EVALUATION REPORT

FY 2005

Early Childhood Mental Health Program (ECMH)

Submitted to the Kentucky Department of Public Health (Adult and Child Health) and Department of Mental Health and Mental Retardation Service (Division of Mental Health and Substance Abuse), Cabinet for Health and Family Services by:

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Program History and Description

Mission: The social and emotional growth of Kentucky's children birth to age five will be supported and promoted by emphasizing the importance of nurturing relationships in multiple settings.

Kentucky's Early Childhood Mental Health (ECMH) Program was created in state fiscal year 2003 as a component of the early childhood development initiative, KIDS NOW. The Department for Mental Health and Mental Retardation Services (DMHMRS) and the Department for Public Health (DPH) co-administer the program. DPH staff have lead responsibility for program oversight and financing, and DMHMRS staff serve as clinical liaison to the program. A Memorandum of Agreement concerning this program exists between the two Departments to allow for the transfer of program support funds to the DMHMRS. These funds are then contracted to the fourteen Regional Mental Health/Mental Retardation Boards (also known as Community Mental Health Centers) for regional program administration.

The primary goals of the ECMH Program are to provide:

1. Program and child-level consultation to early care and education (child care) programs regarding social, emotional, and behavioral issues;
2. Training on working with young children with social, emotional, and behavioral needs and their families to child-serving agencies and individuals; and
3. Evaluation, assessment, and therapeutic services for children age birth to five and their families.

The ECMH Program funds fourteen Early Childhood Mental Health Specialists, one per Regional MHMR Board. The Specialists' time is devoted solely to their

regional ECMH Program. The job duties of the ECMH Specialist include the following:

- Provide free consultation and education services to early care and education staff that serve children age birth to five;
- Provide assessments to children age birth to five with mental health needs at the location most suitable for the child and family;
- Provide therapeutic treatment (i.e. individual, family, and collateral services) to children age birth to five with mental health needs and their families at the location most suitable for the child and family;
- Work closely with local Healthy Start in Child Care consultants and the Health Access and Nurturing Development Services (HANDS) home visitors, and other agencies or programs that serve children birth to five and their families, to provide mental health consultation, assessment and therapeutic treatment services on behalf children age birth to five identified by those programs as needing mental health services;
- Assist families with children age birth to five in identifying and accessing needed community resources;
- Provide information and serve as a resource to private physicians and other caregivers through raising awareness of available services and resources for children age birth to five and their families;
- Offer early childhood mental health training to fellow Regional MH/MR Board staff, as well as other community partners who serve young children;
- Foster community planning for early childhood mental health through local groups and the Community Early Childhood Councils in the area;
- Attend training related to early childhood development and early childhood mental health needs;
- Attend periodic regional consultation and supervision sessions conducted by a statewide early childhood mental health consultant;
- Prepare and submit periodic service reports and evaluation data; and
- Attend quarterly state-level meetings of all ECMH Specialists.

This program is currently in its third year of operation, having received initial funding during Fiscal Year 2003. In its second year, the ECMH Program experienced rapid growth in the number of children referred and served; and it experienced increased stability as specialists became more proficient in their role and programs were integrated into their communities. All fourteen regions reported operating at capacity.

As the ECMH Program has evolved and solidified, so have the performance indicators designed to track its progress and measure outcomes. The most recent performance indicators and measures are depicted below, many of which became the focus of the current evaluation (see highlights):

Performance Indicators

DOMAIN	INDICATOR	MEASURE
Young Children and Families	1. Identify and treat relationship problems	▪ Number of direct interventions provided to children ▪ Quality of interventions measured through parent and provider satisfaction surveys ▪ Effectiveness of interventions measured through comparison of pre- and post-DECA scores
	2. Reduce the incidence of child abuse/neglect substantiations	▪ TWIST child abuse/neglect data compared with pre- and post-ECMH experience
	3. Eliminate the number of expulsions from early care and education settings	▪ Number of expulsions reported by ECMH Specialists
Early Care and Education Professionals	4. Increase the support and capacity of early care and education professionals	▪ Number of trainings and consultations provided to early care and education professionals as reported by ECMH Specialists
	5. Lower the number of referrals from early care and education settings	▪ Number and source of referrals as reported by ECMH Specialists
Mental Health Professionals	6. Increase the capacity of mental health professionals who work with young children	▪ Number of trainings provided to mental health professionals as reported by ECMH Specialists ▪ Quality of training measured through satisfaction surveys
	7. Increase the number of mental health professionals who work with young children	▪ Number of clinicians "recruited" as reported by ECMH Specialists

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Purpose and Scope of Current Evaluation

During Fiscal Year 2005 REACH conducted an evaluation that addressed performance measures related to the impact of the program on young children and their families, early care and education professionals, and mental health professionals.

REACH of Louisville is a subcontractor for the Cabinet for Health and Family Services (Department of Public Health, Division of Adult and Child Health) and, under that contract, was responsible for conducting an outcomes evaluation for the Early Childhood Mental Health (ECMH) program. This evaluation will be used by program administrators to identify current areas of strength and needed improvements, as well as to measure the performance of the program in relation to outcomes with consumers. In addition, information from the evaluation report may be used in program brochures, presentations, statewide initiative descriptions and as data to be included in needs assessment for grant proposals and other funding opportunities.

There were four primary goals for the evaluation: (1) to assess satisfaction among consumers of the ECMH program (parents/guardians, early care and education professionals, mental health clinicians), (2) to analyze TWIST data for implications regarding the degree to which the ECMH program serves as a protective factor for children, (3) to work with ECMH program administrators to design a system for processing and analyzing program data collected through the DECA instrument (not in effect until '06), and (4) to report on several program performance measures including: the number of expulsions from early care and education settings among participating children, the program's impact on increasing the support and capacity of early care and education professionals, and the program's impact on increasing the capacity of mental health professionals to work with young children.

During initial evaluation planning sessions it was determined that the focus of evaluation goals 1 and 2 would be on consumers served during the 2004 calendar year. Program administrators believed this represented the most complete data set for assessing consumer satisfaction and analyzing child abuse/neglect data, due to changes in reporting requirements of ECMH Specialists or limitations in the way program information was kept at the state level. Unfortunately, confusion at the state-level associated with the re-organization of state government (the combining of two Cabinets, and thus two IRB processes into one) caused significant delays in obtaining IRB approval and implementation of the evaluation to be suspended for approximately 5 months.

