  - Arlette Hernandez, Brighter Beginnings
  - Sharmika Higgins, SSA/CWS
  - Jeymmy Pronos, Tiburcio Vasquez Health Center
- Playgroup participants enrolled in Lotus Bloom Child & Family Resource Center, The Unity Council, and Children’s Hospital and Research Center Oakland playgroup programs

Key informant interviewees

- Karen Tanner, Children’s Hospital and Research Center Oakland
- Angela Louie-Howard, Lotus Bloom Child & Family Resource Center
- Iris Preece, City of Fremont Youth & Family Services
- Dr. Veronica Sood, Highland Hospital Pediatrics

Project contacts:

Chris Hwang and Loren Farrar

First 5 Alameda County
1115 Atlantic Ave., Alameda, CA 94501
(510) 227-6900
www.first5alameda.org

Kim Carpenter, PhD and Lisa Colvig-Amir, MA

Applied Survey Research, Bay Area Office
1871 The Alameda, Ste 180, San Jose, CA 95126
(408) 247-8319
www.appliedsurveyresearch.org
# Contents

**Executive Summary** .......................................................................................................................... 6

**Introduction and Purpose** .................................................................................................................. 8

## Part 1: Assessment of Developmental Supports for At-Risk Children in Alameda County .............. 9
- What are characteristics of the people living in Alameda County? .................................................... 9
- Who has the greatest need for developmental support service assets in Alameda County? ............ 10
- What areas of Alameda County have the greatest need for services? .............................................. 12
- What are the developmental support needs of families in Alameda County? .................................. 13
- What developmental and family support services are available and where are they located in Alameda County? .................................................................................................................................................. 15
- What barriers tend to prevent families from accessing services? ..................................................... 19
- What are the predominant gaps between family need and available supports in Alameda County? .. 21
- Summary ............................................................................................................................................. 23

## Part 2: Review of Community Support and Early Prevention Strategies to Address Needs .......... 23
- Overview ............................................................................................................................................... 23
- Evidence-Informed Strategies .............................................................................................................. 24
  - Mental health services for families and children ........................................................................... 24
  - Speech/language issues ...................................................................................................................... 26
  - Parenting education and advocacy skills ......................................................................................... 27
  - Family support .................................................................................................................................. 29
  - Systems that support families ........................................................................................................... 31
- Summary ............................................................................................................................................... 34

## Part 3: Special Study on Developmental Playgroups ........................................................................ 35
- What are playgroups? ............................................................................................................................ 35
- How are developmental playgroups serving families in Alameda County? ...................................... 37
  - Playgroup Characteristics ............................................................................................................... 37
  - Playgroup Programs ......................................................................................................................... 37
  - Benefits of playgroups for children ................................................................................................. 38
  - Benefits of playgroups for parents ................................................................................................... 39
  - Differences in playgroup outcomes ................................................................................................. 40
  - Needs of parents utilizing playgroups in Alameda County ............................................................... 40
- Do developmental playgroups help ameliorate developmental risk or delay? .................................. 41
  - Research on the impact of developmental playgroup participation .............................................. 41
  - Enhanced benefits for low-income and immigrant families ............................................................. 42
- What are considered “best practices” for developmental playgroups? ............................................. 42
Evidence-based and best-practice models for Tier 1 playgroups ................................................................. 43
Evidence-based and best-practice models for Tier 2 playgroups ................................................................. 44
Summary ...................................................................................................................................................... 48
Integration of findings ................................................................................................................................... 48

Summary and Conclusions ............................................................................................................................... 49

References.................................................................................................................................................... 50
# Table of Figures

Figure 1. Population by Race in Alameda County ................................................................. 10
Figure 2. Population statistics for Alameda County in 2010 .................................................. 10
Figure 3. GIS maps of 3rd grade reading scores ................................................................. 12
Figure 4. GIS map of the location of all Help Me Grow Participants since 2009 .................. 13
Figure 5. Developmental concerns expressed by Help Me Grow Linkage Line callers .......... 14
Figure 6. GIS map of all developmental and family support services in Alameda County ...... 15
Figure 7. Number of Agencies offering each type of service, low- or no-cost to families in Alameda County ........................................................................................................... 16
Figure 8. GIS map of developmental therapy services in Alameda County ....................... 17
Figure 9. GIS map of adult, child, and family mental and behavioral health services in Alameda County ........................................................................................................... 17
Figure 10. GIS map of child surveillance and service coordination services in Alameda County .......................................................... 18
Figure 11. GIS map of parenting/child development support services in Alameda County .... 18
Figure 12. GIS map of low-cost family health care and support services in Alameda County ....... 19
Figure 13. Seven recommended strategies for the provision of early childhood mental health services ........................................................................................................... 25
Figure 14. Evidence-based family support programs ......................................................... 30
Figure 15. Pyramid of playgroup types by intensity of service ......................................... 35
Figure 16. Summary of developmental playgroup features by tier ..................................... 36
Figure 17. Evidence-based models with playgroups that significantly increase positive parenting practices and child development outcomes ......................................................... 45
Executive Summary

Alameda County is a complex county with both affluence and poverty. For the nearly one in ten families who live in poverty, services and supports which help their children grow and learn can be scarce, and difficult to access. Research shows that children living in poverty are more likely to have a developmental disorder, which makes early identification and access all the more crucial. This need is also borne out by the high number of children in Alameda County who are failing to meet third grade reading proficiency levels, which is a predictor of later academic success.

Developmental needs and service gaps
Children in Alameda County present a twofold need which must be addressed: the need for early prevention services to support child development and school readiness, and evidence-based early interventions for those with identified developmental support needs.

The results of this investigation include the nature of developmental concerns of families, gaps in the provision of developmental services, and barriers that families commonly face when accessing services.

The good news is that many of these issues can be remediated early on with a variety of evidence-based strategies and promising practices identified in this report.

However, increasing the quality of developmental programs and services in the county may not improve access to services for the families who need them the most. Many families need support navigating a fragmented and complex system of service delivery. Specifically, caregivers need help identifying what their children need, how to access services and support, and how to advocate for their children. Families follow up to ensure children are enrolled in and benefiting from developmental services.

There are also significant barriers presented by the service delivery system that can only be addressed by policy makers. For example, the overloaded service delivery system at the Regional Center repeatedly

Top developmental concerns of families include delays in:
- Language and communication
- Social-emotional functioning
- Physical development
- Cognitive development

Gaps in developmental services include:
- Mental health
- Child care
- Local services
- Services for mild or newly emerging delays
- Case management
- Housing for special needs

Common barriers to access include:
- An overloaded system of service delivery
- Lack of interagency communication and follow-up
- Caregiver denial of issues
- Social stigma
- Restricted services in languages other than English
slashed by budget cuts is not able to provide services for children with mild to moderate delays (defined as less than a 33% deficit in an area of development if under the age of 3 years). Yet, there are few treatment alternatives, particularly for low-income families. Without proper developmental supports early on, children at-risk for delays or with emerging delays are eventually treated once they reach school-age. The costs of missed opportunities for early intervention and remediation are felt by children who often have a more difficult time keeping up in school and by the school system that must provide more intensive services for children previously left out of the system.

**Filling the gaps**
Several recommended strategies are offered for filling the gaps in unmet needs and for breaking down access barriers. Overall, efforts should focus on:

- Using evidence-based programs and best practices in service delivery
- Training more providers how to administer early developmental screenings
- Increase funding of community-based developmental supports for families with young children, such as developmental playgroups, parent education, and literacy events
- Increasing access to child and family mental health services
- Reducing social stigma of developmental and mental health services through public media campaigns
- Increasing availability of comprehensive family support and case management systems such as the medical home model or programs that interlink agencies and provide follow-up with families
- Supporting campaigns to increase funding of IDEA part B and C to increase the number of children who qualify for services.

**Playgroup special study**
Developmental playgroups can be important sources of social support and early intervention that help children grow and learn, especially socially and emotionally. Research corroborates these positive benefits, particularly for low-income and immigrant families. In Alameda County, developmental playgroups models vary considerably. Common gains reported by participants include:

- Children demonstrate a range of improved skills including: social skills, confidence, self-regulation, motor skills and cognitive skills.
- Caregivers learn about child development and what to expect from their children, parenting skills that help them connect with and support their children developmentally. Caregivers also gain social support and more confidence as caregivers.

Although evidence-based playgroup models do not currently exist, several promising practices are recommended from existing early education and home visiting program models.

**Summary**
Families at highest risk for having children with developmental delays tend to have the fewest material and financial resources to meet their children’s needs. Coupled with concomitant factors of health problems, a lack of basic needs, and a challenging service delivery system, families are struggling to provide the support their young children need to thrive. This report identifies primary needs of children and families, current service gaps, and barriers that stand in the way of service access, and presents recommendations for filling those gaps and breaking down those barriers. Finally, this report investigates the benefit of developmental playgroups and offers potential frameworks for implementing a playgroup model using best practices.
Help Me Grow (HMG) in Alameda County comprises a streamlined system of early identification and referral that supports children aged 0-5 years and their families with developmental, behavioral and/or social-emotional concerns. An individual who has concerns about a child’s development can call the HMG “Linkage Line”, discuss concerns, and receive referrals for services including screening, assessment, and therapy for developmental and behavioral issues, as well as community supports to enrich the child’s growth and development. HMG also provides “Family Navigator” services to families that have a high or pervasive need for assistance. Based on a national model, the entire HMG system is designed to help ameliorate and/or mitigate developmental and/or social-emotional delays of young children in order to support kindergarten readiness and optimal development, as well as to reduce the need for more costly interventions later in life.

In addition to direct service with families in Alameda County, HMG builds capacity for early developmental screening and intervention services. HMG works at the system level to build collaboration across sectors, including health care, early care and education, and family support to ensure better outcomes for children. The four core components of a HMG model system include: child health care provider outreach, community outreach, a centralized telephone access point, and data collection and analysis to provide feedback on the health of the support system. HMG operates as an interagency collaborative, with First 5 Alameda County serving as the lead agency for the implementation and coordination of the initiative. Community involvement is necessary to sustaining the system and ensuring that the system is serving the needs of the community. Thus, HMG has a community-based structure of governance that is made up of providers, family members, and advocates and staff from community-based organizations (CBO) in Alameda County.

Between 2009 and 2012, HMG pilot tested the telephone Linkage Line and Family Navigators services through referrals from pediatricians and other service agency staff in the county. Providers have called and referred caregivers to the HMG Linkage Line to get information and referrals to local services to address developmental concerns, including behavioral, social, emotional, physical, communication, cognitive, and adaptive issues. Linkage Line staff provide information by phone. HMG also connects some families to Family Navigators who provide additional help accessing developmental supports in person and over the phone. Over a three year period, almost 2,200 calls were received by the Linkage Line from caregivers, 44% of these spoke English, 44% spoke Spanish and 4% spoke Cantonese. HMG Linkage Line staff connected 53% of families to Family Navigator support services.

First 5 Alameda County is providing evaluation resources to assess HMG strengths, challenges and opportunities for quality improvement. This special study is part of a multi-pronged evaluation strategy to understand families’ experiences as they learn about their child’s development and seek access to developmental services.

Given the purpose of the HMG system and the need to expand and improve services, the three objectives of this special study conducted by Applied Survey Research (ASR) are the following:

1. To identify current assets, needs, and gaps in services and support for children with, or at-risk of, developmental delay including behavioral and social-emotional issues
2. To develop recommendations for filling gaps and unmet needs informed by community-level data and a comprehensive literature review of evidence-based practices

3. To develop a research-based framework, including recommended standards of practice, for the delivery of developmental playgroups for children with, or at-risk of having, developmental delay

ASR utilized multiple resources to conduct this investigation. Information about the needs of families and service availability was derived from a combination of community data, four key informant interviews with providers, five focus groups with caregivers and providers, and a comprehensive internet resource scan of Alameda County. Extensive literature reviews on current theory and practice in the content and delivery of developmental supports and developmental playgroups informed recommendations for evidence-based and best practices. Together, these data strengthen understanding of how Alameda County providers can better meet the developmental needs of families, particularly those with children who have, or are at-risk of, developmental and/or social-emotional delay.

