Early Childhood Specialist Program Report

Fiscal Year 2008-2009

Division of Behavioral Health
Office of Behavioral Health and Housing
Colorado Department of Human Services

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Acknowledgements:

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Executive Summary

This report details the work and results of the Early Childhood Specialist Program during fiscal year (FY) 2008-2009, the third year of operation.

Overview of Services Provided

Each of Colorado's 17 publicly funded community mental health centers receives funding to staff a full-time early childhood mental health specialist to provide direct services, consultative services to families and early care and education and other providers, and cross-systems program development. Early childhood specialists (ECS) screened 14 percent more children for mental health and developmental issues (7,166 children) in FY 2008-2009 compared to the previous year. In addition, ECSs provided 679 in-depth clinical assessments. There were at least 296 new enrollments of non-Medicaid children who received a variety of services, including caregiver interventions, case management, and child interventions through this program. The specialists also provided over 195 trainings in their communities on a variety of early childhood mental health topics, more than provided last fiscal year.

Results

The Early Childhood Specialist Program (ECSP) measured child and family outcomes in three areas: Change in Child Functioning, Change in Child/Family Functioning, and Change in Family Functioning. Two tools were used to collect this data, the Colorado Client Assessment Record (CCAR) and the Parenting Stress Index (PSI). The CCAR is a clinician-completed form and the PSI is a parent-completed instrument.

Results from the CCAR demonstrate a significant difference in the right direction on six of the eight CCAR clinical dimensions using a 95 percent confidence interval. In other words, children served through the ECSP showed significant improvement in the domains of socialization, family, hope, role performance, overall symptom severity and overall level of functioning over a three month time period.

Although the treatment effects as captured by the PSI are not as dramatic as the effects noted during the first year of the project (overall effect size of .52), the changes are still significant. The PSI results for FY 2008-2009 show substantial reductions in parenting stress, in difficult child behavior, and in high-risk problems in the parent-child relationship. A survey of the ECSs across the different mental health agencies suggests that they are now seeing more severe and complex cases, which may be contributing to the lower effect sizes. The actual change in mean scores from pre-test to post test were very similar between the two reports, but the standard deviations for the present report are greater, supporting the clinician reports of greater variability and complexity in the cases.

The Early Childhood Specialist Program at a Glance

The Early Childhood Specialist Program was implemented in FY 2006 after a successful pilot from 1997-2002. The purpose of the program is to place an early childhood mental health specialist position in each of the 17 publicly funded community mental health centers across the State.

Goals of the program are to:

- Provide early childhood mental health services to non-Medicaid children
- Increase the capacity to provide early childhood mental health services at each of the 17 Colorado community mental health centers

Target Population

The Early Childhood Specialist Program targets children ages 0-5 and their families. Early childhood specialists (ECS) are located in each of the 17 community mental health centers across the state. ECS are trained in the unique developmental issues of young children and work with other community agencies to develop and sustain appropriate programming for the mental health needs of young children. While the entire community benefits from the ECS work and expertise, non-Medicaid eligible children, ages birth to 5, are the focus of individual services.

Early Childhood Specialist Job Requirements

Colorado's community mental health centers were required to hire Masters-level clinicians with a background in early childhood. If such professionals are not available, centers are to recruit the best candidates, providing them with extensive clinical training in early childhood mental health.

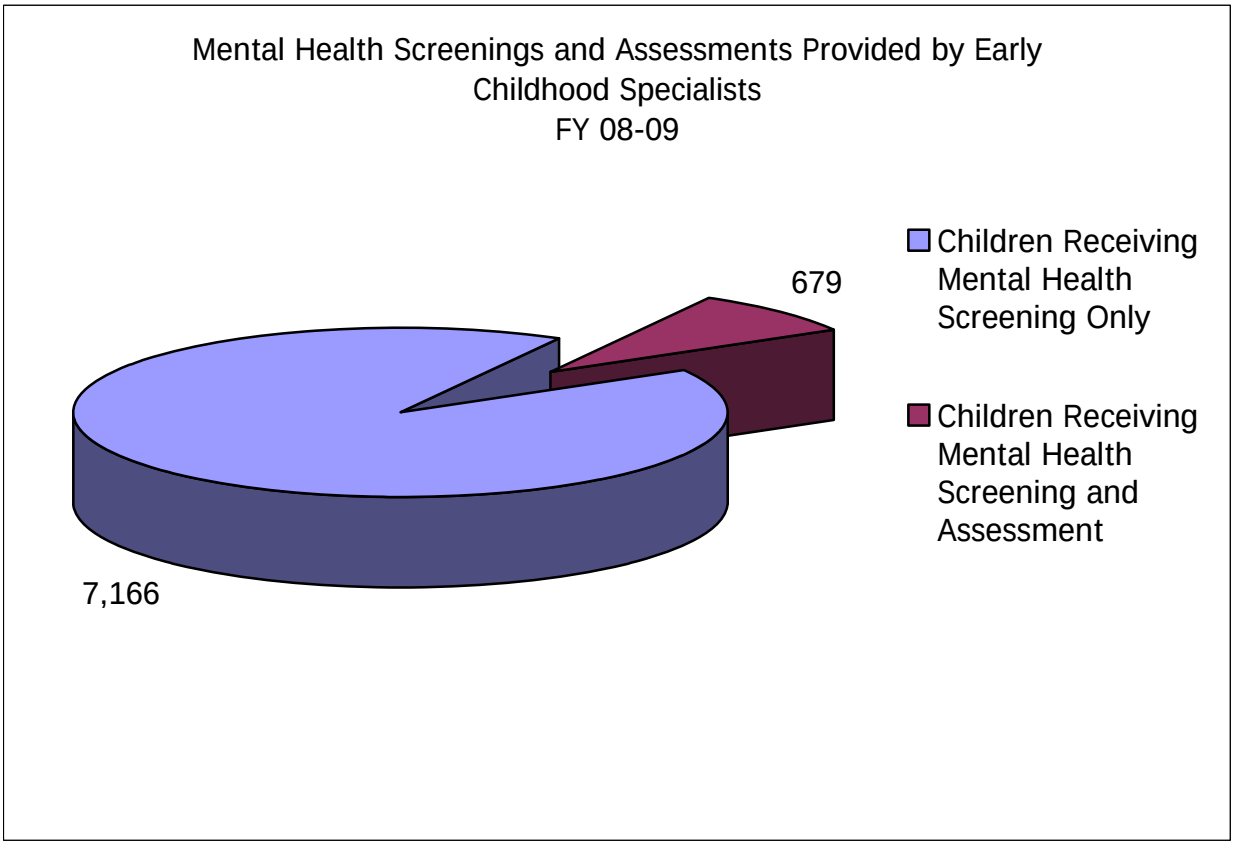
All ECS are required to become proficient in using the DC: 0-3R assessment system. The DC: 0-3R **(**Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood) is a developmentally based system for diagnosing mental health and developmental disorders in infants and toddlers. This system complements existing medical and developmental assessment frameworks such as the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association and the International Classification of Diseases of the World Health Organization. Its diagnostic categories reflect the consensus of a multidisciplinary group of experts in early childhood development and mental health and draws on empirical research and clinical practice. DC: 0-3R is designed to enhance mental health workers', as well a**s** other early childhood professionals' ability to prevent, diagnose, and treat mental health problems in the earliest years by identifying and describing disorders not addressed in other classification systems and by pointing the way to effective intervention approaches.