General methods

REACH created modified versions of the Mental Health Statistical Improvement Project (MHSIP) Consumer Satisfaction Survey and Youth Services Survey for Families (with feedback from 3 ECMH Specialists) and administered them to all levels of consumers who received at least one service from the ECMH program during calendar year 2004. Each regional ECMH Specialist reported the number of early care and education providers and mental health professionals that received at least one service during 2004 and forwarded this information to REACH. Program administrators, in conjunction with their information technologists, queried the DMHMRS client and event data system for a listing of all children age birth through five years who received at least one direct service from an ECMH Specialist during 2004. REACH then sent the appropriate number of all surveys to each ECMH Specialist, who then mailed or hand-delivered the surveys with a cover/consent letter signed jointly by ECMH administrators and REACH evaluators to encourage participation. A pre-paid return envelope was also provided for participants. REACH did not have access to any personally identifying information of consumers. Participation was strictly voluntary and completely anonymous. Data cleaning and descriptive data analyses were performed. Only aggregate level data are summarized in this evaluation report.

REACH analyzed TWIST data (DCBS) for implications regarding the degree to which ECMH may serve as a protective factor for children. In order to do this, those children who entered the ECMH program (in CY 2004) and had a child abuse or neglect substantiation within one year of program entry (as determined via TWIST) were compared with a statewide contrast sample (stratified for age, gender, and region) derived from vital statistics birth data, as well as national and state rates of child abuse and neglect. This allowed REACH to compute rates of substantiated abuse and neglect between the samples and make determinations about the degree to which the ECMH program may help to reduce the incidence of child abuse and neglect substantiations among children served.

REACH conducted preliminary research to assist ECMH program administrators in planning a system for processing and analyzing program outcome data to be collected through the DECA (Devereux Early Childhood Assessment) instrument

beginning in 2006. Tasks included: (a) determining if the DECA-C (clinical version) would be available in an automated, computerized format to facilitate field administration and data-sharing, and (b) reviewing the DECA and BASC (Behavior Assessment System for Children-preschool version) instruments for technical and practical characteristics that may lend support for recommending one version over another if the DECA-C was not available in computerized format. In communications with the Devereux Company REACH learned that the DECA-C was not supported in an electronic format and there was no foreseeable time-frame for this to occur, although the hardware requirements for such a system appeared minimal. REACH purchased comprehensive reviews of the DECA and BASC from the Buros Institute, reviewed them, and ultimately concluded that the DECA was somewhat preferable because it contained significantly fewer items (37 compared to 131 for the BASC) and some concerns were noted about the representativeness of the standardization data for the 4-5 year old cohort of the BASC given that it was collected over ten years ago.

Program performance data (described earlier) from the monthly reporting logs submitted by ECMH Specialists and maintained at DPH were collected and analyzed using descriptive data analyses. Only aggregate-level data were summarized for this report.

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Findings

Demographics and results from consumer satisfaction surveys are presented along with precautions for interpretation. Data regarding the degree to which the ECMH program serves as a protective factor against child abuse and neglect is also offered, in addition to program performance data from the ECMH information system.

Surveys

Consumer satisfaction surveys were received by REACH during a three-month period from December 2005 through February 2006. A total of 183 surveys were returned (across all consumer types). This represents an overall return rate of 14.3% which is considered to be low, although not unusual given the sampling method used and the unfeasibility of incorporating traditional methods to increase mail survey response rates. Demographic information for each survey type is presented below:

Family survey
Sixty-two surveys were returned from parents/guardians, with 9 out of 14 service regions represented. Fifty-five percent of respondents were parents/stepparents, 16% were foster parents, 22% were grandparents, 5% were DCBS social workers, and 2% were "other." Ninety-five percent of the time the child who had received services from ECMH was still living with (or under the care of) the respondent. Eighty-nine percent of children served were Medicaid and/or Passport recipients. The majority of respondents (77%) reported that their children received a "high dose" of the ECMH program, with length of service ranging from 6 months to longer than one 1 year. Twenty-three percent received a "low dose", with length of service ranging from less than one month to 5 months.

Child care provider survey
Sixty-eight surveys were returned from child care providers, with 9 out of 14 service regions represented. Ninety-seven percent of respondents were female, 3% were male. In general, the majority of respondents (52%) reported receiving a "moderate dose" of the ECMH program (2 – 5 contacts with the ECMH Specialist). Fifteen percent reported 6 – 9 contacts and 12% reported 10 or more contacts, for a total of 27%

receiving higher doses. Eighteen percent reported receiving a "low dose" of just 1 contact. The most frequent (56%) type of service received was consultation on a specific child (ren), followed by training (52%), followed by consultation for the child care agency as a whole (15%). A few reported receiving "other" services, such as supplies/snacks or a presentation for parents. Percentages do not equal 100% because child care providers could receive more than one type of service.

Mental health professional survey

Fifty-three surveys were returned from mental health professionals, with 8 out of 14 regions represented. Eighty-nine percent of respondents were female, 11% were male. The majority of respondents (83%) reported receiving a "high dose" of the ECMH program (either 6 -9 *or* 10 or more contacts with the ECMH Specialist). Seventeen percent reported a "low dose," or between 1 and 5 contacts. The most frequent (75%) type of service received was consultation on a specific child (ren), followed by consultation for the mental health agency as a whole (68%), followed by training (15%). A few reported receiving "other" services, such as mentoring or collaboration with an IMPACT service team. Percentages do not equal 100% because mental health professionals could receive more than one type of service.