The report is divided into three parts based on the three objectives of the study stated above. First, information about current assets, needs and gaps in services in Alameda County are presented. Next, a summary of findings with recommendations for filling gaps based on current research are presented. Last, a special investigation of developmental playgroups discusses the research on how playgroups can be beneficial, the views of playgroup providers and caregivers, and best practices for implementing this type of support in a community setting.

**Part 1: Assessment of Developmental Supports for At-Risk Children in Alameda County**

**What are characteristics of the people living in Alameda County?**

According to 2010 US Census reports, 1.5 million resided in Alameda County. The county is racially and ethnically diverse; Approximately 23% of residents identify themselves as of Hispanic or Latino ethnicity; 43% residents identify as racially white (including Latino/Hispanic) and 26% as Asian 52% of these residents lack English proficiency.\(^1\)

Compared to all of California, Alameda County had a larger percentage of college graduates, a higher median household income, slightly lower percent of families whose income was below the poverty level in the last year, and more people with health coverage (see Figure 2). However, there are also neighborhoods where there are significant numbers of families experiencing extreme poverty.

\(^1\) 2009-2011 American Community Survey 3-Year Estimates
Who has the greatest need for developmental support services in Alameda County?

What the community-based numbers reveal is that families in Alameda County are better off on average than the rest of California. However, this rosy picture hides the fact that nearly 1 out of 10 families (approximately 140,000 individuals) is surviving on income below the poverty threshold, with a substantial number of families who qualify as working poor (under 200% of the poverty threshold). In addition, communication in English is limited or not possible for nearly one fifth of residents.

Living in Alameda County is expensive. The March 2012 cost of living estimate for Alameda County was considered “very high” rated as 143.5 (US average=100). The Self-Sufficiency Standard for Alameda County is $78,858 for the sole provider of a family with two adults and two children. Therefore, it is not surprising that one out of four children in Alameda County live in households that have recently received public assistance to take care of basic needs (Supplemental Security Income (SSI), cash public assistance income, or Food Stamp/SNAP benefits). In addition, data from the Department of Health Care Services

---

3 2009-2011 American Community Survey 3-Year Estimates
indicate that just over 109,000 children (0-18 years) were enrolled in Medi-Cal in Alameda County in 2011. Based on National Health Interview Surveys (NHIS) 1997-2008, developmental disorders such as ADHD, intellectual disability, autism, stuttering or stammering, hearing loss, blindness, seizures, learning disorders, and other developmental delays affect around 15% of children aged 3 to 18 years (Boyle, 2011). Analyses of these data also found two prominent associated factors for diagnosis; type of insurance and poverty status. The prevalence of developmental disabilities was nearly twice as high among children with public compared to private forms of insurance. Family income below the poverty level was also associated with higher prevalence of children with developmental disabilities in the family. Therefore, research demonstrates that children from low-income families are at higher risk for developmental issues.

Thus, it follows that the families at highest risk for having children with developmental delays tend to have the fewest material and financial resources to meet those needs if they arise. Caregivers may perceive and experience barriers to support services based on limited economics, transportation, language, and education on child development. Many of these families have the added burden of poor health, a lack of basic needs, and limited social support.

The primary system for serving children with developmental delays and disabilities was created through the Individuals with Disabilities Education Improvement Act (IDEA) part C (ages birth to 2 years) or part B (ages 3 to 5 years). Each state determines eligibility criteria and how IDEA services are administered. Federal funding of the act is historically well below cost, therefore state and local governments must cover the difference to be able to provide services to children in need. In California, reduced funding has been associated with tougher eligibility criteria for children with identified issues. This means that more and more children are not qualifying for services even though they have developmental issues that would have been treated therapeutically before these cuts, or if the family resided in other states with better funding.

In addition, there have always existed populations of children who have experience some developmental and/or social-emotional issues. According to the Individuals with Disabilities Education Act (IDEA), an “infant or toddler with a disability” means an individual under 3 years of age who needs early intervention services because the individual—

(A) is experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more of the areas of cognitive development, physical development, communication development, social or emotional development, and adaptive development; or

(B) has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay

The State of California has set the criteria for ‘developmental delay’ in the state —

(A) for children under 24 months of age at the time of referral:
- 33% delay in one or more areas of development

(B) for children over 24 months of age at the time of referral:
- 50% delay in one area of development, or
- 33% delay in two or more areas of development

---

What is a developmental disability?

5 The Individuals with Disabilities Education Act (IDEA), is a United States federal law that governs how states and public agencies provide early intervention, special education, and related services to children with disabilities.
delays who would benefit from some level of intervention but would not require entitlement-based services.

Therefore, the number of families with children who have unmet prevention and early intervention needs are growing in Alameda County, while low-cost services are not keeping up with demand.

*In summary, the children at greatest need for developmental services and support linkages in Alameda are children who do not qualify for IDEA services, and/or come from families with high economic need. Thus, the focus of this report is on the children who fall into one or both of these categories as they are the most likely to benefit from linkages to developmental services.*

**What areas of Alameda County have the greatest need for services?**

Third grade reading proficiency is an important metric of academic performance of children. Reading skills at the end of third grade have been repeatedly shown to predict a host of health and well-being outcomes for children later in life, including high school graduation, career success, and life satisfaction. Children with low literacy skills in third grade often enter kindergarten without the requisite skills for success across academic and social-emotional domains. Therefore, 3rd grade reading proficiency levels can indicate where early developmental assessment and supports are needed the most. The GIS map of third grade reading scores (Figure 3; see also Appendix A) indicates the location of elementary schools in Alameda County and what percent of the students in each school tested at or below basic reading proficiency in 2010. The size of the dot indicates the number of students tested. Color indicates percent of students not reaching the benchmark. Red dots indicate that 65% of the children at the school are lower than or at basic proficiency in 3rd grade. The areas of lowest proficiency and highest need in Alameda County are in Oakland, San Leandro, and Hayward.

The second GIS map (Figure 4, see also Appendix A) depicts where Help Me Grow participants (2009-2012) reside within Alameda County. The highest number of callers lives in Oakland, with Hayward as a distant second, followed by San Leandro. Together, the data from Figures 3 and 4 indicate that users of HMG services tended to reside in the areas with low literacy in 3rd grade.

*Figure 3. GIS maps of 3rd grade reading scores*
What are the developmental support needs of families in Alameda County?

In order to capture information about the needs of families across sectors of the population, existing data from Help Me Grow (HMG) usage, key information interviews, and focus groups with caregivers were analyzed and summarized.

Although usage data from the HMG pilot roll-out with primarily pediatrician referrals is not representative of all needs across all sectors of the population of Alameda County, it offers some insight as to the needs of families seeking help for physician-identified problems. Data obtained from 1,066 HMG Linkage Line users in 2012 indicate that three out of four families had primary concerns about communication and language development. Over one third of callers had concerns for physical development, 30% for social-emotional concerns, and a quarter had concerns about cognitive functioning (see Figure 5).

HMG staff and home visitors from local service organizations reflected that developmental concerns involving language (lack of speech), delays in walking and toileting, social concerns (i.e., social responsiveness, fixation with an activity, tantrums, autistic behavior) were the most commonly reported. Key informant interviews with community members echoed the needs expressed by HMG callers and family navigators. Iris Preece from the City of Fremont Youth and Family Services division and Dr. Sood from Highland Hospital agreed that language delay followed by behavioral issues were the top needs of families they serve. They specifically mentioned separation distress, sleep issues, lack of compliance with requests, and tantrums.
Iris Preece reiterated her observation that children with special needs add exponential risk to a family already struggling with other risk factors such as poverty and mental illness. Family navigators and home visitors talked at length about the need for family resources when addressing the developmental needs of the children; providing access to services doesn’t help a caregiver who has difficulty making appointments due to a lack of transportation, food security issue, or depression or other illness.

**Figure 5. Developmental concerns documented in referrals to Help Me Grow**

<table>
<thead>
<tr>
<th>Categories of Developmental Concern</th>
<th>Frequency</th>
<th>Percent of callers with concern*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication/Language, Overall</td>
<td>811</td>
<td>76</td>
</tr>
<tr>
<td>Physical, Overall</td>
<td>384</td>
<td>36</td>
</tr>
<tr>
<td>Fine motor</td>
<td>279</td>
<td>26</td>
</tr>
<tr>
<td>Gross motor</td>
<td>184</td>
<td>17</td>
</tr>
<tr>
<td>Feeding/nutrition issues</td>
<td>45</td>
<td>4</td>
</tr>
<tr>
<td>Toilet training issues</td>
<td>21</td>
<td>2</td>
</tr>
<tr>
<td>Social-Emotional, Overall</td>
<td>312</td>
<td>29</td>
</tr>
<tr>
<td>Tantrums/aggression</td>
<td>171</td>
<td>16</td>
</tr>
<tr>
<td>Social skills</td>
<td>123</td>
<td>12</td>
</tr>
<tr>
<td>Coping skills/frustration tolerance</td>
<td>85</td>
<td>8</td>
</tr>
<tr>
<td>Compliance/following directions</td>
<td>83</td>
<td>8</td>
</tr>
<tr>
<td>Crying/consoling issues</td>
<td>63</td>
<td>6</td>
</tr>
<tr>
<td>Shy, withdrawn or clingy</td>
<td>35</td>
<td>3</td>
</tr>
<tr>
<td>Dangerous/risky behavior</td>
<td>30</td>
<td>3</td>
</tr>
<tr>
<td>Temperament</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cognitive Functioning, Overall</td>
<td>273</td>
<td>26</td>
</tr>
<tr>
<td>Caregiver-Child Relationship, Overall</td>
<td>97</td>
<td>9</td>
</tr>
<tr>
<td>Discipline/creating boundaries</td>
<td>79</td>
<td>7</td>
</tr>
<tr>
<td>Relationship or interaction problem</td>
<td>57</td>
<td>5</td>
</tr>
<tr>
<td>General Development (NOS), Overall</td>
<td>75</td>
<td>7</td>
</tr>
<tr>
<td>Self-help/adaptive behavior</td>
<td>71</td>
<td>7</td>
</tr>
<tr>
<td>Self-care and play</td>
<td>5</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Biological insult/medically fragile</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Environmental Stressor, Overall</td>
<td>74</td>
<td>7</td>
</tr>
<tr>
<td>Family stress</td>
<td>74</td>
<td>7</td>
</tr>
<tr>
<td>Child abuse</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Child trauma</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sensory, Overall</td>
<td>35</td>
<td>3</td>
</tr>
<tr>
<td>Vision or Hearing</td>
<td>24</td>
<td>2</td>
</tr>
<tr>
<td>Oversensitivity to stimulation (light, touch, foods, etc.)</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>67</td>
<td>6</td>
</tr>
</tbody>
</table>

N= 1066 HMG callers

*Callers often express more than one concern, therefore percentages total over 100%.
What developmental and family support service assets are available and where are they located in Alameda County?

An extensive scan of the internet for developmental and family support services in Alameda County was conducted to continue to build the HMG resource database as well as to understand where services of different types were offered. Nearly 250 service access points were identified and mapped, each depicted as a yellow house in Figure 6 (see also Appendix A for a larger map). A large concentration of services is found in north Alameda County, with smaller pockets found down the western corridor of the county.