Colorado Early Childhood Specialist Program

ECSs provide screening and assessment services to the community. Many of the screenings may take place in childcare centers and in some cases, the pediatrician's office. A variety of tools may be used such as Ages and Stages, Social Emotional, and the Devereaux Early Childhood Assessment. When children are identified through the use of a screening instrument as having a concern, a more thorough assessment is conducted using other tools and more in-depth interviews with the child's caregivers. Assessments with young children may take longer than with older children or adults as the clinician must interview the caregivers and observe the child in various settings.

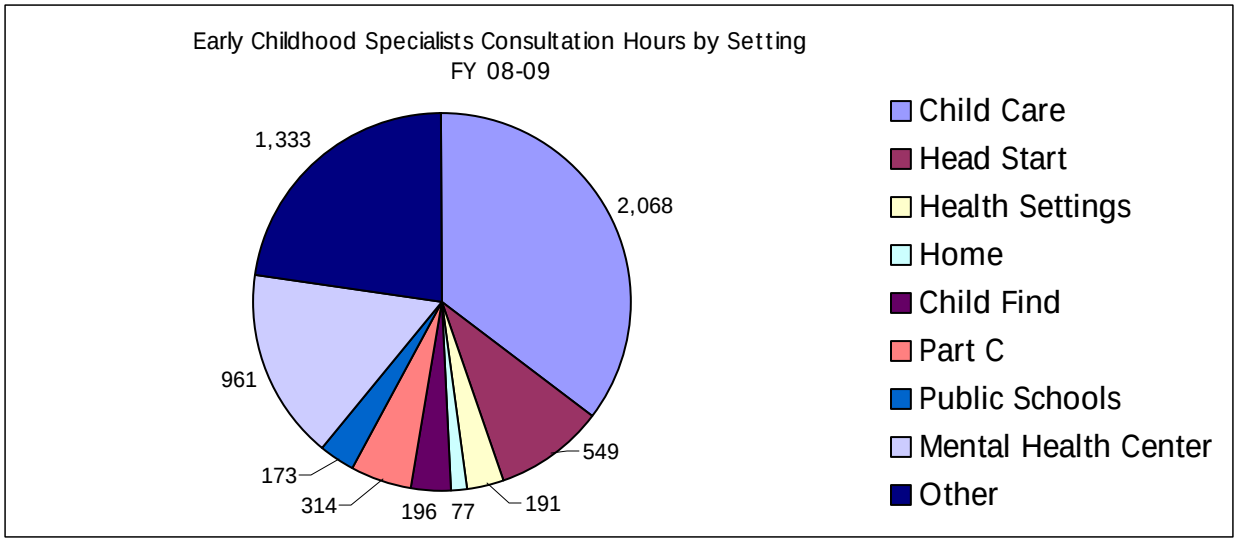
The ECSs provided **screenings for 7,166 children and 679 in-depth assessments.** (Chart 1 below)

Chart 1: Mental Health Screenings and Assessments Provided by Early Childhood Specialists



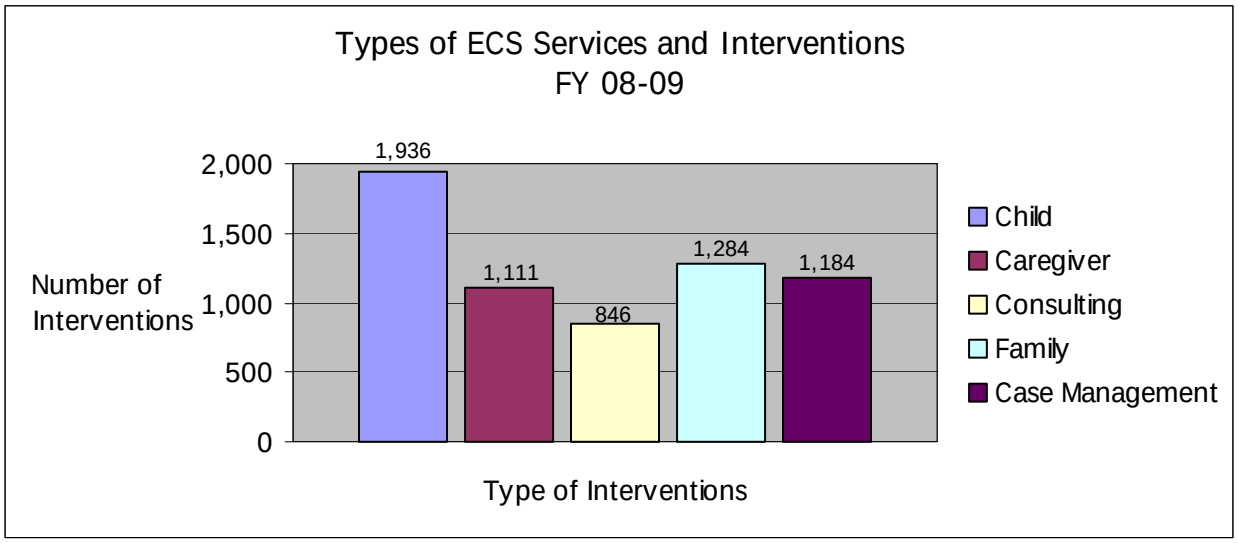
The Early Childhood Specialists are encouraged to interact with children and parents in natural settings and multiple environments. Chart 2 indicates some of the settings in which early childhood mental health services were provided**.**

Chart 2: ECS Consultation Hours by Setting



The ECS provides services to children, parents ,families and other caregivers. Many times services may be indirect work such as consulting with another provider about how to support a young child's mental health. **Chart 3** shows the types of services provided by ECSs during the 2008-2009 FY.