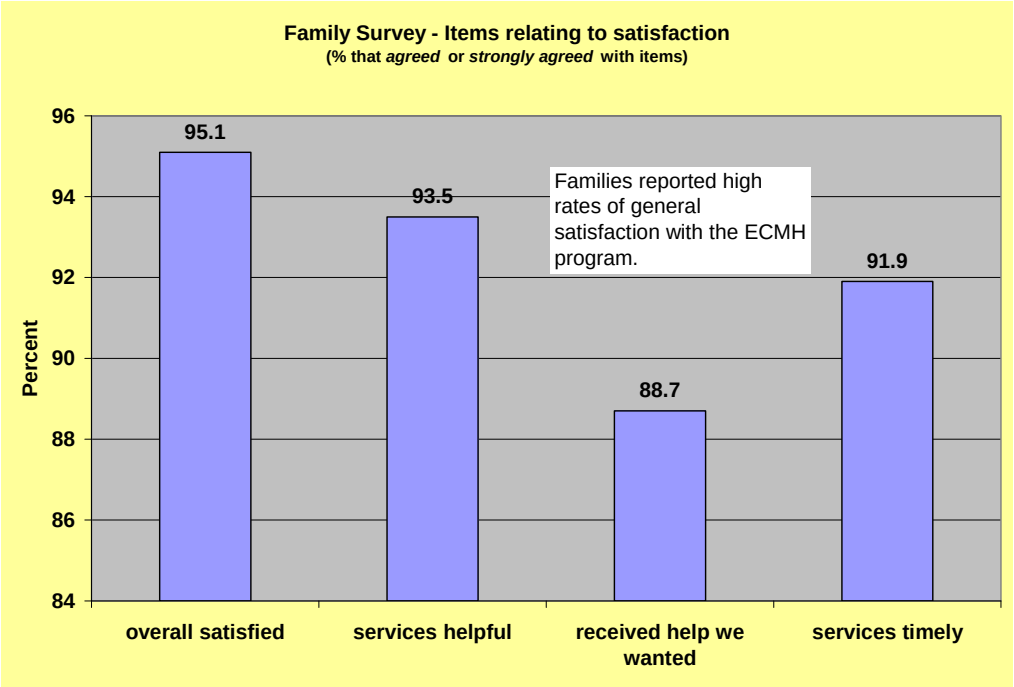
Cautions regarding interpretation of survey data

The results from survey data are not representative of ECMH consumers as a whole or of consumers served during 2004. Rather, they represent a "snapshot" in time. Several reasons account for the non-representativeness of the survey data. Namely, a nonprobability sampling technique was used out of necessity, the overall return rate for surveys was rather low (increasing the non-response bias), and only about 60% of regions were represented for each type of consumer survey. Yet, the results *do* provide a description of the satisfaction of some consumers, representing the first consumer satisfaction data ever collected within the ECMH program. Thus, survey data can offer useful information and a beginning point for programmatic decision-making.

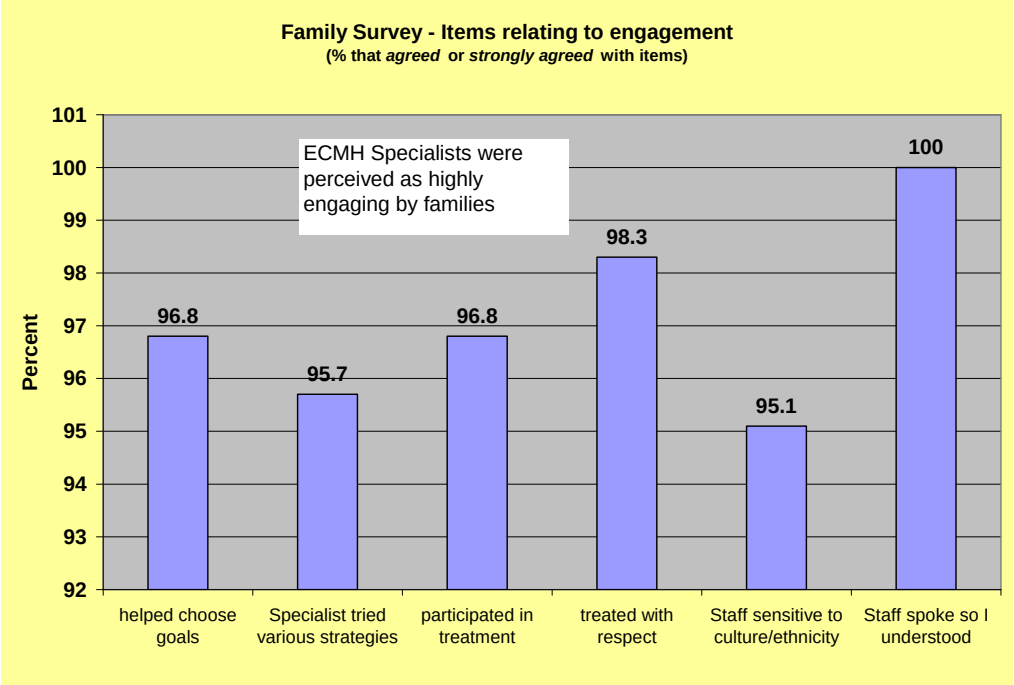
Results

Results from consumer satisfaction surveys are presented by consumer type with charts showing the percentage of respondents who "*agreed*" or "*strongly agreed*" with items. The items are grouped into three domains (e.g. satisfaction, engagement and perceived change) to facilitate interpretation. In general, high rates of satisfaction were reported across consumer types. Mental health professionals and families reported the highest levels of satisfaction, followed closely by child care providers. Similarly, families and mental health professionals endorsed high rates of "engagement behaviors" by ECMH Specialists, again with child care providers a close second. Perhaps more exciting are the perceptions from consumers about the "social validity" of the ECMH program. Approximately 90% of mental health professionals attributed improvements in children under their care, and in their ability to serve children with behavioral health needs, to the services they received from the ECMH program. Families perceived that their children were better at handling daily life (87%), and were able to get along better with others (79%). Seventy-five percent of child care providers attributed becoming more knowledgeable about children with behavioral health needs to ECMH.