Figure 6. GIS map of all developmental and family support services in Alameda County

Services Directory
All services were then catalogued into five groups described below, counted (see Figure 7), and visually represented in GIS maps in Figures 8-12 (see also Appendix A for larger maps). The service categories are:

1) **Developmental therapy** - Physical, occupational, speech, communication, social skills, and disorder-specific, such as autism (See red bars, Figure 7; Figure 8)

2) **Mental health support** - Adult, family, child, and behavior-based therapy (see orange bars in Figure 7; Figure 9)

3) **Child Surveillance and service coordination** - child assessment and surveillance, case management (see yellow bars, Figure 7; Figure 10)

4) **Parenting/developmental support** - child care and early education, developmental playgroups, parent education and support classes and groups, community-based activities such as story time, and resources for finding care and early education services for children (see green bars, Figure 7; Figure 11)

5) **Family support** - family health care and health screening, aid for domestic violence, basic needs, and legal assistance with SIS and other entitlement services (See blue bars, Figure 7; Figure 12)

**Figure 7. Number of Agencies offering each type of service, low- or no-cost to families in Alameda County**

The individual GIS maps of services help to show how services are spread around the county. Services are population-based with higher concentrations of services in the north. Union City and Dublin have very few resources, followed closely by the eastern cities of Pleasanton and Livermore.

Developmental therapy services are highly specialized and the least prevalent within the county. Mental health for adults, children and families had some of the highest prevalence rates. Community-based supports are also fairly prevalent due in a large part to early literacy services offered at local libraries. Low cost childcare and preschool resources were lacking.
Figure 8. GIS map of developmental therapy services in Alameda County

Figure 9. GIS map of adult, child, and family mental and behavioral health services in Alameda County
Figure 10. GIS map of child surveillance and service coordination services in Alameda County

Figure 11. GIS map of parenting/child development support services in Alameda County
Common barriers to services include:

- An overloaded system of service delivery
- Lack of interagency communication and follow-up
- Caregiver denial of issues
- Social stigma
- Restricted services in native languages

What barriers tend to prevent families from accessing services?

Help Me Grow staff and key informants described families seeking services for their children as stressed, confused, low in social support, and in denial about issues. Community informants shared that a congested system of service delivery, lack of knowledge or denial of issues, communication barriers, and transportation issues were among the most common. Other significant barriers include family support needs due to poverty and poor physical and/or mental health. For many of these reasons, families need guidance in how to help their children. The most prevalent barriers are discussed in the ensuing paragraphs.

An overloaded system of service delivery prevents families from accessing needed services in a reasonable time frame. Home visitors stated that delayed access to services was the most significant issue for their families. Providers quipped that if they had so much difficulty getting through phone lines and setting up services for families… what are the chances that a family in crisis, with low literacy, mental health issues, or a language barrier will succeed? Home visitors called for backline access to agencies, similar to doctors calling other doctor’s offices, as well as training on the appropriate use of assessment tools and what to do with the information once
obtained. One provider stated that after she administered the ASQ-SE, she didn’t know what the results meant or what to do with them. Having a properly trained work force with back-line access will enable more children to be identified and assessed with minimal delay, wasted time, or duplicated effort.

Caregivers also had difficulty once they qualified for services. There are too few appointments given the demand for services. Caregivers reported a four month wait list for speech therapy and two months for playgroups. Services for infants and young children need to be addressed quickly and effectively to achieve the best outcomes.

Many children are not meeting eligibility requirements for services. For example, in response to declines in funding, the California legislature has raised the criteria for the California Early Start program (operated in Alameda County by Regional Center of the East Bay) requiring more severe levels of impairment to qualify for services. Caregivers report few or no affordable options to help children who are assessed as having delays, but not severe enough to meet current service eligibility criteria. The “wait and see” approach to early childhood developmental issues should not be the standard of care.

The potential for children to fall through the cracks is extremely high without developmental support structures and interagency communication to provide continuity of care and case management. Caregivers reported that case management services are not fulfilling their role to help link and maintain services for children and their families. Some caregivers talked about overworked social workers who did not return calls for months at a time. Both providers and caregivers discussed the need for case management and warm handoffs between agencies or programs to help with continuity of care. Well-trained case managers or family navigators who have more experience with available services can guide families and ensure the proper assessments and services are attained. Sometimes primary doctors play this role, but Dr. Sood voiced difficulty following up on mental health service utilization since primary care doctors do not have direct communication with most providers of mental health services due to patient confidentiality regulations.

As discussed in the next section, there are gaps in service availability. However, there are also utilization issues due to caregiver beliefs and decision-making processes. Practitioners and providers report that some caregivers are in denial that their child may have issues. In her medical practice, Dr. Sood observed that families typically do not recognize many of these problems as developmental issues and rarely seek help for these alone. Even when problems are recognized by caregivers, there is considerable negative social stigma attached
to services for special needs or disorders, particularly those involving mental health. According to Dr. Sood, stigma paired with extended family and friends convincing caregivers that things are “OK” and that the child will “grow out of it” lead to some assessment and service utilization delays. There was also evidence of fear among undocumented residents associated with accessing government-funded services. Caregivers hold the false belief that accessing these support services will negatively impact their chances for citizenship. Yet another problem with mental health services in particular is that undocumented families do not have access to many of these services because most of them only accept Medi-Cal. In Alameda County, there are few undocumented children under age 5, however, they may be part of families in which the caregiver is undocumented. According to providers and caregivers, services offered in languages other than English are limited. When they are offered, service availability is often limited to a few hour time slots a week. The already difficult process of accessing services for caregivers who speak languages others than English is too frequently met with longer wait times for bilingual practitioners.

The providers who we interviewed all serve low-income families. They conveyed the fact that a majority of these families are in crisis, which significantly impacted their ability to detect problems, advocate for services for their children, and even attend appointments with their children. Transportation was a common barrier for services located out of the neighborhood or city where the families reside. Families had difficulty linking several modes of transportation to get to services with their child(ren), exacerbated by the cost of travel and time-off required to get to appointments and return home. Home visiting professionals also conveyed the grave health conditions of many caregivers. Chronic disease and severe mental illness were not uncommon. When family well-being is depleted by poverty, stress, and chronic disease, there may be less opportunity to observe children’s development.

What are the predominant gaps between family need and available supports in Alameda County?

Gaps in developmental and family support services were identified through HMG records, interviews with key informants and focus group participants. These sources identified multiple areas where services were needed including: mental health, child care, case management, developmental supports for mild delays, service locations outside Oakland and San Leandro, and housing for families with special needs. However, all informants talked about the dire need for family support to better equip families to be able to address concerns about child development and advocate for services. Thus, gaps in developmental services as well as family support needs are included in these analyses.

Service providers identified significant need for mental health services for caregivers and children. The resource scan of Alameda County found 59 service access points for adult psychological services and 61 for child psychological services (see Figures 7 & 9). However, family navigators found that these were not adequately addressing needs for family counseling, mental health consultation at child care centers, availability of services in Spanish and
southeast Asian languages, and pediatric psychiatrists to provide medication management. Other informants saw a need for low cost fee-for-service arrangements for the uninsured, including undocumented residents.

Availability of affordable child care is a common problem for families across the United States, including families in Alameda County. Focus group participants called out gaps in funding for subsidized care, programs that meet children’s needs for developmental support/special needs, and access to onsite specialists. Many families in focus groups reported that they were just below the cutoff to qualify for Head Start/Early Start and could not afford other programs that had slots available. Some caregivers without affordable care options utilized developmental playgroups, such as Lotus Boom in Oakland, to provide social, emotional, and cognitive skill development for their children. Although quite happy with the service, the need to be present during playgroup sessions did not allow caregivers flexibility to take care of other needs or do paid work that standard child care arrangements offer.

As expected, developmental services and supports were needed for families with children who live outside of Oakland and San Leandro or have newly emerging issues or mild delays that don’t qualify them for intensive services. Oakland has the largest population density in the county and includes the Children’s Hospital and Research Center Oakland (CHRCO). Both CHRCO and the Regional Center of the East Bay (RCEB) in San Leandro provide the majority of intensive therapeutic services for children diagnosed with developmental delays and disorders in the county; however it is important to note that while the administrative offices are located in Oakland or San Leandro, the services may be home-based. Unfortunately, some families living outside of these areas who qualify for services experience difficulty coordinating transportation to appointments. There are also numerous children that don’t qualify for intensive therapeutic services, yet can’t find other community level supports in their area. Thus, more wide-spread and prevention/light intervention services are needed, in addition to linkages to transportation services to enable families to attend medical appointments at CHRCO and RCEB.

Multiple informants discussed the need for family strengthening supports such as home visits and case management to enable families to address all their needs and the barriers that prevent usage of needed services. Many families are in crisis and thus have moderately to severely diminished capacity to identify developmental issues in their children, get assessments, and follow-up when needed. For example, informants reported that struggling families had difficulty enrolling and staying enrolled in developmental and family support services. Many caregivers with young children were also isolated in small apartments, with little interaction with the outside world. Providers who work with highly vulnerable families expressed the need for providers who can offer linkages to services including medical case management and family planning.

Safe and affordable housing was a significant unmet need according to focus group participants. Unstable or unsafe living conditions increase stress, endangers children, and make it much less likely that children are exposed to an enriching home environment. Families with children with special needs have additional struggles when locating housing. There are relative few options that provide physical supports for disabled children or understanding by neighbors of behavioral issues (disruptive behavior, the need for physical restraint, etc.). Family navigators pointed out that families with children who have special needs should be a priority on wait lists for housing. Finally, home
visitors called out the need for more shelters that serve homeless families and minors.

Summary

This assessment of developmental supports in Alameda County identified who and where developmental support services are needed, common developmental needs of families, prominent barriers families encounter when accessing support services, and finally, a summation of the service gaps in the county. Although a relatively affluent county in the State of California, there is substantial evidence of economic need, including over 100,000 children on Medi-Cal, concentrated in Oakland, San Leandro, and Hayward. HMG provided data indicating high need for services addressing language and communication, cognitive functioning, fine motor control, and behavioral issues. Other informants add social interaction skills, attachment/separation issues, and sleep as prominent needs as well. Caregivers also stated affordable child care was not available to them.

Reported barriers to accessing services (by families and providers) include system-related difficulties including long wait times, eligibility, and availability of services in languages other than English. Interagency linkages were also an issue, which contributed to discontinuity of care and services. Caregivers were also reluctant to engage services, sometimes discouraged by family and friends or just not able to accept that there may be a problem. Finally, many families were in crisis and needed basic family support services to even begin to address issues with their children.

In conclusion, gaps in service availability in Alameda County appear largest for mental health services for adults and children. Other gaps included child care, nearby services, prevention and early intervention for mild issues, case management, and housing. The next section will explore evidence-based and best practices for addressing gaps in developmental services, family support, and the service delivery system.

Part 2: Review of Community Support and Early Prevention Strategies to Address Needs

Overview

The data presented in this report indicate that there are significant unmet needs of families in Alameda County with children at risk for, or already experiencing, developmental delays. Few-low cost developmental support services are available to address mild delays or to foster normative growth and development in at-risk children. Three out of four Help Me Grow users needed support for language and communication issues, making these services an important focus. A majority of caregivers in focus groups voiced their need for affordable childcare. Providers identified critical service gaps, including family mental health and basic needs, as well as fast-track pathways to link services to families. Services in languages other than English were also in short supply, as was geographic diversity of services for families outside of Oakland and San Leandro. Knowledge of child development and caregiver advocacy training is also important to prevent further delay in obtaining developmental assessments or services. On the whole, caregivers and providers alike felt that the service delivery system significantly impeded access to services resulting in discontinuity and delays in care.
The interplay of needs and services is complex, as are the strategies needed to rectify these gaps. Overwhelming feedback on problems with the system of service delivery led to investigating how the system can be improved in addition to early prevention and support strategies to address specific developmental needs of families and children.

**Evidence-Based Strategies and Promising Practices**

**Mental health services for families and children**

When social and emotional problems arise that impede a child’s learning or a caregivers’ ability to cope, it is critical that the adult, child, or family receive the support they need to get back on track. Social-emotional issues such as tantrums, defiance, and withdrawal, and extreme upset are common with young children and frequently addressed through parenting skills training and support (see recommended strategies and models under the next subheading.) The focus in this section is on strategies for increasing access to individualized mental health services and support for behavioral, social, and emotional issues in the home and school setting.