Chart 3: Types of Services and Interventions



Training

A component of the ECS role is to share knowledge with the community concerning early childhood mental health as well as attend early childhood specific trainings to further their expertise. In the FY 2008-2009, ECSs presented over 195 trainings statewide to early childhood professionals, parents, and community members.

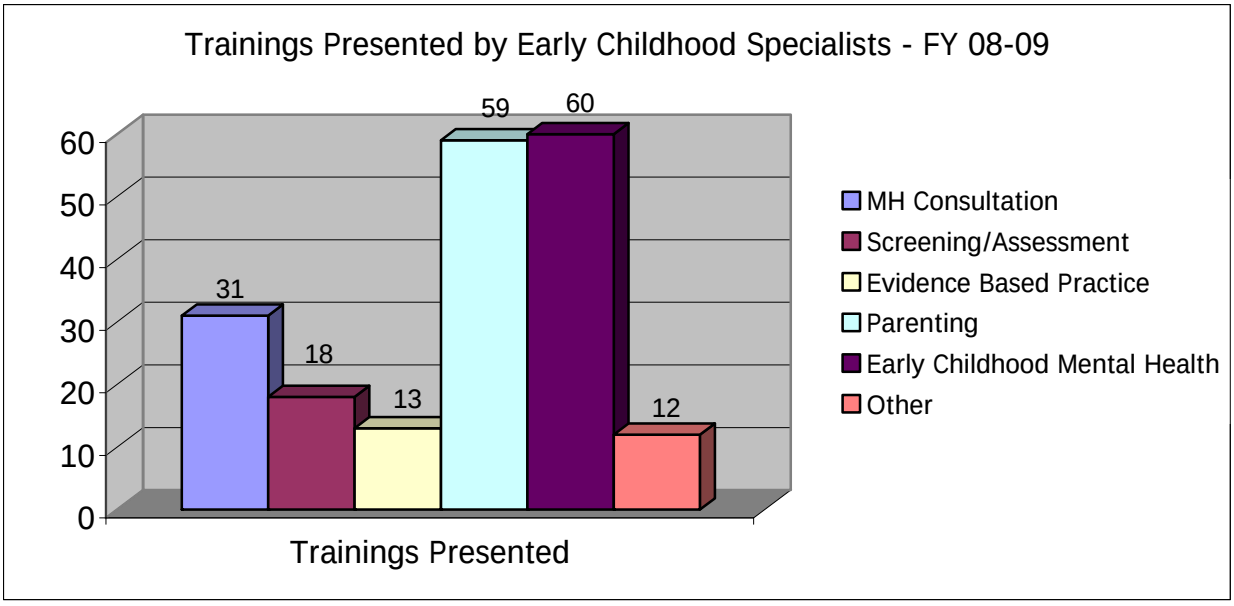
Nearly all ECSs (87 percent) provided mental health consultation or challenging behavior trainings to childcare providers and over half (53 percent) presented parenting skills and strategy trainings such as, "Love and Logic", "Effective Disciple for Foster Parents", and "Time-In with Your Child". ECSs also presented information about health and mental health, prevention/early intervention, and DC: 0-3 R training. One-forth (25 percent) of all trainings given to parents, early childhood providers, mental health centers, and community members specifically focused on education about infant and early childhood mental health.

As ECSs offer expertise to the community, furthering professional knowledge and staying current is key to providing the best practices in the field and effectively serving young children and their families. The State of Colorado offers bi-annual training and networking sessions for this purpose. Comprehensive training took place during the FY 2008-2009 at conferences such as the Colorado Child and Adolescent Mental Health Conference in the spring and sessions at the annual Colorado Behavioral Health Care (CBHC) Conference held annually in the fall.

In addition to state sponsored training, the specialists have pursued other trainings to enhance their skills. During FY 2008-2009, the ECSs participated in over 170 training sessions.

Chart 4 below shows the types of training that early childhood specialists presented to their communities during this program year.

Chart 4: Trainings Presented by Early Childhood Specialists



Outcomes and Results

In order to assess the relative value and effectiveness of the Early Childhood Specialist Program, the following performance outcome measures were identified and used to measure the program results, which are detailed in **Table 1** below.

Table 1: Performance Outcome and Measures

Outcome	Indicator	Tool	Measure
Change in child functioning	Child's mental health symptoms	CCAR	Overall symptom severity at admit and discharge
	Level of functioning	CCAR	Overall level of functioning at admit and discharge
	Social skills	CCAR	Interpersonal Domain and/or Socialization Domain ratings
	Change in rate of childcare expulsions	PSI Form	Reported on PSI Form
	School readiness	CCAR	Outcome section for under 6yrs old
Change in child/family functioning	Family relationships	CCAR PSI	Family Domain Ratings at admit and discharge and PIR-GAS Parent/Child Interaction
Change in family functioning	Change in rates of out-of-home placements	CCAR	CCAR update completed for "current living arrangement" when placement changes
	Family stress	PSI-Short Form	Overall score
	Family isolation/social supports	CCAR	Social Support Domain rating
	Family sense of competence	CCAR	Empowerment Domain
Increase in early childhood mental health professional development	Trainings attended and delivered	Yearly reports to DMH	
Infuse mental health into early childhood system	Number of screenings/assessments completed	Reports to DMH	

Reporting Requirements

ECSs are required to submit monthly performance reports to the Division of Behavioral Health using a Web-based reporting system developed by the Division of Behavioral Health. ECSs submit data for all children receiving mental health services using the Colorado Client Assessment Record (CCAR), and the Parenting Stress Index (PSI). They also submit a year-end activity report listing all trainings attended and trainings provided, as well as success stories. Results from the various data sources are discussed in the following sections.