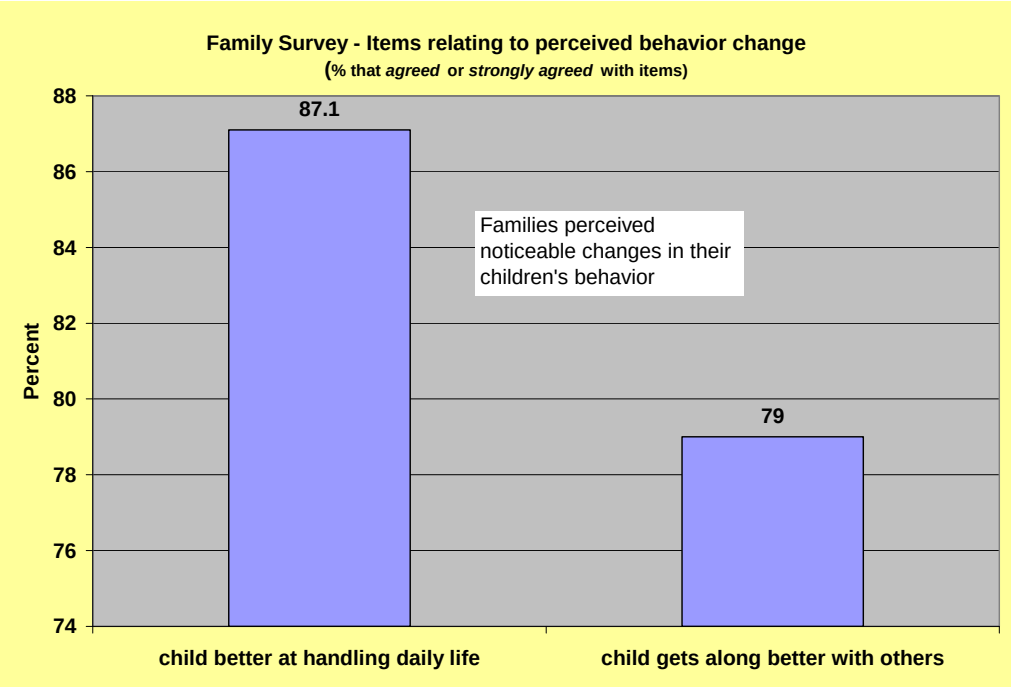
Family Surveys – Satisfaction items



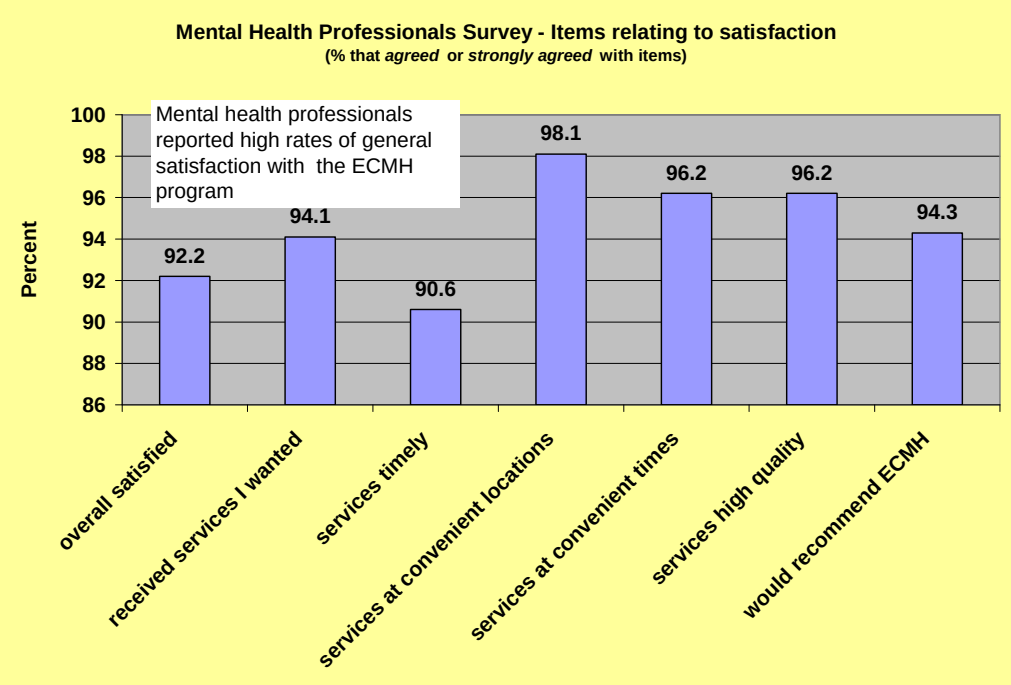
Family Surveys – Engagement items



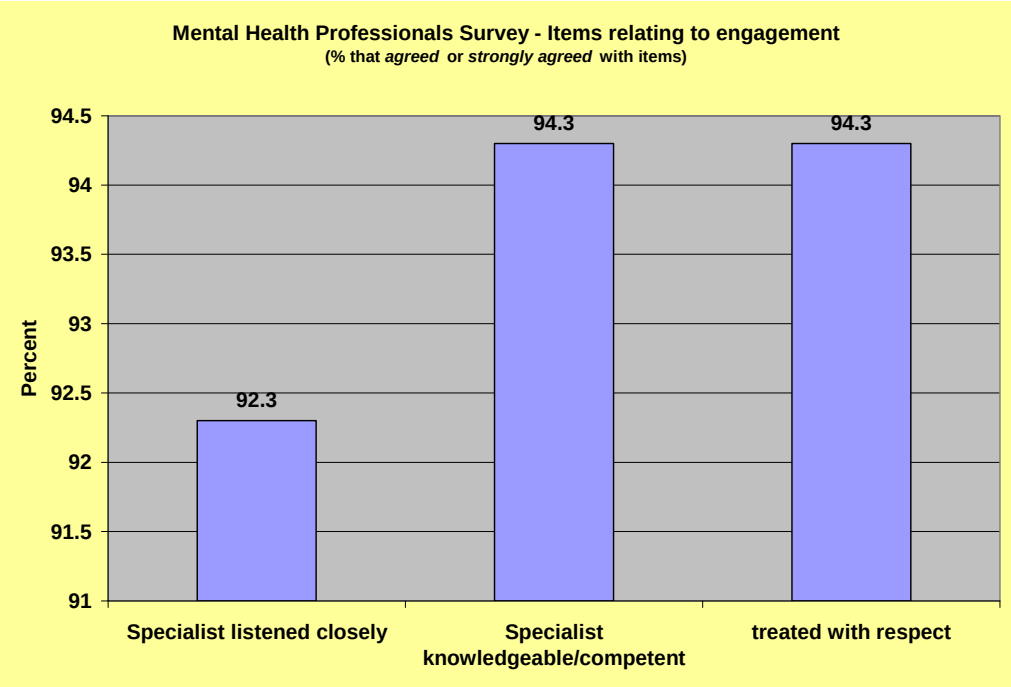
Family Surveys – Change items



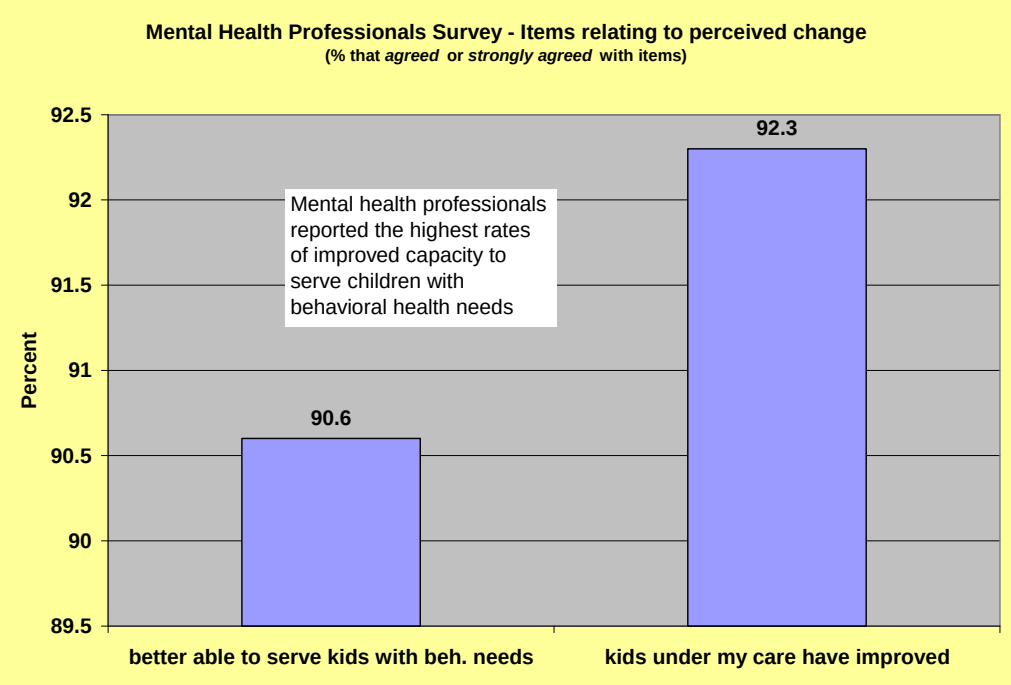