Four main factors discussed in the previous sections tend to affect the utilization of mental health services. The number of families who receive the mental health support that they need is greatly reduced by:

- Resistance to services because of stigma
- Rare follow-up by referring practitioners
- Lack of practitioners that operate on a fee-for-service basis, and are low-cost/accept Medi-Cal
- Lack of practitioners who communicate in multiple languages

*What strategies are likely to break through these access and usage barriers?*

A recent report out of the National Center for Children in Poverty entitled, *Building strong systems of support for young children’s mental health: Key strategies for states and a planning tool* (2011) identified seven key strategies that should be part of a comprehensive system of supports for young children’s mental health services. Emphasis is placed on screening, embedding mental health services in other programs, and providing family support for the most vulnerable children (see Figure 13). Example programs and models are provided to illustrate how each strategy has been effectively utilized.

A few prevention models in schools also deserve mention. SAMHSA evidence-based early detection and/or intervention models for schools include: *Primary Project*, *Al’s Pals: Kids Making Healthy Choices*, *I Can Problem Solve (ICPS)*, *Lesson One: The ABCs of Life*, and *Promoting Alternative Thinking Strategies (PATHS)*. As school-based models, all of these programs begin in preschool and focus on building social and emotional competency. School-based services have the advantage of reaching more children,
however the programs typically focus more on relationships with peers and teachers. Thus, issues within the family that may produce problems at school are not directly addressed.

**Figure 13. Seven recommended strategies for the provision of early childhood mental health services**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Examples of programs and models that support the strategy</th>
</tr>
</thead>
</table>
| 1) Promote early childhood mental health (ECMH) in home visiting and parenting programs | • Mental health consultants are hired to provide support for families enrolled in the Nurse-Family Partnership home-visiting program.  
• North Carolina’s statewide implementation of the Incredible Years-Parent Training Program: BASIC-Early Childhood |
| 2) Enhance supports for ECMH in early care and education programs | • Arkansas’ Early Childhood Mental Health Consultation Project and Connecticut’s Early Childhood Consultation Partnership (ECCP) offers consultation services to all state early care and education programs, center-based and home-based.  
• WestEd’s Program for Infant/Toddler Caregivers (PITC) in Ohio offers direct training and coaching with teachers and providers to create a foundation for social-emotional growth in young children.  
• Pyramid Plus: The center for Social Emotional Competence and Inclusion in Colorado provides training, technical assistance, planning, and information dissemination to promote the use of evidence-based models in early education. |
| 3) Screen parents for depression | • Illinois Perinatal Mental Health Project offers online information for health care providers about common mental health disorders, screening tools, billing, and additional training. It also began implementing interventions for depressed women in community health centers.  
• Ohio’s Help Me Grow Home Visiting program helps identify and find treatment for depression in women during the prenatal and postnatal periods. |
| 4) Screen children for social-emotional problems | • Minnesota’s Follow Along and Early Childhood Screening programs screen 12% of infants and toddlers and 80% of preschoolers in the state using ASQ and ASQ-SE.  
• California Statewide Screening Collaborative (CSSC) aims to increase coordination across state agencies and organizations involved in early screening for developmental issues, and bring agencies together on initiatives that focus on young children’s mental health and wellness. |
| 5) Develop a better-trained workforce to address the social-emotional needs of young children | • California’s Early Childhood Mental Health Workforce Training and Competency Guidelines describe the competencies needed by professionals to work with young children and families and promote mental health.  
• Michigan Association for Infant Mental Health (MI-AIMH) promotes the career development of infant and family professionals through published competency guidelines in Michigan and 14 other states |
Figure 13. Seven recommended strategies for the provision of early childhood mental health services (continued)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Examples of programs and models that support the strategy</th>
</tr>
</thead>
</table>
| 6) Use evidence-based practices and evaluation to promote effective ECMH programs | • Incredible Years-BASIC Early Childhood  
• Parent-Child Psychotherapy  
• ECCP  
• Parent-Child Interaction Therapy (PCIT) |
| 7) Support the well-being of exceptionally vulnerable children | • Assess risk using New Mexico’s Family Infant & Toddler Environmental Risk Assessment Tool or the Devereux Early Childhood Assessment (DECA)  
• Early Childhood Mental Health/Child Welfare Demonstration (ECMH/CW) provides mental health assessment and referral services to children involved in the child welfare system.  
• ECCP |

In summary, effective mental health programs and services for children require early detection, services brought to children in the home or school, and additional support for at-risk families. There are several model home-visiting and mental health consultation programs that provide services as an integrated part of other services. Integration with other services is beneficial for case management and also tends to reduce the stigma associated with mental health services. A critical part of delivering mental health services to children and their families that should not be overlooked is an adequately trained and compensated workforce.

**Speech/language issues**

Young children rapidly gain the capacity to comprehend spoken language, and utter words, phrases and sentences, all before the age of three. Like other aspects of development, rapid early growth makes early identification and intervention of language issues extremely important. Although 18 of 22 (81%) of caregivers with concerns about their child’s language or communication were successfully linked to appropriate services through Help Me Grow (First 5 Alameda County, March, 2013), both caregivers and providers indicate that high demand for speech/language pathologists create wait lists that are several months long, lessening the time for remediation before starting school. Timing is critical because communication and language skills are closely tied with early literacy, and thus, kindergarten readiness. Thus, this is a service area that needs to grow capacity to better serve families in Alameda County.

There are few evidence-based guidelines for speech and language early intervention. A recent evidence-based literature review sponsored by the American Speech-Language-Hearing Association’s (ASHA) National Center for Evidence-Based Practice in Communication Disorders (Schooling, 2010) investigated best practices in speech-language service delivery for children birth to 5 years of age. One of the main conclusions was that “the current science of Speech-Language Pathology (SLP) service delivery to young children remains woefully understudied.” Few conclusions that could inform practice were reached given extant published data. One notable exception included evidence for a promising strategy in the
use of caregivers as primary intervention providers. Exposure to language in the home plays a critical role in language development, thus it is not surprising that caregivers trained in language-building skills enhance therapeutic outcomes. Caregivers generally have more time to practice skills with their children than therapists.

Although a meta-analysis of parent-implemented early language interventions found positive effects on child language, methodological problems limited understanding of what worked and what didn’t (Roberts & Kaiser, 2011; 2012). However, four common strategies did emerge from the existing literature. They include: 1) responding to child communication, 2) increasing quality of linguistic input, 3) adjusting the balance of adult-child communication, and 4) expanding or recasting child communication.

Widely researched with parents and preschoolers, an early language intervention called enhanced milieu teaching (EMT) shows promise as one of the home-based early intervention programs for 2-4 year olds (Roberts & Kaiser, 2012). EMT is a conversation-based model of early language intervention that is directed according to child interest and everyday contexts to model and prompt language use. A randomized control trial demonstrated that parents can be trained to provide this language intervention. However, the program model included training parents over 24 sessions which is difficult to implement for community-based services. However, it is possible that a speech-language-focused playgroup or parent support group may be able to successfully adopt many of the lessons and strategies found in EMT parent training if facilitated by a well-trained provider.

In summary, it is clear that early language intervention is a burgeoning area of research. Currently there are few well-controlled or well-described studies to provide evidence-based guidelines for implementation. However, the value of training caregivers on language-building techniques to use with their children with expressive and/or receptive language issues is emerging as a promising early intervention practice.

Parenting education and advocacy skills

In the current fragmented service delivery system, caregivers must be knowledgeable, persistent advocates for their children in order to obtain developmental services. Parent advocacy requires that caregivers are knowledgeable of child development milestones, have conversations with service providers about milestones and their concerns, and show persistence in getting screenings or referrals to know if additional services are needed. Caregivers must also seek out prevention resources in the community, such as early literacy programs.

Relatively few low cost caregiver resources were found in Alameda County (see Figure 11 or Appendix A). Existing resources such as family resource centers, home visitors, pediatricians, playgroup facilitators, and HMG family navigators can help fill this gap by providing parenting knowledge and support, including child development tip sheets and resources. In addition, evidence-based parenting
education programs can be implemented. According to the SAMHSA resource database\(^6\) and a National Association for the Education of Young Children (NAEYC) report (Halgunseth, 2009), examples of programs that include evidence-based parenting knowledge and skill components include: Chicago Parent Program (CPP), Dare to Be You, Early Risers, Family Foundations, Incredible Years, Nurse-Family Partnership, ParentCorps, Parenting Fundamentals, Parents as Teachers (PAT), Systematic Training for Effective Parenting (STEP), and Triple P.

The provision of **developmental playgroups** in family support programs and early education settings is growing in the United States. Playgroups are increasingly recognized as important social support mechanisms, and more importantly as accepted vehicles for hands-on learning about positive parenting, child development, and ways to enhance child learning. The benefits to families gleaned from primarily qualitative sources indicates the value of playgroups for creating community, providing social support, developing parenting skills, enhancing child development and school readiness, and parent-child relationship building. The next section of the report on developmental playgroups delves into the what, how and why playgroups impact families and young children.

Dr. Sood suggested the use of a **public health media campaign** similar to the pertussis campaign to teach the public about child development. Caregivers asked her about the pertussis vaccine, and accepted the vaccine when recommended by a doctor more readily as a result of hearing the ads. A child development campaign focused on learning games, reading, and sleep could help to educate caregivers about these and other developmental milestones. It would hopefully prompt caregivers to ask medical and other service providers about what they heard. The effect would be to raise awareness of child development in caregivers and the community in general.

Caregivers empowered with **knowledge of child development** are likely to be better advocates for their children. Parent advocacy can be encouraged through parent education resources discussed previously, including pairing a family with a case manager or HMG family navigator. A family survey of HMG users found that caregivers became more confident as a parent advocate, understood eligibility criteria and how to obtain services better, and gained knowledge of the service delivery system and available resources as a result of their contact with HMG. Families can learn about resources in the community, how to be better advocates for their children, and understand their children’s needs better.

Caregivers want their children to develop healthy and strong, so it is often hard for caregivers to accept that their child has developmental or social-emotional issues. Providers interviewed for this report stated that they meet resistance from caregivers when sharing their concerns about issues. It is relatively common that other family members convince caregivers that “nothing is wrong” or “there is nothing to worry about” so recommendations for developmental assessment are not followed.

---

Educating caregivers through informal training such as developmental playgroups or other community resources, semi-structured parenting classes, or through child development-focused media campaigns are likely to reduce the stigma associated with the labels “delay”, “disability”, and “mental health”. With acceptance, it is more likely that caregivers will be active partners with service providers in their children’s care and better advocates for their children.

In summary, parenting knowledge and advocacy skills play important roles in helping children gain access to the services and supports that they need for behavioral, social-emotional, and other developmental issues. There are a number of evidence-based programs that teach positive parenting, however the limited reach of these programs necessitates the use of other mechanisms to educate families. Home-visitors, HMG family navigators/case managers, pediatricians, community supports such as playgroups and family resource centers, and media campaigns are additional mechanisms that can be leveraged to promote positive parenting practices and greater knowledge about child development. This in turn, can empower caregivers to be better advocates for their children.

Family support

Most families can benefit from support when accessing all levels of service- from prevention to intensive intervention. Problems at the system level are rampant (discussed in the next subheading), but access is also impaired by family support needs. Low-income families often have multiple factors that impede access including: limited understanding of the service delivery system, difficulty meeting their basic needs, poor physical and/or mental health, lack of transportation, and language barriers.

What can be done to help families, many of whom are in crisis?