CCAR Results

The Colorado Client Assessment Record (CCAR) is the statewide client information system developed and maintained by the Division of Behavioral Health. The Colorado Client Assessment Record (CCAR) was developed over 25 years ago. It has been required on all Admissions and Discharges to the Colorado Public Mental Health System since 1978. It has undergone several major revisions with the start of Colorado's Managed Care program and its use has broadened across systems (i.e., Division of Youth Corrections, Child Welfare, Residential Treatment Centers, etc.).

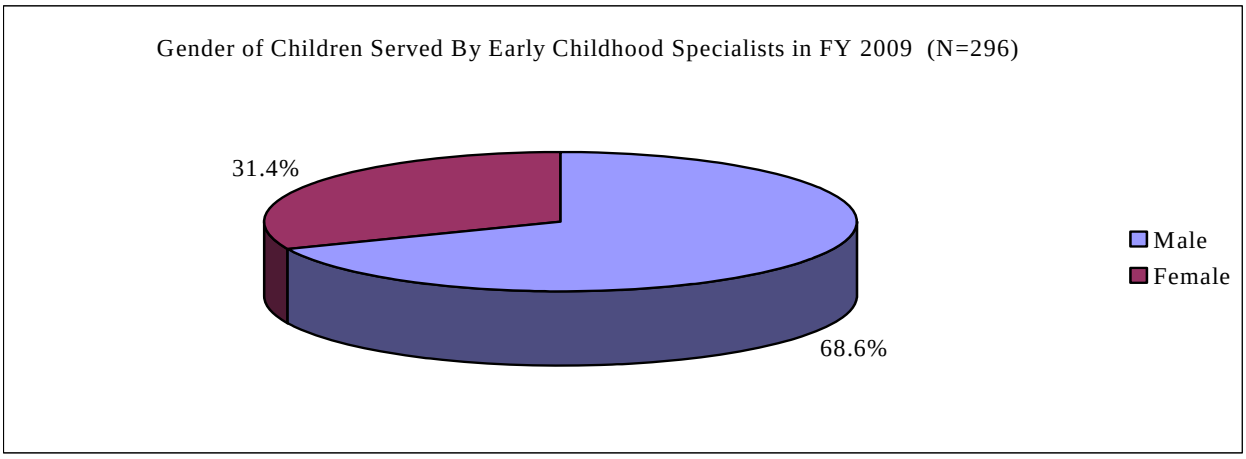
CCAR has many uses. Initially it was used to count admissions for monitoring performance contracts between the State of Colorado and the mental health centers. Services data has been collected since 1995 and has been matched with CCARs at the client level for studies and reports. Single variable studies such as ethnicity, income, and diagnosis are commonly done. Trends can be examined for periods ranging from quarterly to several years. However, outcome is most often studied.

In summary, CCAR is well established, well researched, and lends itself well to applied research studies. Its utility in Colorado's public mental health system is known; it provides information on everything from simple counts to program evaluation data. Linked with services, it can provide information on cost benefit and other more complex kinds of research questions. Furthermore, CCAR has been used in Arizona, Delaware, Florida, Wyoming, and Ontario.

Recently, this system was updated and several sections pertinent to young children were added. The CCAR was completed by the early childhood specialist at intake, every 6 months, and then re-administered at program discharge. The following is a summary of the performance data related the Early Childhood Specialist Program.

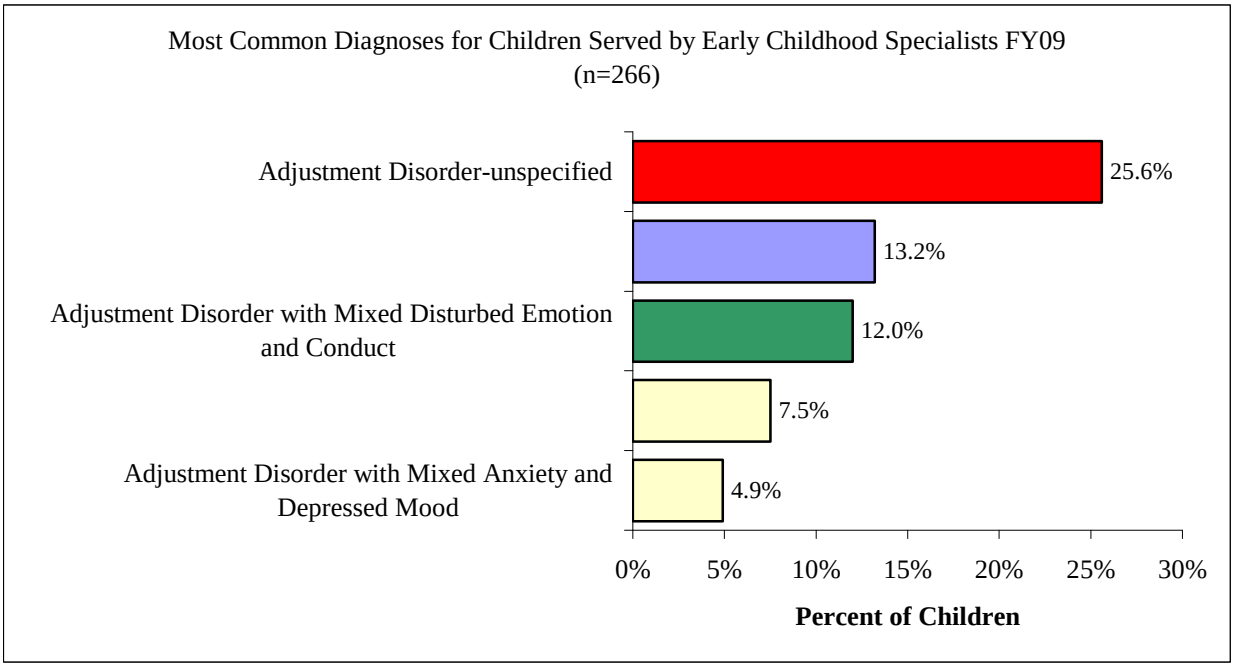
The Early Childhood Specialist Program as recorded by the 2009 CCAR database served 296 children. Approximately 68.6% of those children were male (n=203), and 31.4% were female (n=93). (See Chart 5)

Chart 5: Gender of Children Served by Early Childhood Specialists in FY 2009 (N=296)



The majority of children receiving services were Caucasian (n=180; 60.8%). Children ranged in age from 0.17 to 6.92 years old during FY 09 with average age being 4.08 (median age = 4.30). Children exhibited approximately 31 different Axis I diagnoses (e.g., adjustment disorder-unspecified (n= 68), disruptive behavior disorder NOS (n=35), and adjustment disorder with mixed disturbed emotion & conduct (n=32)). The most common diagnoses are shown in Chart 7.