Mental Health Professional Surveys – Satisfaction items



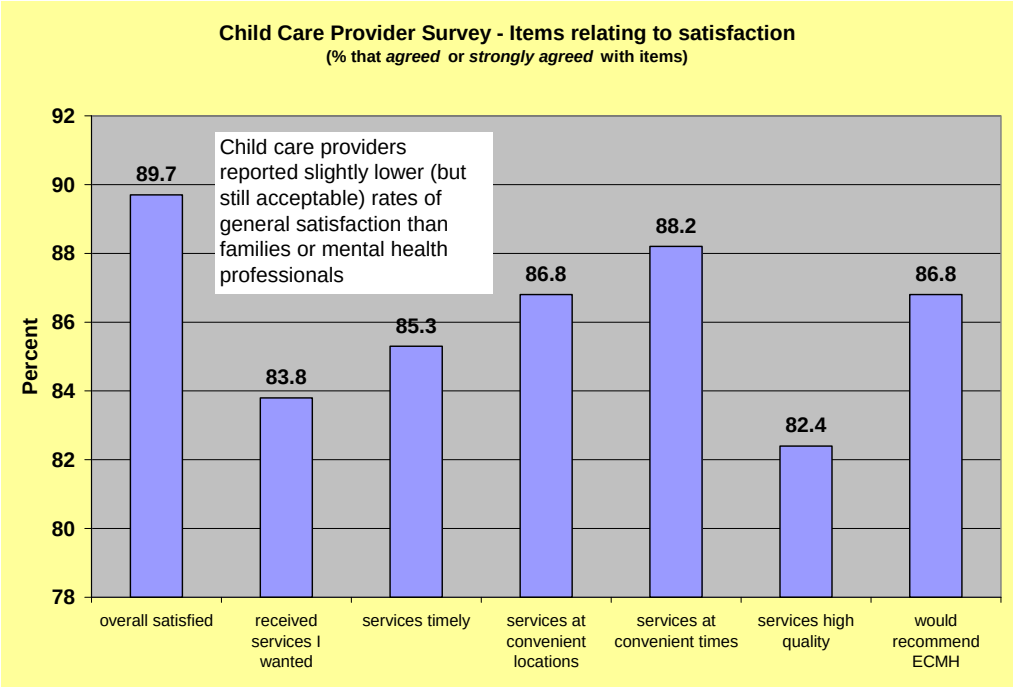
Mental Health Professional Surveys – Engagement items



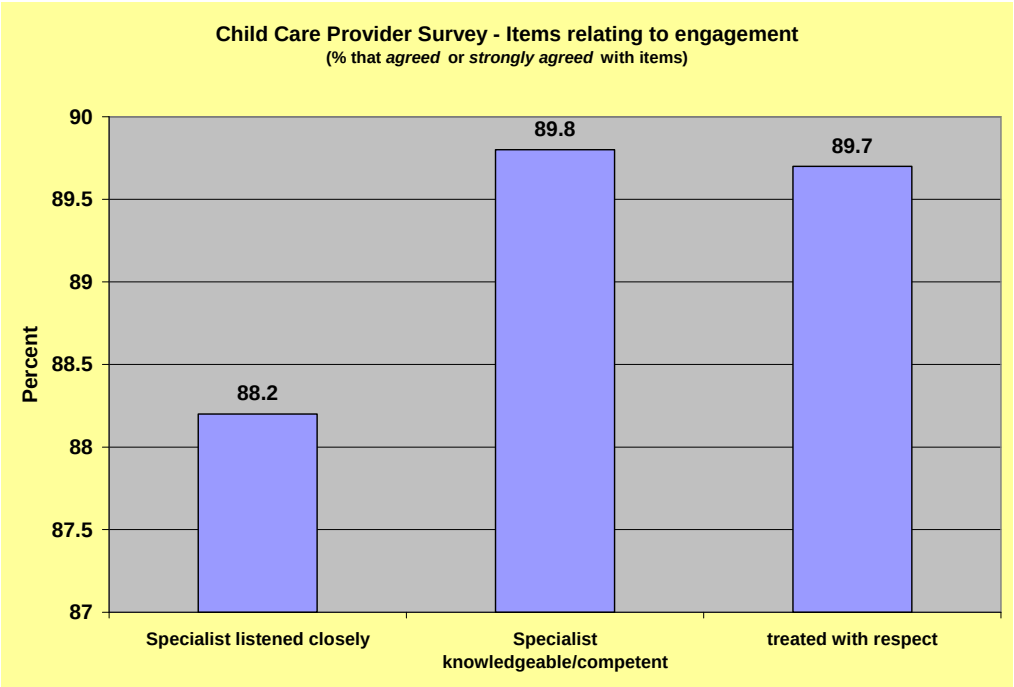
Mental Health Professional Surveys – Change items