Home-based case management services are necessary to help families in crisis with access and continuity of care. Soft and even firm handoffs to agencies that perform assessments and provide services or linkages are often underutilized by these families due to transportation issues, scheduling time away from work or home (particularly when caring for more than one child), illness, or physical handicap. Case managers need to visit fragile families where they are to identify each families’ individual needs and strengths, as well as the barriers to accessing assessments, child appointments, and community-based services such as early literacy events, playgroups, and parent education or support groups. A family advocate or HMG family navigator can address multiple issues by providing books or toys to families who lack educational materials, legal aid to obtain entitled services, and social support. These same advocates can guide families through developmental screenings and linkages to services when needed.

A systematic and comprehensive review of home visiting programs by the U.S. Department of Health and Human Services (DHHS) indicates that 13 evidence-based program models strengthen maternal health, child health, and/or
A review of Substance Abuse and Mental Health Service Administration (SAMHSA) database of family strengthening programs added four more evidence-based programs appropriate for 0-5 year-old children and their families (see Figure 14).

Figure 14. Evidence-based family support programs

<table>
<thead>
<tr>
<th>Program Models</th>
<th>Evidence-based criteria</th>
<th>Target Population</th>
<th>Favorable outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Child FIRST</td>
<td>DHHS</td>
<td>Birth-4+ years of age</td>
<td>Maternal health, child development and school readiness, reductions in child maltreatment, linkages and referrals</td>
</tr>
<tr>
<td>2. Dare to Be You</td>
<td>SAMHSA</td>
<td>2-5 years of age</td>
<td>Improved child behavior, positive parenting practices, greater family social support and connection</td>
</tr>
<tr>
<td>3. Early Head Start-Home Visiting</td>
<td>DHHS</td>
<td>Pregnant Women, Birth-3 years of age</td>
<td>Child development and school readiness, positive parenting practices, family economic self-sufficiency</td>
</tr>
<tr>
<td>4. Early Intervention Program for Adolescent Mothers</td>
<td>DHHS</td>
<td>Pregnant Women, Birth-1 year of age</td>
<td>Child health, family economic self-sufficiency</td>
</tr>
<tr>
<td>5. Early Risers</td>
<td>SAMHSA</td>
<td>4-7 years of age</td>
<td>Child development and school readiness, positive parenting practices, family social functioning</td>
</tr>
<tr>
<td>6. Early Start (New Zealand)</td>
<td>DHHS</td>
<td>Birth-4+ years of age</td>
<td>Child health, child development and school readiness, reductions in child maltreatment</td>
</tr>
<tr>
<td>7. Family Check-Up</td>
<td>DHHS</td>
<td>1-4+ years of age</td>
<td>Maternal health, child development and school readiness, positive parenting practices</td>
</tr>
<tr>
<td>8. Healthy Families America (HFA)</td>
<td>DHHS</td>
<td>Pregnant Women, Birth-4+ years of age</td>
<td>Child health, child development and school readiness, reductions in child maltreatment, positive parenting practices, family economic self-sufficiency, linkages and referrals</td>
</tr>
<tr>
<td>9. Healthy Steps</td>
<td>DHHS</td>
<td>Birth-3 years of age</td>
<td>Child health, positive parenting practices</td>
</tr>
<tr>
<td>10. HighScope Curriculum</td>
<td>SAMHSA</td>
<td>3-5 years of age</td>
<td>Child development and school readiness</td>
</tr>
<tr>
<td>11. Home Instruction for Parents of Preschool Youngsters (HIPPY)</td>
<td>DHHS</td>
<td>3-4+ years of age</td>
<td>Child development and school readiness, positive parenting practices</td>
</tr>
<tr>
<td>12. Incredible Years</td>
<td>SAMHSA</td>
<td>2-6 years of age</td>
<td>Child development and school readiness, positive parenting practices</td>
</tr>
</tbody>
</table>

7 http://homvee.acf.hhs.gov/programs.aspx
Figure 14. Evidence-based family support programs (continued)

<table>
<thead>
<tr>
<th>Program Models</th>
<th>Evidence-based criteria</th>
<th>Target Population</th>
<th>Favorable outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Nurse Family Partnership (NFP)</td>
<td>DHHS, SAMHSA</td>
<td>Pregnant Women, Birth-2 years of age</td>
<td>Maternal health, child health, child development and school readiness, reductions in child maltreatment, reductions in juvenile delinquency, family violence, and crime, positive parenting practices, family economic self-sufficiency</td>
</tr>
<tr>
<td>14. Oklahoma’s Community-Based Family Resource and Support (CBFRS) Program</td>
<td>DHHS</td>
<td>Pregnant Women, Birth-1 year of age</td>
<td>Maternal health, positive parenting practices</td>
</tr>
<tr>
<td>15. Parents as Teachers (PAT)</td>
<td>DHHS, SAMHSA</td>
<td>Birth-6 years of age</td>
<td>Child development and school readiness, positive parenting practices</td>
</tr>
<tr>
<td>16. Play and Learning Strategies (PALS)</td>
<td>DHHS (PALS Infant Only)</td>
<td>Birth-3 years of age</td>
<td>Child development and school readiness</td>
</tr>
<tr>
<td>17. Project 12-Ways/SafeCare</td>
<td>DHHS (SafeCare Augmented Only)</td>
<td>Birth-4+ years of age</td>
<td>Reductions in child maltreatment</td>
</tr>
</tbody>
</table>


In summary, family support is a critical component of care for many families in crisis or otherwise experiencing difficulty coping. These pressures must be relieved for families to be able to focus attention on issues with their children’s development or social-emotional issue. A total of 17 evidence-based programs were identified to provide primarily home-based family support. These programs are associated with a myriad of gains for caregivers and children.

**Systems that support families**

Caregivers, providers, and the scientific literature agree that the service delivery system must adapt to better serve children and families. From the moment that a caregiver or doctor has a concern about a child’s development, that caregiver often faces road block after road block in establishing eligibility, accessing services, and maintaining quality care. As services through the California Early Start program and elsewhere are cut, the eligibility criteria has increased to ensure the highest need children still obtain services. Thus, children with mild to moderate delays who would have received services at another time are increasingly being turned away. When eligibility criteria are not met, caregivers are left in a virtual no-man’s-land to do what they can with the resources that they have available. The system is not currently able to serve the needs of many families. The ensuing paragraphs contain suggested strategies for improvement.
Early identification
To effectively reduce or remediate developmental problems, children must be screened and monitored for developmental issues from birth. This gives each child the best opportunity for success when entering school and presumably throughout life.

Early identification requires that routine screenings are performed. Pediatricians, early educators, and family support providers need the tools and training to conduct evidence-based child assessments (e.g., Ages and Stages Questionnaires [ASQ, ASQ-SE])\(^8\). According to Bethell’s (2011) review of 2007 National Survey of Children’s Health data, less than 20% of U.S. children under age 6 receive a parent-completed developmental screening as recommended by national guidelines. The same report showed that this rate varied by state (10.7 to 47%) which implies policies and incentives can be successfully leveraged to improve developmental assessment rates.

Early identification also requires that there are clear pathways after screening children. Service providers using developmental assessments must know the next steps in addressing identified needs or concerns. A Help Me Grow is particularly helpful since it provides a central point of access for developmental information and referrals. Local agencies should also conduct provider trainings in the use of established evidence-based screening tools. Even when developmental surveillance and screening efforts are in place, these efforts are wasted if families are not provided appropriate next steps.

The ‘medical home’ as an organizing framework
The child health care system is considered by many to be an optimal gateway for the promotion of physical, developmental and mental health for children. Thus, a unified system of developmental and mental health screening, referral, and follow-up within a medical framework has the opportunity to reach almost all children through well-child appointments. The majority of extant literature on the subject discusses the use of a medical home framework. In brief, providing medical homes is an approach to providing comprehensive, relationship-focused primary care in partnership with parents (American Academy of Pediatrics, 2002).

According to the American Academy of Pediatrics, Medical Home Initiatives for Children with Special Health Care Needs Project Advisory Committee (2004), key characteristics of a medical home include:

- **ACCESSIBILITY**- in the child’s community, accepts all insurance, direct communication with the physician
- **FAMILY-CENTERED**- family is recognized as the center of strength and support for the child, information is shared on an ongoing basis
- **CONTINUOUS**- the same pediatrician is available from infancy through adolescence
- **COMPREHENSIVE**- 24 hours a day, 7 days a week, preventive as well as primary and tertiary care; community/state resource information is shared
- **COORDINATED**- families linked to support, education, and community-based services; centralized information resource
- **COMPASSIONATE**- concern for well-being of child and family is expressed and demonstrated

• **CULTURALLY EFFECTIVE**: Cultural backgrounds are recognized, valued, and respected; translators and interpreters available as needed to ensure full comprehension of medical advice and care.

According to a Zero to Three report (2011) on the well-being of California’s infants and toddlers, there is room for improvement when it comes to having an established primary care provider: Only 62% of children on public insurance had a medical home. Reliance on emergency or urgent care instead of primary care negatively impacts the likelihood of families developing a trusting doctor-patient relationship, talking with doctors about developmental issues, and attending well-child check-ups and follow-up appointments.

There are areas of the medical home framework that may be unfamiliar to a traditional model of pediatric primary care. These aspects include community partnerships with service providers and more comprehensive case management models. A report by Fine and Mayer in 2006 entitled “Beyond referral: Pediatric care linkages to improve developmental health” identified several practice, partnership, and community-wide strategies to improve the success of developmental service linkages and outcomes for families through a medical home framework. They are listed below.

### System-level strategies to improve developmental service linkages:

1. **PRACTICE-WIDE SYSTEMS CHANGE**
   - *Provide routine, systematic screening and surveillance*
   - *Have a referral and linkage point person and follow-up system*. Have a person or system (such as Help Me Grow) in place that is knowledgeable about available services and supports. Follow-up reminders should prompt additional contact to see how the referred services are meeting the families’ needs.
   - *Enhanced staffing*. Add a care coordinator, social worker, child development specialist, psychologist, etc. to enhance developmental care. As an example, one primary care office added a mental health specialist to fill in this service gap.

2. **SERVICE PROVIDER PARTNERSHIP IMPROVEMENT**
   - *Co-location of services*. Community agencies share the same building or office space to provide streamline routing of families to address common needs.
   - *Co-management*. Collaborative case-management enables secure partnerships with community agencies and assurance that a child’s developmental needs are being addressed.
   - *Networking and information sharing*. This uncovers gaps in services and set the stage for collaborative community efforts.

3. **COMMUNITY-WIDE SYSTEMS CHANGE**
   - *New or enhanced community resources*. A knowledge-base of available resources in the community is maintained and shared.
   - *System training and support programs*.
   - *System-wide policies and protocols*. This provides sustained linkage for developmental supports.
The California Medical Home Project\(^9\) funded by the California HealthCare Foundation is tasked with building capacity for implementing medical models to close the gaps in care for children with special health and developmental needs in California. Since 2002, the Alameda County Committee on Children with Special Needs has been one of the locally-based coalitions working to increase the number of family-centered medical homes and number of children accessing them. The committee, supported by Lucile Packard Children’s Hospital, Every Child Counts/First 5 Alameda County, and Alameda County Public Health Department, produced a medical home resource guide in 2010. It aids providers and their staff in making appropriate referrals by providing a “snapshot” of each available program, including: eligibility, requirements, services provided, application procedures, and contact information for each resource. It is essential to have this information available, however, a more flexible information delivery system needs to be in place to ensure information about available services is up to date. Programs like Help Me Grow that maintain more fluid resource databases are critical for pediatric offices to provide the best information to caregivers. A public web-based resource database will increase access to the most up to date information for both caregivers and providers.

**In sum, medical homes have the capacity to keep families with children who need additional support from falling through the cracks.** It provides the framework for early screening, close handoffs, and follow-up with community service partners ensuring continuity of care and the best available care for children and families. **Focus on partnership with the family helps increase knowledge of developmental milestones, parenting confidence, and advocacy.** Centralized case management helps streamline the support a family receives with fewer service gaps or duplication of efforts. Alameda is already working to make medical homes a reality for families in Alameda County. It is strongly recommended that these efforts continue to be supported.