Chart 7: Most Common Diagnoses for Children Served by Early Childhood Specialists



In an attempt to determine the program effectiveness, a subset of the total population was examined using CCARs. For children with more than one CCAR assessment in FY 09 and a minimum of 90 days between assessments, the first and last CCARs were compared on nine domains including Socialization, Family, Social Support, Hope, Empowerment, Role Performance, Overall Symptom Severity, Overall Level of Functioning, and School Readiness. As the first eight domains were scored using a Likert scale, a paired sample t-test was conducted.

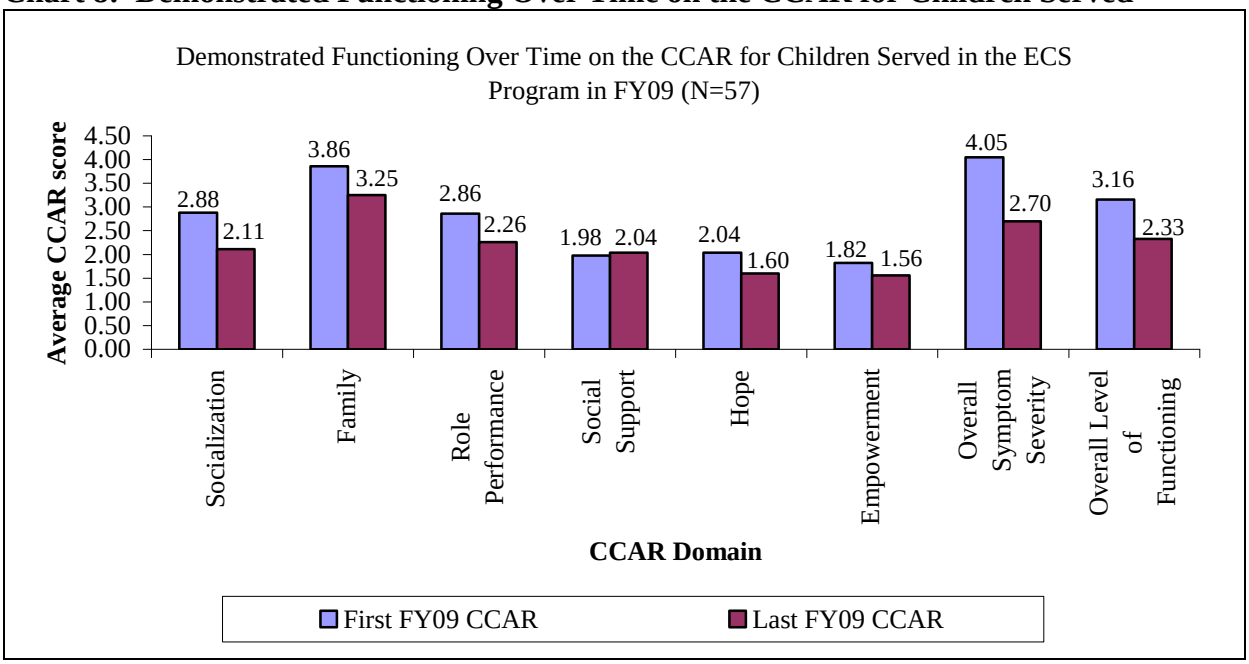
On six of the eight dimensions, a significant difference was observed in the appropriate direction utilizing a 95% confidence interval. In other words, children served through the ECS program showed significant improvement in the domains of Socialization, Family, Hope, Role Performance, Overall Symptom Severity, and Overall Level of Functioning over a time lapse of at least three months (see Table 2).

Table 2: Paired Sample Comparison of CCAR Domains

Domain	CCAR	Mean	*t*	Significance
Socialization (n=57)	First CCAR Last CCAR	2.88 2.11	5.07	p < .01
Family (n=57)	First CCAR Last CCAR	3.86 3.25	4.10	p < .01
Role Performance (n=57)	First CCAR Last CCAR	2.86 2.26	3.93	p < .01
Social Support (n=57)	First CCAR Last CCAR	1.98 2.04	-0.52	Not significant
Hope (n=57)	First CCAR Last CCAR	2.04 1.60	3.37	p < .01
Empowerment (n=57)	First CCAR Last CCAR	1.82 1.56	1.48	Not significant
Overall Symptom Severity (n=57)	First CCAR Last CCAR	4.05 2.70	7.92	p < .01
Overall Level of Functioning (n=57)	First CCAR Last CCAR	3.16 2.33	4.79	p < .01

The information contained in Table 2 is reflected in Chart 8. On seven of the eight domains listed the concerns diminished. On all but one of these domains, the average scores between time one and time two decreased showing improvement[1].

Chart 8: Demonstrated Functioning Over Time on the CCAR for Children Served



In addition, first and last CCARs were compared on the dimension of School Readiness. As School Readiness was a dichotomous variable, a Chi-square analysis was conducted. Statistically significant differences ($p < .01$) were demonstrated between the first and last CCAR

[1] A decrease in CCAR scores represents an increase in success in that area of functioning

data. Overall, the school readiness variable increased from 51% of clients considered ready for school[2] on the first CCAR to 65% on their second CCAR.