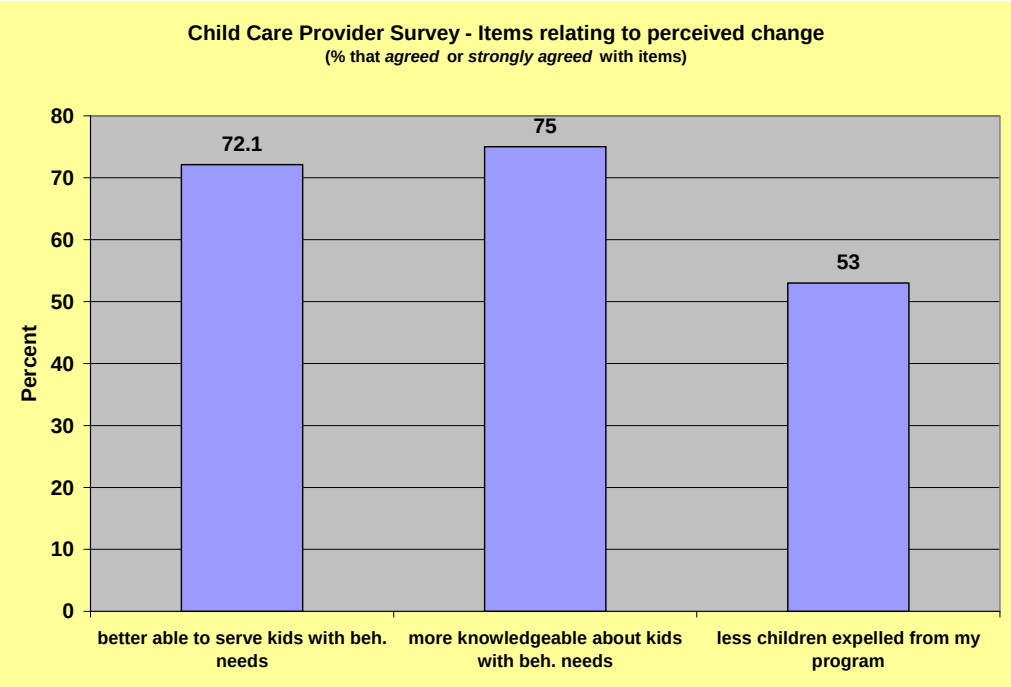
Child Care Provider Surveys – Satisfaction items



Child Care Provider Surveys – Engagement items



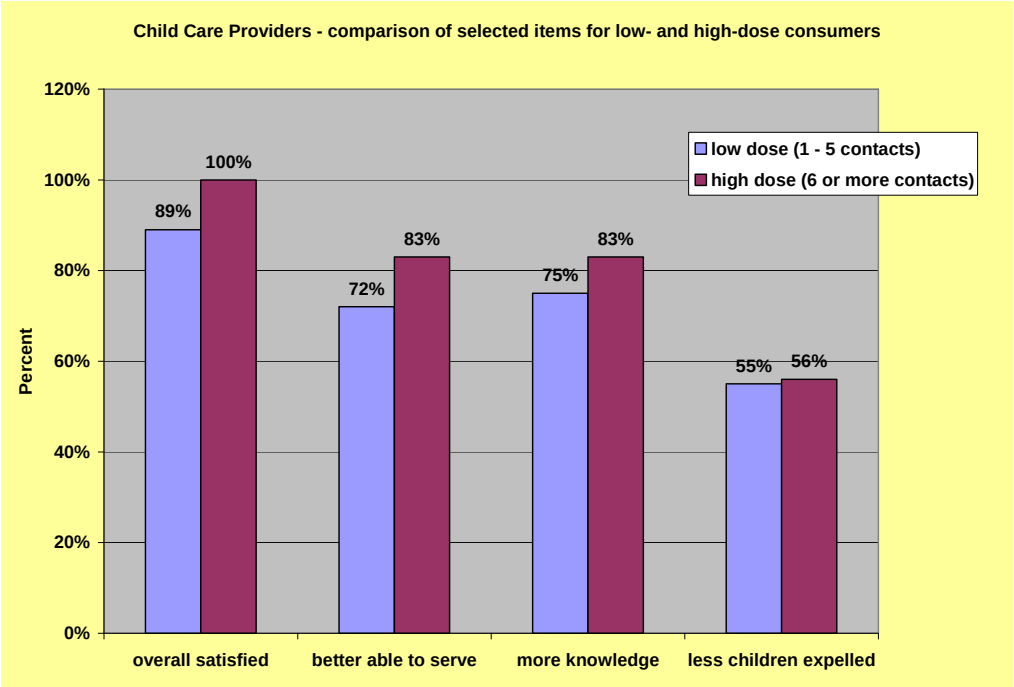
Child Care Provider Surveys – Change items