**Summary**

This section of the report reviewed strategies to address unmet needs of families with young children with developmental issues in Alameda County. Key implementation strategies for mental health, speech/language issues, parenting education and advocacy, family support, and systems are reviewed, with evidence-based models or best practices offered when appropriate.

Investment in a more functional and efficient system of service delivery can provide an organizing framework to coordinate services, from behavioral therapy to literacy programs at local libraries. Services for children needing developmental and social-emotional supports also need to increase to better support families in Alameda County. Integrating services and providing them as home- or school-based services, particularly mental health services, will also improve service utilization. There are many existing service models shown to effect positive change in the areas of need, most evident in the areas of mental health, parenting and child development knowledge, and family support. Efforts to build medical homes for families is strongly recommended to provide a more centralized system of service delivery and monitoring of outcomes, family engagement, and satisfaction with care. Funding for quality, affordable childcare is also needed to help families thrive.

---

Part 3: Special Study on Developmental Playgroups

What are playgroups?

Playgroups emerged in the 1960’s internationally, and have been traditionally more popular in Europe, the British Isles, and Australia than in the United States. Playgroup models come in all shapes and sizes, ranging from informal social gatherings of caregivers and young children, to more structured caregiver training devices designed to support more intensive developmental needs of children birth-5 years of age.

The Commonwealth of Australia supports three playgroup models which are described in the taxonomy in Figure 15. They include: community playgroups, supported playgroups, and intensive supported playgroups. These three playgroup types are displayed as three tiers of a pyramid according to the intensity of support provided. Key features of each type are described in Figure 16.

Figure 15. Pyramid of playgroup types by intensity of service

- **Tier 1: Intensive Supported Developmental**
  - High risk and/or high need families

- **Tier 2: Supported Developmental**
  - Led by at least one trained facilitator targeting families with identified needs and/or developmental challenges

- **Tier 3: Community**
  - Self-managed social groups meetings with parents and their young children
  - Can be affiliated with a church, school, or community/neighborhood
  - Can be specific to a caregiver type, child age, or culture
Figure 16. Summary of developmental playgroup features by tier

<table>
<thead>
<tr>
<th>Tier:</th>
<th>Child level of need</th>
<th>Primary purpose</th>
<th>Structure</th>
<th>Staff training in child development</th>
<th>Evidence-based models</th>
</tr>
</thead>
<tbody>
<tr>
<td>1- Intensive</td>
<td>high</td>
<td>intervention</td>
<td>high</td>
<td>professional</td>
<td>Yes</td>
</tr>
<tr>
<td>2- Supported</td>
<td>moderate</td>
<td>prevention</td>
<td>low to moderate</td>
<td>limited</td>
<td>No</td>
</tr>
<tr>
<td>3- Community</td>
<td>low</td>
<td>social</td>
<td>low</td>
<td>none</td>
<td>No</td>
</tr>
</tbody>
</table>

“Tier 3” playgroups, or “Community” playgroups, provide the lightest touch in terms of service intensity. They are generally socially driven in that they primarily provide social support for adults and the opportunity for children to play together. Meetings are typically informal, with no set curriculum or theoretical model driving activities. Groups are generally caregiver-organized, thus the governance of the groups is dependent on volunteers. Tier 3 playgroups are often organized through caregiver organizations, community members using web-based tools like “MeetUp”, religious or church groups, or by schools to help caregivers and children become familiar with the school environment, staff, and routine. Groups can form for a specific demographic such as fathers, grandparents, or teen moms. Some groups are culture-specific, language-specific, or purposefully multicultural in orientation. In summary, community playgroups tend to focus on child play and adult social connection.

“Tier 2” playgroups fall into the “Supported Developmental” category because they target families with higher needs that are not addressed in community groups. Families are often given more personalized support by a trained facilitator and are likely to be referred to other support services if needed. Although the level of structure varies, parenting skills training is often an included component. Group size is generally small (5-15 caregivers) to provide individualized support, with class participation organized into multi-week sessions. This provides more structure and increases the likelihood of an established curriculum in use. Tier 2 groups can be targeted to a specific population similar to Tier 1 groups (e.g., multicultural, grandmothers, teen moms, etc.). Social connection is a common benefit of participation in Tier 2 playgroups, however additional focus is placed on developmental enrichment and problem prevention for children at-risk due to individual child characteristics, poverty, language barriers, or cultural differences. Caregivers and children learn and practice ways of interacting and exploring together to help children be socially, emotionally, and cognitively prepared for preschool and kindergarten.

“Tier 1” playgroups, or “Intensive Supported Developmental” playgroups, provide therapeutic intervention for families with complex and/or high need. Families are typically identified and referred by maternal and child health nurses, pediatricians, local government family services or other support agencies including supported developmental playgroups. The groups are typically staffed by trained child development specialists with help from other service providers or specialists in the community. Activities for these playgroups include guided participation and strong parenting support components, including access to a system of supports based on the child’s needs. Groups are often designed for children with special needs, which include families with children with identified disabilities, developmental delays, or risk such as premature birth. Some of these groups are specific to a condition
or deficit area (premature birth, communication or social skill development, autism spectrum, etc.), while others address multiple areas of need. For example, playgroups in Australia for highly marginalized groups of families (i.e., transient) fall under this category due to the comprehensive support provided for parenting skills, child education, relationship building, and mental health services (Playgroup Plus, National Dissemination Program, 2003). “Integrated playgroups” are one type specialized tier 1 playgroup that combines special needs and typically developing children in a structured play setting. These groups are commonly used to develop social skills among children on the autism spectrum, but they are also used for other conditions that affect a child’s ability to make friends or play well with others. Thus, hallmarks of tier 1 playgroups include: an established set of specific treatment goals for children or families (e.g., child skill development or abatement of behavioral issues), caregiver training on how to effectively parent a child with special needs, and a structured curriculum delivered by trained professionals provided through public health, hospitals, or counseling centers.

As one progresses up the playgroup pyramid, the likelihood of adherence to evidence-based and theory-driven service models, specialized training of staff members, and other hallmarks of program quality (such as small class size) also increases.

**How are developmental playgroups serving families in Alameda County?**

**Playgroup Characteristics**

The resource scan found 34 low-cost developmental playgroup offerings in Alameda County. As depicted in Figure 11, playgroups are primarily located in the higher population density zones in northern Alameda County.

The data used for this section of the report include in two interviews with developmental playgroup administrators, and three focus groups with developmental playgroup (Tier 1 & 2) participants. In all, 22 caregivers participated in the discussions. Two groups were held in Spanish, and the other was conducted in English.

There was ethnic and linguistic variety among the parents in the study, although the largest proportion of participants was Latino. A few fathers participated, however a vast majority of participants were stay-at-home mothers. Most participants live in Oakland, and many were new to the neighborhood or to the country.

**Playgroup Programs**

All playgroup programs surveyed require that a caregiver remain with the child during the playgroup. The format generally includes some free play, structured activities, and a caregiver education component, typically occurring over a 2 to 3 hour duration. One playgroup would be considered a developmental Tier 2 group (A). The other two are intensive developmental playgroups (Tier 1) and are facilitated by a mental health consultant and a developmental specialist. In one of these groups (group B), the children all had identified special needs or delays. However, in group C, families are able to enroll whether or not the children have identified delays or special needs.

Families found the playgroups in different ways. Some were referred by pediatricians or First 5 Alameda. Children with developmental delays (including those born prematurely) were often referred by visiting
nurses or Children’s Hospital and Research Center Oakland. In group A and C, many caregivers were referred by friends, or found the program by walking by and inquiring about the program.

The parental education component generally takes place for one hour while the children are in the main playroom. However, the structure was different in each group. In the group A, caregivers learned about parenting and about their child’s development including Ages and Stages Questionnaire (ASQ-3) training. In group B, caregivers spend their breakout time in a support group where they discuss subjects specific to parenting children with special needs. In playgroup C, caregivers participate in a support group where the topics are driven by the participants. In some instances, they discuss issues involving the care of infants and small children, and sometimes they talk about other things that impact them emotionally, such as neighborhood violence.

Common activities in all playgroups are story time, singing songs, fine motor activities and creative play.

**Benefits of playgroups for children**

Caregiver who participated in focus group discussions about playgroups that they attended saw benefits in multiple domains: social-emotional, motor skills and cognitive/academic skills.

**Social-emotional**

Caregivers saw improvements in their child’s behavior, confidence and interactions with other children, including their ability to share toys with others. Every group discussed the improved confidence of their children as evidenced by an increase in exploring their environment and in demonstrating independence. Healthy detachment was something that caregivers discussed in depth, and some past participants shared stories about how their children were able to make successful transitions to kindergarten because they had learned how to interact with other children and to trust other adults through their participation in the playgroups. Many caregivers were grateful for “less crying” and better behavior from their children as a result of participating in playgroups.

**Motor skills**

Caregivers and key informants alike mentioned the development of fine motor and gross motor skills. Caregivers shared that children do not have space to play and develop gross motor skills in their small living spaces, and some did not have a safe place to play prior to attending playgroups. Structured playgroup activities have helped children develop fine motor skills, such as threading beads and using fingers to show their ages.

**Cognitive/academic skills**

Preschool academics were something that most caregivers expected from playgroups, and all expressed satisfaction with the results. They mentioned skills such as naming colors, numbers and letters as well as tying shoes. Caregivers in the developmental groups mentioned language skills specifically; all shared that they saw improvements in speech and language development as well as in increase in verbal expression. Caregivers also felt that their children learned more from one another than they could have
taught them directly, attributing some of their motivation to positive models and wanting to do the same things as other children.

_In summary, children demonstrate a range of improved skills as a result of participating in playgroups, including social skills, confidence, self-regulation, motor skills and cognitive skills. The playgroup environment provides a safe place to play and learn from one another with developmentally appropriate support._

**Benefits of playgroups for caregivers**

Alameda County families that attend playgroups expressed increased support from and connection to the community, knowledge of child development, and improvement in parenting skills.

**Community connection**

Community connection was a common theme in the focus groups and key informant interviews. Many families are isolated due to their unfamiliarity with Oakland, and because they do not speak English. These caregivers find connection through the playgroups. Caregivers discussed changes in their feelings from isolated and alone to accepted and included by the community. This also has led to a feeling of support, especially for immigrants and caregivers of children with special needs who have found “family where there was no family.”

**Child development**

All groups discussed child development knowledge gains as a result of participation, which has led to more appropriate expectations of their children. Some caregivers learned from parenting “breakout lessons”, and others learned indirectly from seeing other children and observing other parenting styles and behaviors. Some caregivers learned that their children are capable of far more than they thought possible for their age. Imaginative play was something that many caregivers cited as new information, saying that they didn’t know how much it contributes to how a child’s learning.

**Parenting skills**

As a result of learning about child development and communication skills, caregivers reported improved ability to relate to their children and support them developmentally. Discussion in the groups centered around playing more with children, doing more activities with them, and supporting their independence by letting them do things for themselves. Caregivers also felt more patient and calm with their children. Key informants echoed this as well; They reported seeing strong improvements in the relationships between children and their caregivers.

Caregivers with children with special needs have learned how to accept their children for who they are; shifting focus from identifying what is “wrong” with them to increasing their own understanding of their child’s individual needs.

_In sum, caregivers learned about child development and what to expect from their children through their participation in playgroup sessions. In addition, they have acquired parenting skills that help them_
connect with their children, and support them developmentally. By sharing their “worries and joys” with caregivers they have met through the playgroups, they have increased their feeling of support, and developed more confidence as caregivers.