Parenting Stress Index Results

The Parenting Stress Index/Short Form (PSI/SF; Abidin, 1995) is a parent-report, 36-item questionnaire completed by parents or caregivers about their experience of stress in relation to parenting their child. The PSI/SF is designed for use with children ages 1 month to 12 years. It takes approximately 10 minutes to complete and has a 5th grade reading level. It has a built-in defensiveness scale to evaluate validity of responses. The PSI/SF has been validated across different groups and cultures and both the English and Spanish (Solis, 1991) versions were used in this evaluation. There are three subscales that measure parental stress, stress in the parent-child interaction and difficult child behaviors. In children under two, elevated scores on the difficult child behaviors subscale are often associated with dysregulated behavior in the child. The three subscales combine for a total Parenting Stress score. Higher scores indicate higher stress that potentially lowers the ability to appropriately parent the child.

Results of the Parenting Stress Index/Short Form

Parents were asked to complete the PSI/SF during the first couple sessions after a level of rapport was established between the therapist and parent. Parents also were asked to complete a follow-up PSI/SF at either 6 months or discharge. Data were collected between March 2007 and December 2009. Of the 17 participating agencies, 9 (53%) submitted PSI/SF data on a total of 43 children. The majority (59%) of the PSI/SF's were completed by mothers, 22% by fathers, 2% by grandmothers, and the remaining 17% did not have the respondent indicated. Four children had PSI/SF data from both parents. Overall, there were 47 valid pre and posttest PSI/SF reports on 43 children.

Agency	No. of PSIs*	No. of Valid PSIs**	No. of kids	Valid PSI completed by Mother	Valid PSI completed by Father	Valid PSI completed by Grandmother
Aurora Mental Health Center	2	0	0	0	0	0
MHC for Boulder/Broomfield	11	8	8	missing	missing	missing
Community Reach	6	4	4	3	1	0
Jefferson Center for MH	2	2	2	2	0	0
Larimer Center for MH	15	14	14	10	3	1
MHCD	2	2	2	2	0	0
North Range BH	13	12	8	7	5	0
San Luis Valley MHC	3	1	1	1	0	0
West Central MHC	5	4	4	3	1	0
Total	59	47	43	28	10	1

*The number of PSIs refers to the number of paired pre and post PSIs. Clients with only a pre-test PSI were not included in the analysis.

**Valid PSIs are those with a defensive responding score greater than 10.

[2]The particular CCAR item is worded as follows: "Is the Child at a Developmentally Appropriate Level with Respect to Readiness for School"

The PSI/SF is sometimes a difficult survey for parents to complete because it asks them to describe their feelings about their child's relationship with them and their own stress as a parent. As are results, some parents feel so anxious that they tend to under-report until they feel safe in the treatment process. The Defensive Responding validity Scale identifies parents who are under-reporting due to defensiveness or anxiety. Overall, PSIs for 12-PSI surveys were invalid due to the defensive responding score 10 or less. These surveys were not included in the analysis.

The Parenting Stress Index /Short Form (PSI/SF) is a particularly revealing instrument because it captures to some degree the following three critical dimensions that contribute to the quality of the parent-child relationship and the parenting environment:

- Parental dimension – that is, the degree to which the parent feels competent, supported, and emotionally available to parent the child;
- Child dimension – that is, the degree to which this child is experienced as a difficult child to parent, perhaps because of regulatory problems; and
- Parent-child relationship dimension – that is, the parent's experience of being connected to or alienated/rejected by this child.

Over half (53.2%) of the 47 parent/caregivers reported Total Parenting Stress in the clinical range at the point in which their children entered treatment. This had decreased to 29.8 percent on the post-test. The post-test may be administered at discharge or as an update at 6 or 12 months after entry into treatment.

- 42.6% of the parents reported a significant level of stress in the parenting role (score > 85) on the pre-test, particularly related to feelings of incompetence, limited ability to meet the demands of parenting, emotional distress, and or limited social support.
- 48.9% of the parents reported a clinically elevated level of stress (score >25) in the parent-child relationship on the pre-test, including feelings of being rejected by or alienated from the child. Overall, 34% of the parents reported very high scores (score >30) on the pre-test suggesting that the parent-child bond is either threatened or has never been adequately established, thus identifying a sample of children who are at high risk of attachment problems.
- 63.8% of the parents reported a significant level of stress regarding the child's behavior (score > 32) on the pre-test, indicating that the child's behavior is more difficult to manage than is typical. In very young children, 0-3, this suggests significant problems with regulation, while with children older than two; problems may be related to the parent's difficulty in managing the child's behavior as well as problems with the child's emotional regulation.

Follow-up data is available on 47 children who have completed a minimum of 6 months of treatment or who were discharged. They were seen by for an average of 19.2 weeks (STD dev = 9.8), with a range of 6 to 51 weeks.

The following significant clinical improvements were identified:

- **Parental stress** was significantly reduced (from 42.6% to 17% in the clinical range) indicating a significant improvement in parental feelings of competence, emotional functioning, and/or social support. The change in mean scores for parental stress was statistically significant.
- The quality of the **parent-child relationship** was significantly improved at the follow-up testing, going from 48.9% to 38.3% in the clinical range after an average of 19 weeks of treatment.
- The proportion of parents no longer reporting in the very high-risk range for relationship stress was lower with 34% of the 47 parents reporting a very high level of stress in the parent-child relationship at pre-test, compared with 17% at post-test. ***This is a very important finding when looking at the mental health of young children***.
- There was a decrease in stress related to the **parental experience of the child's behavior**, with 63.8% of the parents reporting that their children's behaviors were in the clinical range at pre-treatment, compared with only 27.7% at the 6 month follow-up or discharge point.
- The proportion of parents reporting clinically elevated levels of parenting stress decreased from 53.2% to 29.8% between pre and post-test.

Number of parents reporting a clinically elevated level of stress (N=47)

Scores	Pre-test	Post-test
Total stress PSI/SF - high (score >85)	53.2%	29.8%
Parental Distress Subscale - high (score >32)	42.6%	17.0%
Parent-Child Relationship Stress Subscale - high or very high	48.9%	38.3%
Parent-Child Relationship Stress Subscale - high (score >25 and <30)	14.9%	21.3%
Parent-Child Relationship Stress Subscale - very high (score >= 30)	34.0%	17.0%
Difficult Child Behavior Subscale - high or very high	63.8%	27.7%
Difficult Child Behavior Subscale - high (score >32 and <39)	36.2%	12.8%
Difficult Child Behavior Subscale - very high (score >= 39)	27.7%	14.9%

Paired T-test were used to were used to compare the pre- and post-treatment PSI/SF scores. For each of the subscales, decreases in scores were statistically significant at the probability level of 0.05. Repeated-measures analyses of variance (RANOVA) were used to compare the pre- and post-treatment PSI/SF scores using a two-tailed test and probability level of .05. Effect sizes were based on eta[2.]