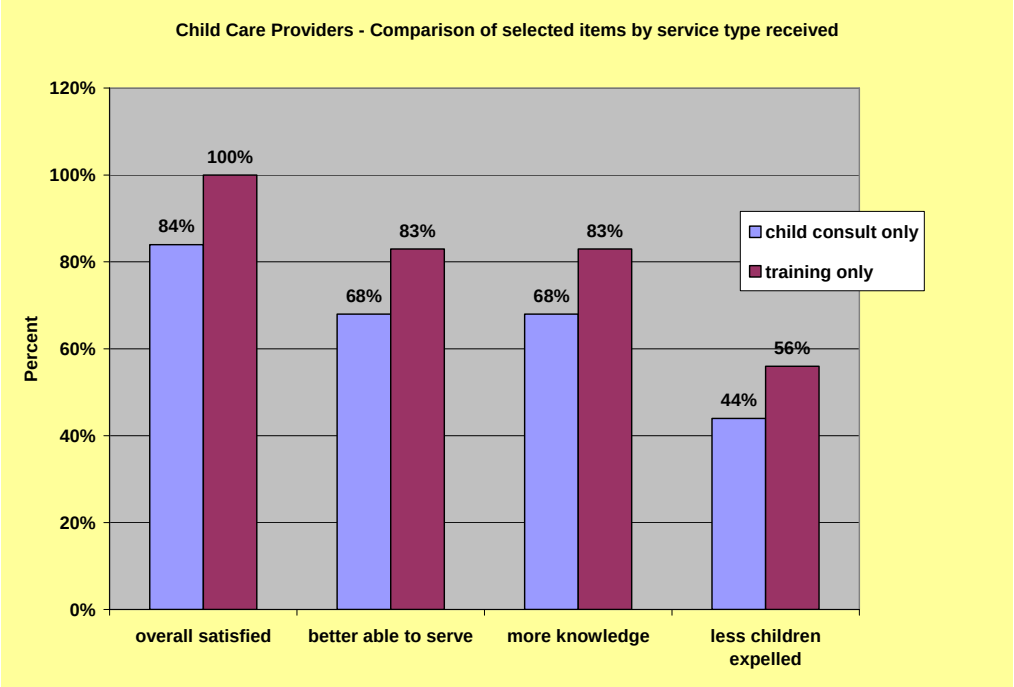
Satisfaction patterns were also compared with data on service dosage (number of contacts) and type (e.g. consultation, training). These data are portrayed with charts beginning on the next page in a similar fashion to the previous charts, such that the results show the percentage of respondents who "*strongly agreed*" or "*agreed*" with the items.

In general, the more involvement (high dosage) consumers had with the ECMH program the higher their overall satisfaction and perceptions of positive change. Two exceptions to this were noted; child care providers reported similar rates of expulsion from their programs regardless of service dosage, and families reported no real differences in the ability of their child to get along better with others. Among child care providers, those who received "training only" reported higher overall satisfaction and perceptions of positive change, than did child care providers who received consultation on a specific child.

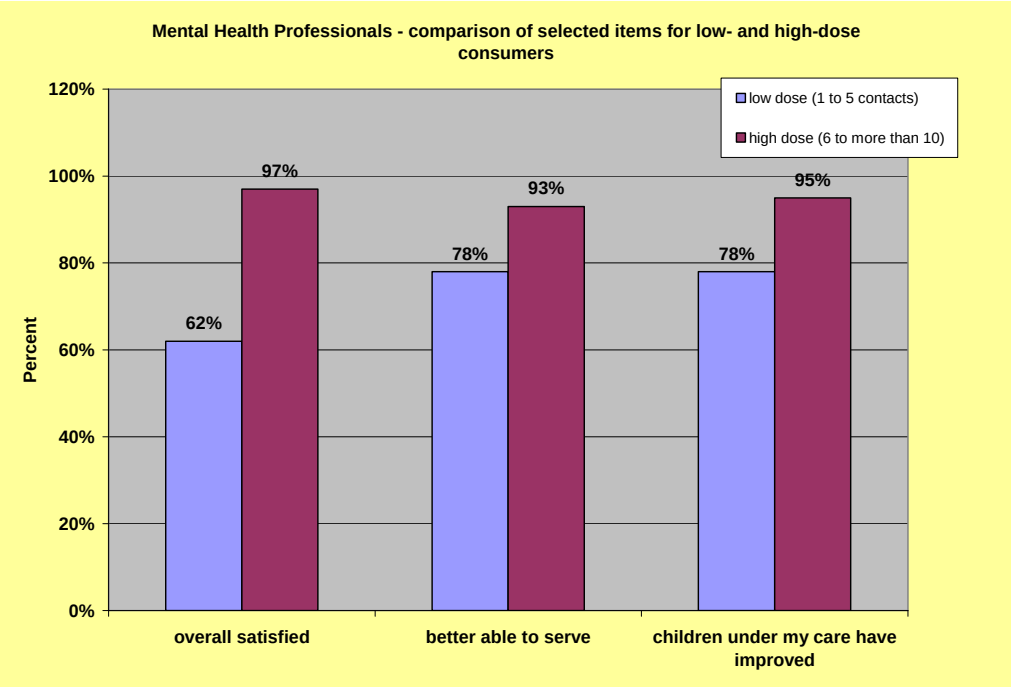
Child Care Providers – satisfaction and perceived change by dosage



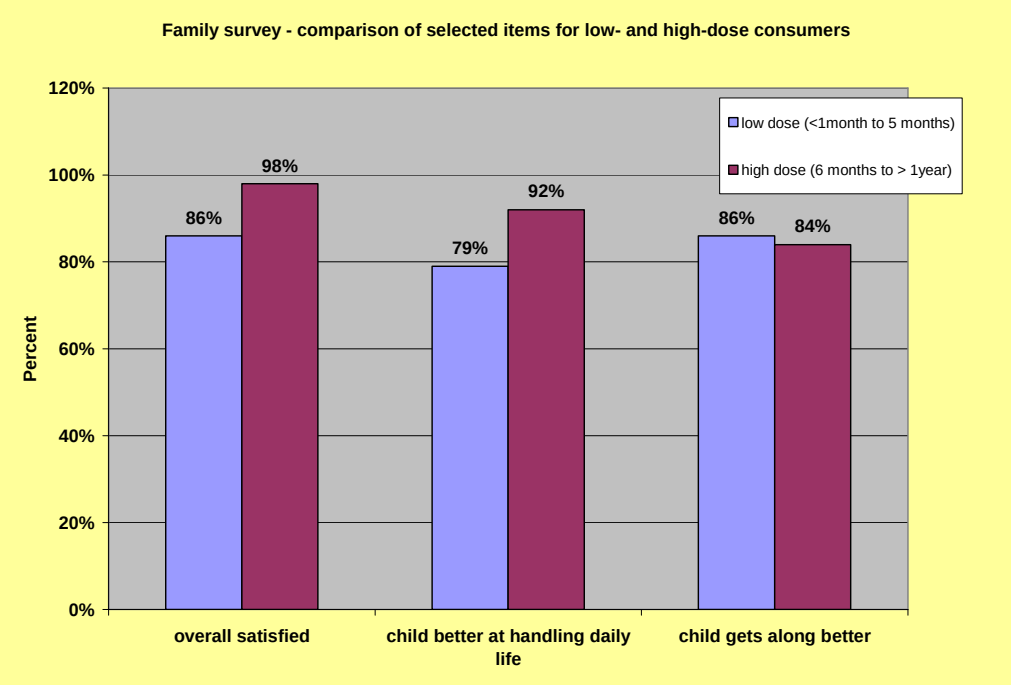
Child Care Providers – satisfaction and perceived change by service type