**Differences in playgroup outcomes**

Although most child and caregiver outcomes were shared across all playgroups, one notable difference was found in caregiver self-awareness. Caregivers who mentioned caregiver-focused activities during the playgroups (in the form of parental education or parental support group) were able to clearly express things they have learned as caregivers, and also felt that the playgroup provided learning opportunities for their children that they could not provide. In the group that did not mention parental education, caregivers talked very little about their own learning and their children’s cognitive development. This was also the group whose parent education component was unstructured. The populations among the groups differed; Group A participants were somewhat older, group C were caregivers with children born prematurely. Thus, self-awareness about parenting and child development gains may be biased by differences inherent in the groups, or it could be due to differences in parent education programming. Further investigation is needed to understand this difference between groups, as it has far reaching implications.

**Needs of caregivers utilizing playgroups in Alameda County**

Playgroups meet the needs of caregivers and children for socialization, community connection and learning. However, families also have needs for other support services, including affordable day care and preschool, basic needs, housing, transportation and safe places for children to play. In addition to basic family supports, caregivers communicated a lack of services and supports for things that support their children’s development. Caregivers listed developmental assessment, mental health services, and free/low-cost community-based activities that expose their children to music, art and culture. Playgroups play an important role in providing developmental support, but families still seek additional services and supports to fulfill all their needs.

In general, all caregivers had a positive perception of the playgroups and did not express any sense of stigma about attending the playgroups. Some caregivers joined the group with the knowledge that their children had some delays and needed support, and others joined just for the play and learned about their child’s development as a result of participating in the group. However, there was a notable difference between the groups in caregivers’ **self-awareness** about gains associated with playgroup participation. Next, a case for how and why developmental playgroups can benefit at-risk children and families is explored.
Do developmental playgroups help ameliorate developmental risk or delay?

At their core, all playgroups provide opportunity for interaction and social support at a time when many caregivers feel socially isolated and lack confidence in their parenting skills. Feedback from focus groups of playgroup caregivers indicates that opportunities to socialize and interact with their children are important factors that attracted them to playgroups. Thus, all types of playgroups serve an important social support function and build community amongst its members.

Research on the impact of developmental playgroup participation

In addition to social support, developmental playgroups (tiers 1 and 2) also provide a semi-structured supported setting that creates unique opportunities for mutual caregiver-child learning and engagement. “Learning by doing” in playgroups shows caregivers how to engage their children, successfully manage behavior, and show affection. Focus group feedback revealed that the learning does transfer beyond the play session; caregivers are more apt to adopt new practices that were demonstrated and already “tried out” with their children (see also, Landry and others, 2012). Caregivers also revealed that children are eager to repeat playgroup activities—particularly songs. Thus, developmental playgroups tend to provide a base for caregivers to learn about how their children are developing, and how to build strong, secure bonds of attachment.

There is growing evidence that caregivers’ active participation in their children’s early learning has significant long term benefit (e.g., Pan, & others, 2005, Harvard Family Research Project10). Specifically, current theories and evidence support that caregiver engagement in early learning activities help build strong academic, social, and emotional skills in children. Given the known importance of caregiver participation, the National Association for Education of Young Children (NAEYC) embarked on a project entitled “Engaging Diverse Families” to understand how the best early education programs engage families in their children’s early learning and development.11 Their efforts found that successful family engagement practices included the provision of learning activities for the home and in the community. Developmental playgroups are one tool that can provide support to caregivers to engage in these important activities.

A review of research on playgroups cautions that there is considerable variability in the content and quality of playgroups, which makes generalizations about effects of playgroup participation quite difficult to analyze (Lloyd, 1989). Despite this challenge, the author concludes that pre-school playgroup participation benefited children’s development and educational attainment. A more recent article published by Dadich and Spooner (2008) in Australia reports many potential benefits of playgroup participation which were also echoed by playgroup participants in Alameda County. Reported caregiver and child benefits from the research literature are found on the following page.

---

10 http://www.hfrp.org/publications-resources/publications-series/family-involvement-makes-a-difference
11 http://www.naeyc.org/familyengagement
Playgroup benefits for caregivers:
- Improved well-being and reduced stress
- Improved parenting skills
- Enhanced self-confidence
- Quality time with the child and greater awareness of their needs
- Social networks
- Access to training and educational opportunities that extend beyond the parental domain

Playgroup benefits for children:
- Improved well-being and self-confidence
- Cognitive and/or behavioral development
- Age-appropriate stimulation
- Improved parent-child relationships
- More healthy play and creativity
- Enhanced communication and cooperation skills
- More smooth home-to-school transition

Enhanced benefits for low-income and immigrant families

Playgroups may play a more significant protective role for marginalized families. Empirical research suggests that cultural ideals on the importance of familial child-rearing, distrust of government systems, and a lack of financial resources keep a disproportionate number of low-income and/or immigrant families away from child care and preschool services (Karoly, 2011). There are also many families whose children do not qualify for Head Start services and yet can’t find other affordable child care. Thus, developmental playgroups are an opportunity for some children to gain skills needed for school outside of more traditional educational practices. For example, an Australian study of refugee families in the process of resettlement found that supported playgroups served as a protective environment (Jackson, 2006). The teacher-created curricula focused on teaching caregivers about the importance of play and how to emotionally support their children, in addition to working on socialization and relationship-building goals. Participating families reported having more emotional support and developing new social networks which led to reduced stress and anxiety. In addition, caregivers felt greater “connectedness” to their children, and reported that children demonstrated improvement in mood and behavior. Further evidence indicated that participation in playgroups held at the school helped refugee children transition into school with less stress. This and other evidence (Takanishi, 2004) suggest that playgroups can play important roles in early education, mental health, and caregiver-child relationships, and they may play an important protective role for immigrant and marginalized families that tend not to utilize center-based or other forms of non-familial care as frequently.

What are considered “best practices” for developmental playgroups?

Developmental playgroup models have been implemented at the national level in countries such as Australia, England, and Ireland, as well as at the state level in the United States as a part of early education and caregiver support programs. In the U.S., Massachusetts is one of the leading state-wide implementers of playgroups. The Massachusetts Department of Early Education and Care provides funds to school districts for developmental playgroups and other forms of family support. As an example, Medford public schools provide a service called the “Medford Family Network” to every child prenatal-to 7 years of age and caregiver who lives or works in the city. It is a family support and parenting education program that provides a variety of opportunities for school-home-community connections,
including drop-in playgroups as well as 10-week structured facilitated playgroups to foster parent-child interaction, provide child development knowledge, social connections for parents, and information about community resources. Although not yet considered an evidence-based practice, family strengthening collaboratives like these show promise as a way to integrate families into the school system, foster family engagement, and increase home and community learning opportunities.

Despite the popularity and wide implementation of playgroup programs, there are few available guidelines for implementing quality supported playgroups. In Australia, The Department of Families, Housing, Community Services and Indigenous Affairs funded a project in 2002 to investigate best practices in playgroups throughout Australia. The report found that playgroup best practices included these common features:

1. Participants build friendships and social supports
2. Children learn and develop through play
3. Everyone takes responsibility and works together
4. The playgroup provides a safe and supportive environment
5. Adults exchange ideas and shared parenting experiences

Based on these five features of best practices in playgroups, ‘Playgroup Victoria’ developed a training course for playgroup administration.¹²

An informative report from First 5 Monterey County in California and the David and Lucile Packard Foundation (2011) on best practices in playgroups provides a detailed summary of features associated with the most successful supported playgroups in terms of structure, environment, staffing, parent/child relationships, curriculum, and system sustainability. Although the use of evidenced-based models was one of the recommended best practices, no model or curriculum was identified at that time. The report recommended adapting successful early education models that already incorporate the features, specifically Parents as Teachers (PAT), The Creative Curriculum, and HighScope programs. This report extends this work by delving deeper into the use of evidence-based practices and models for playgroup administration, including family strengthening models that have relationship-building, parenting skill improvement, and enhancing child development as program goals.

**Evidence-based and best-practice models for Tier 1 playgroups**

Among the levels of playgroups, Tier 1 with highly intensive developmental support provide the best evidence for successful evidence-based playgroup models. For example, The National Standards Project Report which provides a systemic review of the behavioral and educational peer-reviewed treatment

literature involving children and adolescents with autism spectrum disorders (ASD) provides quality ratings of each treatment model. One of the models includes a peer playgroup component. The evidence-based Integrated Playgroups (IPG) model developed by Pamela Wolfberg in the late 1980’s includes a “Peer Training Package” to develop stronger social interaction skills among children who are autistic. The interventions involve teaching children without disabilities (e.g., classmates and siblings) strategies on how to facilitate play and social interaction with children on the autism spectrum. Children are then brought together to play in small playgroups. Evidence from 33 studies using this method showed increases in communication, interpersonal, and play skills among children age 3-14 years diagnosed with Autism Spectrum Disorder (ASD) (National Autism Center, 2009). Other similar models are considered “promising” practices, such as Project DATA (Developmentally Appropriate Treatment for Autism) out of the University of Washington which targets children 1-3 years of age with ASD or related symptoms.

**Evidence-based and best-practice models for Tier 2 playgroups**

An exhaustive search of the research literature and the World Wide Web confirmed that current developmental Tier 2 playgroup models do not operate using independent evidence-based implementation frameworks. One explanation for this is that Tier 2 playgroups are highly responsive to group need, thus they are more flexible in content and structure than the Tier 1 playgroups. This makes adhering to a specific playgroup curriculum, let alone evaluating its merits, exceedingly difficult (see also, Dadich, 2008). As suggested by the First 5 Monterey report (First 5 Monterey County, 2011), a playgroup framework should be built upon adaptations of best practices and evidence-based models in early education and special education. Research for this report also found several evidence-based home visiting programs that could serve as a useful framework.

**Home-visiting Models**

Home visiting programs often have similar goals as playgroups, specifically in the areas of caregiver-child relationship building, parenting education, and child development. Although the activities are implemented at the level of the individual instead of the group, these service models seem fairly easily adapted for playgroups. The Department of Health and Human Services launched the Home Visiting Evidence of Effectiveness (HomVEE) project to conduct and maintain a thorough and transparent review of the home visiting research literature and provide an assessment of the evidence of effectiveness for home visiting program models that target families with pregnant women and children from birth to age 5. Ten models that have published research studies on effectiveness meet the DHHS evidence-based criteria (also called the Maternal, Infant, Early Childhood Home Visiting program [MIECHV] criteria) for substantiated improvement in parenting practices and child development/school readiness. However, only three evidence-based home-visiting models plus two SAMHSA evidence-based models have playgroup components (see Figure 17).

The ‘DARE To Be You’ (DTBY) program for families with preschool children represents one evidence-based family strengthening program with a structured playgroup component. As an original Substance Abuse and Mental Health Service Agency (SAMHSA) National Model program, it is designed to address factors associated with the development or perpetuation of family drug and alcohol abuse. Caregivers

---

and their preschool children (2-5 years of age) participate in activities that support family resilience. The preschool component includes 10 to 12 weekly sessions, including two hours of workshops and a family meal. According to SAMHSA, program objectives focus on children's developmental attainments and aspects of parenting that contribute to youth resilience to later substance abuse including parental self-efficacy, effective child rearing, social support, and problem-solving skills.