Discussion of PSI/SF Results

These data support that young children can be in significant distress behaviorally, emotionally, and in the context of the parent-child relationship, placing their future development and functioning at risk. Although the treatment effects noted in this report are not as dramatic as the effects noted during the first year of the project (overall effect size of .52), the changes are still significant, with substantial reductions in parenting stress, in difficult child behavior, and in high risk problems in the parent-child relationship. A survey of the clinicians across the different agencies suggests that we are now seeing more severe and complex cases, which may be

contributing to the lower effect sizes. The actual change in mean scores from pre-test to post test were very similar between the two reports, but the standard deviations for the present report are greater, supporting the clinician reports of greater variability and complexity in the cases.

Stories of Success

The Early Childhood Specialists (ECS) reported various success stories related to both client interventions and system coordination during the 2008-09 fiscal year. Many reported positive client outcomes specifically as a result of their ability to accurately and appropriately diagnosis clients aged 0-5 using the DC: 0-3R and provide effective evidenced-based early childhood interventions. During the 2008-09 fiscal year, the ECS's collaborative efforts with other agencies and systems have also been highly successful, producing positive outcomes on behalf of children 0-5 and their families. Stories of successful advocacy, mediation, treatment interventions, and skill development with children, families, and their involved systems resulted in numerous successful transition for clients with severe behavioral problems and/or socio-emotional developmental issues into mainstream classrooms and their increased ability to self-regulate, develop relationships, and focus on learning, furthering future successes in young clients' lives.

Client Success Stories

I have worked with a child and his family since he was 20 months old and he is now starting first grade. He is complicated diagnostically and has frequent and severe behavioral outbursts. When I first started working with the family the parents were very close to giving this child up for adoption. The success involves finding early childhood partners in the community, using specialized early childhood mental health training, and keeping this child in his home with parents who are significantly more hopeful. The frequency and intensity of services provided were possible because of this program.

A single father of a 5 year old child was encouraged to seek mental health services after his child was asked to leave numerous daycares for aggressive and inappropriate behavior. The child demonstrated symptoms of impulsivity, aggression, and poor boundaries with others. He began treatment with the ECS team, including weekly individual treatment, parenting support, collaboration with school staff, and medication management services. His father has diligently participated in therapy, learning about how to meet his child's needs. Since beginning treatment, the child has shown a dramatic improvement in his ability to remain safe and experience success across settings. The child has shown a positive response to medication and demonstrated growth in his coping skills. He successfully completed kindergarten, and will begin 1st grade in the fall. His teacher reports he is a "joy to be around" and a quick learner. His father has expressed gratitude for the access to services that he would otherwise not have. His father was unexpectedly laid off, and the grant made it possible for his child to receive services fundamental to his success at home and in school.

4 yr old boy attending a local preschool was identified as being at risk of expulsion. The teacher was exhausted from dealing with his aggression, tantrums, and negative reactions all day long. The staff at the school, including the director, has tried talking with the family but got nowhere. This was the first child pointed out to the early childhood specialist. She met with the teacher, observed the child, and reached out to the father. Because she was able to meet with this single dad on his one day off, in the park, they formed a relationship and when the ECS recommended a Child Find evaluation (which the school had previously tried), the dad requested the ECS attend.

At the evaluation, the Child Find staff welcomed the ECS's input and shortly thereafter, this child qualified for services in 3 domains, including social/emotional

I began working with this two year-old child shortly after she came to Child Find for a developmental evaluation. Her ethnicity included Hispanic, Anglo, and Native American. She was diagnosed with speech delay, probable cognitive delay, screened positive for sensory integration issues, and was having social-emotional as well as behavior problems at home. The DECA assessment tool we used, completed by her aunt, revealed concerns in all areas. Her background included a history of neglect, abuse, and abandonment by her biological mother. Her father was unknown by mom's report. Her mother had abused alcohol and drugs during the pregnancy and it appeared this little girl had been mildly affected. At the time of the evaluation, she was living with her mother's aunt, who was willing to keep her "for awhile", but did not "want" her in the long term. The aunt complained that the child had frequent temper outbursts, regular nightmares and terrors, could not be consoled when upset or angry, and would not listen to and follow the household rules. She saw her biological mother occasionally, and acted out quite severely after the visits. The child's family used spanking as their main form of punishment, and thought the little girl was "spoiled, that's why she's acting out so much".
After the family agreed to begin Mental Health services, I worked with our Part C service coordinator and the family to get her connected with Speech Therapy, Occupational Therapy, and Early Childhood Special Education services. The Department of Human Services was also involved and a decision was made to place this child in a foster/adopt home as soon as possible. I began having sessions with a chosen foster family, the child, and her biological family, to work on separation and transition issues, behavior modification, parenting and discipline issues (with both families), and also completed several supervised visitation sessions before the move between homes was made permanent. At first, she was confused, sad, angry, and torn between the two homes. Her foster family was an older couple that had had many foster children over the years, but this was their first adoptive endeavor. They so wanted to please the child that it was difficult at first for them to set healthy rules, boundaries, and limits, along with the loving, firm structure she so desperately needed. The biological family was ambivalent, sometimes showing up for visits, sometimes not, also giving the child mixed messages of affection and rejection during visits.

I worked with this child and both her families for almost a year during her transition and eventual adoption. She rapidly made progress in speech and cognitive skills, developed a strong, healthy attachment to her new parents, and they learned to set limits for her so her acting out decreased significantly, and she felt more secure. When I last saw this child, she was happy, bubbly, well loved and cared for, and chattering up a storm. Her adoptive parents were very proud of her progress and considered her their greatest blessing. It was rewarding to have been involved with a story that had such a positive outcome for this little girl.

Systems Success Stories

After the fires in our community children began coming for services due to experiencing the trauma of the fires. Our mental health specialists provided therapy for these children and families using TF-CBT for preschoolers. The children were able to decrease trauma related symptoms and increase ability to feel safe and secure in the community.