Mental Health Professionals – satisfaction and perceived change by dosage



Family Survey – satisfaction and perceived change by dosage



TWIST Data Analysis

REACH analyzed TWIST data (DCBS) for implications regarding the degree to which ECMH may serve as a protective factor for children. In order to do this, those children who entered the ECMH program (in CY 2004) *and* had a child abuse or neglect substantiation *within one year of entering the program* were compared with a statewide contrast sample (carefully stratified for age, gender, and region) derived from vital statistics birth record data, as well as the state rate of child abuse and neglect substantiations for 0-5 year olds derived from the 2004 National Child Abuse and Neglect Data System (NCANDS) data set. This allowed REACH to compute rates of substantiated abuse and neglect between the cohorts and make determinations about the degree to which the ECMH program may help to reduce the incidence of child abuse and neglect substantiations among children served.

Compared to the statewide rate of substantiated abuse and neglect for 0-5 year olds derived from NCANDS (3.2%) and the statewide contrast sample derived from vital statistics birth record data (3.2%), the ECMH cohort exhibited a higher rate of substantiated abuse and neglect (6.5%). When the rate was statistically adjusted for higher levels of reporting (a possible artifact of being involved with ECMH and social service system) the rate of substantiated abuse within ECMH was still higher than the NCANDS and statewide contrast sample rates (4.3% v. 3.2%), although less so.

Examining the ECMH group alone, over time, provided some explanation of this finding. First, it appears that the ECMH group, prior to program entry, is about 4 times more likely (14.5%) than the general population (3.2%) to have a substantiation of abuse or neglect. Clearly, the ECMH group appears to be far more high-risk. It also appears that after receiving the program the rate of abuse and neglect for the ECMH group decreases to 6.5% within the first year. This may be attributable, in part, to protective effects associated with the ECMH program. Looking at the ECMH group more closely, the following information can be gleaned:

- 81.5% of the ECMH group had **no prior** substantiations (1 year before program entry) and **no subsequent** substantiations (1 year after program entry)
- 3.9% of the ECMH group had **no prior** substantiations and then had **1 or more subsequent** substantiations
- 12% of the ECMH group had **1 or more prior** substantiations and **no subsequent** substantiations
- 2.5% of the ECMH group had **1 or more prior** substantiations and **1 or more subsequent** substantiations

In summary then, it appears that upon program entry the ECMH group is far more likely than the general population of young children to have been abused

(14.5%), and therefore they are at much higher risk for abuse to begin with. Despite this fact, in the year following entry into ECMH, the rate of substantiated abuse drops to 6.5%, which is still higher than the general population, but the gap seems to be narrowing. This may be at least partly attributable to the effects of ECMH. For the ECMH children who had prior abuse substantiation, 82.7% did not have another substantiation within the year following entry into the program. This again may, at least in part, be attributable to a protective effect associated with program participation. There were some ECMH children who were abused (3.9%) or re-abused (2.5%) in the year following program entry. While this may be a function of the fact that this population is high-risk to begin with, this finding also emphasizes the need to re-double efforts to work toward even lower rates of abuse and re-abuse.

The higher rate of substantiated abuse and neglect for ECMH children should be considered in context; that is, because the ECMH children are an "at-risk" group to begin with, they are therefore likely to have elevated rates of child abuse and neglect compared to the general population. Indeed, the higher rates of substantiated abuse and neglect may better reflect a description of the population served by ECMH, rather than an outcome of the program. A more equitable comparison between a similarly "at-risk" group of children who did *not* receive the ECMH would provide a more useful measure of the effectiveness of the ECMH program.

Program Performance Measures

Performance measure data were gathered from aggregates of ECMH Specialist monthly reporting logs maintained at the Department of Public Health (DPH). The following data were available for aggregation across all service regions. Several changes in the reporting requirements of ECMH Specialists after July 2004, and/or limitations in the way program information was kept at the state level didn't allow for all elements to be reported. For example, some data elements weren't tracked prior to July 2004, and electronic data collection wasn't implemented until some time during FY 2004. In previous evaluations performance data were estimated from ECMH Specialist verbal report.

Performance data available do suggest that the ECMH program is generally performing at capacity and has achieved stability in operation. The number of children who were discharged (expelled) from child care programs increased slightly; however it is unknown how many children were considered to be *at-risk* for discharge by ECMH Specialists (something that was estimated in previous evaluations). Roughly the same numbers of children were served. The number of trainings to mental health professionals decreased insignificantly, and may be

attributable to periodic vacancies and turn-over in ECMH Specialists throughout FY 2005. The number of trainings to child care providers was comparable to FY 2004.

FY 2005 Performance Measures - multiyear comparison			
	FY 2005	FY 2004	FY 2003
Number of children expelled from childcare	18	13	8
Number of trainings - child care providers	126	126 (based on ½ year estimate)	Unable to report
Number of trainings - mental health professionals	90	103	Unable to report
Approximate number of children served	558	578	413

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Recommendations

Recommendations from evaluation results are offered for continued program improvement:

1. Consider the results from the TWIST data analysis in context; that is, because the ECMH children are an at-risk group to begin with, they are therefore likely to have elevated rates of child abuse and neglect substantiations compared to the general population. A more equitable comparison between a similarly at-risk group of children who did *not* receive the ECMH would provide a more useful measure of the effectiveness of the program.

2. Systematic implementation of the DECA with every child served by the ECMH Program (across service regions) to enable for a more direct measure of child-related outcomes, something that is currently unavailable.

3. Development of a comprehensive automated electronic information system that captures consumer-level demographic, service delivery and outcome data, in addition to program performance measures.

5

Appendices

(Listed in order)

- Survey for Families
- Consent form for Families
- Survey for Mental Health Professionals
- Consent form for Mental Health Professionals
- Survey for Early Care and Education (Child Care) Providers
- Consent form for Early Care and Education (Child Care) Providers
- Survey Administration Instructions for ECMH Specialists