**Figure 17. Evidence-based models with playgroups that significantly increase positive parenting practices and child development outcomes**

<table>
<thead>
<tr>
<th>Models</th>
<th>Evidence-based</th>
<th>Target Population</th>
<th>Favorable outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dare To Be You (DTBY)</td>
<td>SAMHSA</td>
<td>2-5 years of age</td>
<td>Improved child behavior, positive parenting practices, greater family social support and connection</td>
</tr>
<tr>
<td>Early Head Start-Home Visiting</td>
<td>DHHS</td>
<td>Pregnant Women, Birth-3 years of age</td>
<td>Child development and school readiness, positive parenting practices, family economic self-sufficiency</td>
</tr>
<tr>
<td>Families and Schools Together (FAST)</td>
<td>SAMHSA</td>
<td>5-12 years of age at risk for problem behavior</td>
<td>Child development and school readiness, child MH and behavioral problems, parent self-referral to Substance/MH treatment, improved social connections, leadership</td>
</tr>
<tr>
<td>Home Instruction for Parents of Preschool Youngsters (HIPPY)</td>
<td>DHHS</td>
<td>3-5 years of age</td>
<td>Child development and school readiness, positive parenting practices</td>
</tr>
<tr>
<td>Parents as Teachers (PAT)</td>
<td>DHHS</td>
<td>Birth-4+ years of age</td>
<td>Child development and school readiness, positive parenting practices</td>
</tr>
</tbody>
</table>


The HomVEE program model review describes the **Early Head Start (EHS)- Home visiting** model as focused on providing high quality, flexible, and culturally competent child development and parent support services with an emphasis on the role of the primary caregiver as the child’s first, and most important, relationship. The program targets low-income pregnant women and families with children from birth through age 3 years, most of whom are at or below the federal poverty level or who are eligible for Part C services under the Individuals with Disabilities Education Act (IDEA) in their state. Components of EHS home-based services include: 1) weekly 90-minute home visits, and 2) two group socialization activities per month for caregivers and their children. The playgroups are designed for caregivers to socialize, interact, and bond with their 0-3 year-old child, and to learn about child development.

According to a 2001 report from the Early Head Start National Resource Center on the implementation of EHS “socializations” for infants and toddlers (i.e., playgroups), curriculum development was driven by individual grantees. The Early Head Start program grantees took to utilizing current teaching philosophies and adapting materials to address the individual needs of their specific playgroups. None of the seven grantees reported following a set curriculum, but instead following evidence-based and evidence-informed educational guidelines. Several grantees mentioned adhering to Head Start Program
Performance Standards\textsuperscript{16}, borrowing ideas from ZERO TO THREE\textsuperscript{17} and the Creative Curriculum for Infant and Toddlers\textsuperscript{18}. Four grantees specifically mentioned three training models that informed their practice: Parents as Teachers (PAT)\textsuperscript{19}, Program for Infant/Toddler Care (PITC)\textsuperscript{20}, and Resources for Infant Educators (RIE)\textsuperscript{21}. RIE is not an evidence-based program, thus it is not included as a recommended program.

According to the HomVEE program model overview, Home Instruction for Parents of Preschool Youngsters (HIPPY) is a home visiting program model that focuses on parent-involved early learning.\textsuperscript{22} The HIPPY model includes four distinct features: 1) a developmentally appropriate curriculum, 2) weekly home visits and monthly group meetings, 3) role play as the method of instruction, and 4) a staffing structure that includes peer home visitors from the community in which the family is being served and professional coordinators with sensitivity to the needs of vulnerable families. The primary mission of HIPPY is to help caregivers prepare their children for success in school and beyond, and to empower caregivers as their children’s first teacher by giving them the tools, skills, and confidence they need to work with their children in the home. The program is designed for caregivers who lack confidence in their ability to prepare their child for school, with a focus on caregiver-involved early learning for children 3-5 years of age.

The Parents as Teachers (PAT) model contains four main components: home visits, group connections (i.e., playgroups), health and developmental screening, and family resource networking. According to program documentation, “group connections” are designed so that families build social connections with each other, engage in caregiver-child interaction, and increase their knowledge of ways to support their children’s development. Program documentation indicates that PAT supervisors develop the group connections curriculum a year at a time, with programming that is sensitive to the interests, needs, and cultural backgrounds of the caregivers as well as the ages of the children who attend. Meetings are staffed by at least one model-certified parent educator or PAT supervisor. Group connections are held approximately once per month and use diverse formats including family activities, presentations, community events, and a “parent café” support service.

\textbf{Educational frameworks}

Building a playgroup model from existing early education training and curriculum resources is another approach to building a playgroups model curriculum. The Program for Infant/Toddler Care (PITC)\textsuperscript{23} mentioned as a resource by the EHS grantees was developed by WestEd in collaboration with the California Department of Education and is used for Head Start staff training. PITC is a comprehensive training system that promotes responsive, caring relationships for

---

\textsuperscript{16} http://eclkc.ohs.acf.hhs.gov/hslc/standards/Head%20Start%20Requirements  
\textsuperscript{17} http://www.zerotothree.org  
\textsuperscript{18} http://www.teachingstrategies.com/page/74258-creative-curriculum-infants-toddlers.cfm  
\textsuperscript{19} http://www.parentsasteachers.org  
\textsuperscript{20} http://www.pitc.org/pub/pitc_docs/home.csp  
\textsuperscript{21} http://www.rie.org/educaring  
\textsuperscript{22} http://homvee.acf.hhs.gov/document.aspx?rid=1&sid=13&mid=2  
\textsuperscript{23} http://www.pitc.org/pub/pitc_docs/home.csp
infants and toddlers utilizing best available practices. In 2002, the National Center for Children in Poverty\textsuperscript{24} selected PITC as a model initiative to support infants, toddlers, and their families. It promotes a philosophy of caregiving but it may be limited in terms of curriculum for use with caregivers.

A more comprehensive research-based early education framework exemplar comes from Carl Dunst and colleagues from The Family, Infant and Preschool Program (FIPP) Center for the Advanced Study of Excellence in Early Childhood and Family Support Practices (CASE) in North Carolina. They have been developing a comprehensive evidence-based early childhood intervention and family support framework over the last 25 years to support families of young children. The program is one of 20 National Centers of Excellence in Early Childhood, and serves as a research and training institute as well as an early childhood intervention program for children (ages birth to 5 years), families, and women who are pregnant. FIPP provides early intervention services, Early Head Start home and center-based supports, pregnancy supports, neonatal intensive care follow-up, fatherhood initiatives, as well as collaborative work with other agencies to further the use of evidence-based intervention for all young children and their families.

The FIPP program is driven by Contextually Mediated Practices (CMP) to enhance caregiver-child relationships, Kindergarten readiness, and parenting skills. The model developed at CASE utilizes and promotes everyday family and community activities and child interests as the bases for caregiver-mediated child participation and learning in those activities (Dunst, 2006). The key features of the model are in line with playgroup goals and include: 1) caregiver-mediated child learning, 2) focus on child interests and assets, 3) everyday activities, and 4) increasing learning opportunities. The CMP model is built upon resource-based intervention practices which draw on decades of research and theory in the field of community development, early childhood intervention, family support and developmental disabilities. The main focus is on encouraging and enabling families to participate fully in family and community life (Mott, Operationalizing Resource-Based Intervention Practices, 2006). CASE provides a large research-base, training, and tools for implementing these practices.

Other early education resources applicable to playgroup program development include evidence-based and best-practices curriculums from High Scope Preschool Project\textsuperscript{25}, the Abecedarian Project, Chicago Child-Parent Centers, and the Creative Curriculum for Infant and Toddlers\textsuperscript{26}. Brazelton’s Touchpoints Center\textsuperscript{27} is another option for developing deeper knowledge of child development and relationship-building. Further investigation is needed to determine how the curriculums from these programs can be adapted for a playgroup model.

\textsuperscript{24} http://www.nccp.org/
\textsuperscript{25} http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=18
\textsuperscript{26} https://www.teachingstrategies.com/page/ccs_overview.cfm
\textsuperscript{27} http://www.brazeltonontouchpoints.org/about/evidence-based-research/
Summary

Playgroups serve an important role for families who utilize these services. However, implementing playgroups presents its own unique challenge. Developmental playgroups are flexible on purpose; this allows facilitators to develop activities and curricula that provide families individualized support in the areas where they need it the most. However, this leads to vast differences in playgroup implementation and quality.

Even though there are no evidence-based playgroup service models, there are other program models available with interactive social group components with similar goals of social connection, strengthening caregiver–child relationships, parenting skills training, and child learning enrichment. Three evidence-based home-visiting models, one evidence-based family strengthening model, and several comprehensive early education models (notably the FIPP center for a complete model framework) have playgroup components which may be relatively easily adapted for playgroups. Caution should be raised however, in that evidence-based models are only considered as such with full-model implementation. There is no clear documentation that the playgroup portion of these models is standardized with best practices in mind (DTBY and CMP are notable exceptions). The success of implementing just the playgroup portion of the multifaceted models is yet to be determined.

Integration of findings

Research studies and feedback from focus groups indicate that developmental playgroups provide valuable social support to caregivers, and relationship building and learning opportunities for caregivers and children. However, key features and implementation strategies to achieve these outcomes differ among playgroups. Australia’s three-tier system provides a general structure for cataloguing playgroup models. However even within Tier 1 and 2, playgroups vary in size, demographics, curriculum, and staff. The First 5 Monterey report (2011) provides good general guidelines on the features associated with successful supported developmental “Tier 2” playgroups in terms of structure, environment, staffing, and session activities. However, at this time, there are no evidence-based playgroup program “maps” to follow.

One primary benefit of playgroups is that although based in education and family support best-practices, programming is nimble enough to adjust to the needs of the group (a hallmark of quality). For the most part, curricula are developed by a supervisor or playgroup facilitator based on family need, available resources, and known best-practices borrowed from other service sectors. This creates a challenge; How then do you develop an evidence-based framework to implement high quality playgroup programs?

The difficult work of implementing evidence-based developmental playgroups requires forging new territory. Evidence-based home visiting models may provide guidelines for best practices, and early education models may contribute to strong curricula to strengthen caregiver-child relationships, child development, and caregiving skills. This report provides insight as to what an evidence-based playgroup model framework could look like based on current playgroup programs, family support services, and early education models.
Summary and Conclusions

Help Me Grow (HMG) Alameda County is building capacity for early screening and intervention services for families with children aged birth to five years old. The purpose of this report is to build understanding of the developmental needs of families with children birth to five years, identify assets as well as gaps in service availability, and the barriers that prevent access to needed services. The three main objectives and main findings are:

1. Identify current assets, needs, and gaps in services and support for children with, or at-risk of, developmental delay including behavioral and social-emotional issues
   - Primary needs include services for: Language and communication, social-emotional functioning, physical development, cognitive development
   - Primary gaps include services for: Family and child mental health, child care, services in the local area, services for mild or newly emerging delays, case management, housing for special needs

2. Develop recommendations for filling gaps and unmet needs informed by community-level data and a comprehensive literature review
   - Use evidence-based programs and best practices in service delivery.
   - Train more providers how to administer early developmental screenings.
   - Improve access to child and family mental health services and quality childcare.
   - Reduce social stigma of developmental and mental health services through public media campaigns.
   - Increase funding of community-based developmental supports for families with young children, such as developmental playgroups, parent education, and literacy events.
   - Offer more comprehensive family support and case management through medical home models or other programs that interlink agencies and provide follow-up with families.
   - Support campaigns to increase funding of IDEA part B and C to increase the number of children who qualify for services.

3. Develop a research-based framework, including recommended standards of practice, for the delivery of developmental playgroups for children with, or at-risk of having, developmental delay
   - Research corroborates positive benefits of developmental playgroups as important sources of social support and early intervention for families
   - Although evidence-based playgroup models do not currently exist, evidence-based home visiting models include playgroup components that can provide a framework for establishing standards of practice for developmental playgroup administration.
   - Evidence-based educational models may be useful for enhancing playgroup curricula

Families are struggling to provide the developmental support their young children need to thrive. Unmet needs, gaps, and barriers that stand in the way of service access are identified and recommendations for improving access and availability are presented. Finally, benefits of developmental playgroups are discussed and potential frameworks for implementing a playgroup model using best practices are offered.
References


Appendix A: Full Size GIS Maps
3rd Grade Reading Scores
Developmental Therapy Directory

Legend
- Physical/Occupational Therapy
- Speech/Language Therapy
- Other Developmental Therapy

Alameda County Map with markers for different therapies in various cities including Albany, Berkeley, Emeryville, Piedmont, Oakland, Alameda, San Leandro, Hayward, Union City, Newark, Fremont, Dublin, Livermore, Pleasanton.