Our community collaborations continue to grow and provide increasing capacity in our ability to educate providers, professionals, and parents, about early childhood mental health. Our ECH specialists are active in their local early childhood councils and provide ongoing community trainings through this partnership. A training provided by the ECS to members of the Early Childhood Council was so well received that it was offered five times during the school year to accommodate all people who wanted to participate, with a total of 42 child care providers completing the training. Our education to families also increased this year due to the partnership with the early childhood council. The ECH specialists worked with the ECH council to provide family nights where information on social – emotional development and activities to build relationship between parents and children were provided to over 80 parents. We have continued to promote local strategies to address community wide needs in the domain of social, emotional, and mental health as it relates to the Early Childhood Colorado Framework.

Jose (not his real name) is a 4 year old, Spanish speaking, active and difficult to control little boy. He has his mother, father, sister, preschool teacher and most other adults who come in contact with him, exhausted after less than an hour. He was seen at the Healthy Child Clinic as he made the rounds to the different available screenings.

His family built a rapport with the Family Center Spanish Speaking worker. Jose's mother voiced her concern to the worker regarding Jose's recent repetitive behavior of head banging on soft furniture and his mother's lap and holding his head in his hand. His overactive behavior was also a concern. Since this ECS has worked closely on other cases with the Family Center, the worker suggested to Jose's mother that she invite her in to do an assessment.

This very nice collaboration is commonplace between the ECS, the family center, and the home visitation program in our area. A trust has been built and many families have invited the ECS into their home for help with anything from simple parenting issues to severe disabilities.
In Jose's case, after meeting and gathering some social history with his mother, he slowed down long enough to come and meet the guests. It was immediately obvious that he had a misshapen head. Mother was asked more questions around the shape of his head, headaches, and behavior patterns. The ECS impressed upon mother, with the help of the translator, to have the child seen immediately by his PCP for the purpose of pointing out these particular issues. The child was seen three days later, referred to the neurology clinic, which was full, but phone calls from the PCP, ECS, and Family Center worker made sure that he was seen at this clinic since it is only held quarterly in this area. As a result of that clinic, Jose was seen at Children's Hospital. Although the details were not made available to the ECS, it was known that the situation was urgent.

I bring this story to your attention because, although it is not related to direct MH services, it is clearly an example of how the ECS, who is in the community, building rapport with other agencies, working closely with reports regarding children with challenging behaviors can be useful in all aspects of a child's life. The ability to go into the homes is paramount since families are hesitant and fearful to go to a MH office. The more families we can touch through other agencies, the more children are helped and the more the stigma of MH services is lessened.

Discussion and Summary

Significant progress continues to be made on all five outcomes. The number of children and services increased during this past year. Each outcome will be listed and results highlighted.

Change in Child Functioning: Children served by the ECS showed significant improvement in the areas of Socialization, Role Performance, Overall Symptom Severity and Overall Level of Functioning. Stories also confirm improvements in child functioning allowing them to remain in their childcare settings

Change in Child/Family Functioning: The Early Childhood Specialist Program positively influenced child and family relationships. The Parenting Stress index showed that the quality of the parent-child relationship was significantly improved during the course of specialized early childhood services. Stories also describe significant changes in child/family functioning.

Change in Family Functioning: Parents experiencing very high parenting stress dramatically reduced as a result of their and their child's involvement in the Early Childhood Specialist Program. The proportion of parents reporting clinically elevated levels of parenting stress decreased from 53% to 30%. Although the results demonstrated through the Parenting Stress Index are not quite as strong as last year's results they are still significant. It appears from the data and the Specialist's reports that they are working with more difficult and complex families. In addition, improvements in family functioning were demonstrated by the CCAR results with improvements in the family's sense of socialization, hope and role performance.

Increase in Early Childhood Professional Development: The ECS knowledge was advanced through participation in 170 trainings provided in their community and by the state. However the specialists conducted 195 training sessions. This represents a growing expertise and the community recognition of that expertise.

Infuse Mental Health into Early Childhood System: It is clear from monthly reports that ECS are providing services in a number of settings. Over 50% of the consultation hours are provided in childcare and Headstart. Most specialists are involved with Part C in their communities. A survey this year revealed that most specialists are providing consultation, evaluation and assessment. Specialists are also involved in their local Early Childhood Councils finding ways to increase services for all children in their region.

In conclusion, ECS have provided substantially more services this year. Significant results have been achieved in each of the program's five outcomes. It is anticipated that early childhood mental health programs will continue to develop in communities across the state. While many more young children are receiving services there are still many more that are unserved.

References

Abidin. R. R. (1995). *Parenting stress index: Professional manual* (3rd Ed.). Odessa, FL: Psychological Assessment Resource.

Hoover, S., Zundel, C. (eds.) (2008) *Colorado's Strategic Plan for Early Childhood Mental Health.* Blue Ribbon Policy Council for Early Childhood Mental Health. *http://www.cdhs.state.co.us/dmh/PDFs/Blue_Ribbon_Strategic_Plan_Early_Childhood.pdfealth*

Center on the Developing Child at Harvard University (2008). *Mental Health Problems in Early Childhood Can Impair Learning and Behavior For Life* http://www.developingchild.harvard.edu

Cimino, J., Forrest, L., Smith, B., Stainback-Tracy, K. (2007) *Evidence-based Competencies for Promoting Social and Emotional Development and Addressing Challenging Behavior in Early Care and Education Settings.* Project BLOOM Professional Development Committee.

Colorado Department of Education (2009) *Colorado Preschool Program, 2009 Legislative Report.* Colorado Department of Education.

Cooper, J.Aratani, Y. Knitzer, J. Douglas Hall, A. Masi, R. Banghart, P. Dababnah, S. (2008) *Unclaimed Children Revisited The Status of Children's Mental Health Policy in the United States.* New York: National Center for Children in Poverty, Columbia University, Mailman School of Public Health.

Solis, M. L. (1991). The Spanish Version Parenting Stress Index: a Psychometric Study. *Journal of Clinical Child Psychology, 20* (4), 372-378.

Western Interstate Commission for Higher Education, (2008). *Behavioral Health Prevalence Estimates for Colorado,* Colorado Department of Human Services, Division of Behavioral Health.