

SFY 2009 EARLY CHILDHOOD MENTAL HEALTH PROGRAM REPORT

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Submitted By:

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EARLY CHILDHOOD MENTAL HEALTH

Early relationships and experiences at home and in other environments set the stage for how a child learns to manage his or her emotions. Since 2000, the Ohio Department of Mental Health (ODMH) has provided cross-system leadership in the development of the Early Childhood Mental Health (ECMH) program. This program supports evidence-based programs to equip parents and caregivers of young children with the skills to help their children develop into mentally healthy individuals. Parents and teachers who effectively nurture, support and connect with young children, especially those experiencing social or emotional difficulty, can ameliorate future disabling problems. In addition to parent education activities, it is imperative to identify and support families experiencing the effect of maternal depression through screening and referral to effective services.

What is Early Childhood Mental Health?

Early childhood mental health is the social, emotional and behavioral well-being of children birth to six years and their families, including the capacity to:

- Experience, regulate and express emotion
- Form close, secure relationships
- Explore the environment and learn

Early childhood mental health is influenced by:

- Physical characteristics of the young child
- Quality of the adult relationships in the child's life
- Caregiving environments the child is in
- Community context in which the child and family lives

For infants, toddlers, preschool-age children and their families, the system of care is built upon a set of values that includes family and child-centered practice and policy, cultural and linguistic competence and grounding in developmental knowledge. The system of care provides a comprehensive cross-system, cross-agency infrastructure that sustains services and supports that:

- Promote positive mental health
- Prevent mental health problems in children and families
- Intervene for children and families impacted by mental health disorders

ODMH endeavors to increase knowledge, awareness, resources and skills necessary for communities to meet the behavioral health needs of young children and their families, especially those at risk for abuse, neglect and poor social and emotional health. The ECMH program is aimed at promoting healthy social and emotional development (i.e., good mental health) of young children (birth to six years). It focuses on ensuring these children thrive by addressing their behavioral health care needs, which increases their readiness for school and later academic success. This is accomplished by building protective factors in young children's lives and increasing competencies and skills of parents and early childhood providers.

Over the past nine years, much of the development and implementation of the Ohio Early Childhood Mental Health Program has been built upon the research and resources available from the Georgetown University Center for Child and Human Development (GUCCHD).

Ohio has adopted the GUCCHD definition of Early Childhood Mental Health. It recognizes both mental health consultation and therapy as problem-solving and capacity building interventions.

Guiding Principles of an Early Childhood Mental Health Service System

A family-centered early childhood mental health service system is:

- Supportive of parents of young children by nurturing and building caring relationships with them.
- Supportive of non-parental caregivers of young children by nurturing and building caring relationships with them.
- Delivered, to the greatest extent possible, in natural settings – including homes, child care, health care, and family support settings.
- Respectful of developmental processes and is flexible and individualized to meet the behavioral health needs of young children.
- Sensitive to the cultural, community, and ethnic values of families.
- Accessible to caregivers, home visitors, family workers, and administrators working with infants, toddlers, and preschoolers and includes clinical services, case consultation and clinical supervision.
- Accessible to family services workers, home visitors and others working with families of infants, toddlers, and preschoolers and includes mental health program consultation, case consultation and back up support for families requiring more intensive interventions.
- Accessible to caregivers, home visitors, family workers, and administrators working with families of infants, toddlers, and preschoolers and includes clinical supervision and support in dealing with such staff issues as burnout, cultural, and work place conflicts.
- Accessible immediately and as necessary for crisis intervention and support to young children, families, and programs experiencing crises related to violence, community disasters or family-specific traumatic events.
- Built on partnerships among both primary and secondary support services at the community and state level.

Adapted from Early Childhood Mental Health Services: A Policy and Systems Development Perspective, by Jane Knitzer, National Center for Children in Poverty, Columbia School of Public Health, 1998.

Values of an Early Childhood Mental Health Service System

- All young children deserve to spend their days in a safe, stable, caring, nurturing environment.
- To meet the mental health needs of very young children, it is necessary not only to consider the young child and his or her parents as individuals; it is also critical to consider the quality of the child's many relationships.
- Families are considered to be full participants in all aspects of the design, implementation, and evaluation of programs and services for their young children.
- ECMH services are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- ECMH practices build upon, promote, and enhance individual, family, and early childhood staff strengths, rather than focus solely on weaknesses or problems.

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Adapted from Early Childhood Mental Health Consultation, by Elana Cohen and Roxanne Kaufmann, a Publication of CMHS, SAMHSA, USDHHS April 2000.

I. EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

“Mental health consultation in early childhood settings is a problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals, primarily child care center staff, with other areas of expertise. Early childhood mental health consultation aims to build the capacity (improve the ability) of staff, families, programs, and systems to prevent, identify, treat and reduce the impact of mental health problems among children from birth to age 6 and their families.” (Cohen & Kaufmann, 2005)

According to research from Yale University’s Edward Zigler Center in Child Development and Social Policy Early childhood mental health consultation (ECMHC) may be an effective means for decreasing the likelihood that children with challenging classroom behaviors will be expelled. In a recent statewide random-controlled study, prekindergarten classes that received ECMHC demonstrated significant decreases in teacher-rated acting-out behavior problems in the classroom. Effects were greatest in the areas of oppositional behaviors and hyperactivity. ECMHC was assessed an effective means for reducing disruptive classroom behaviors that are likely causes of prekindergarten expulsion.

“Prekindergarten teachers should have access to early childhood mental health consultants,” concluded Gilliam. “Teachers who have ongoing relationships with classroom-based mental health consultants are about half as likely to report expelling preschoolers as teachers with no such support.” (Gilliam 2008)

The primary goal of Ohio’s Early Childhood Mental Health Consultation Program (ECMHC) is to increase knowledge, awareness, resources and skills necessary for communities to meet the behavioral health needs of young children and their families, especially those at risk for abuse, neglect and poor social and emotional health by building protective factors in young children and increasing competencies and skills of parents and early childhood providers. ECMHC targets the healthy social and emotional development of all young children in Ohio to ensure they thrive and are ready for school.

The ECMHC program had been funded as part of the Access to Better Care Initiative for the past 3 years at \$2.5 million with \$1 million ODMH GRF 505 funds and \$1.5 million from Ohio Children’s Trust Fund (OCTF). OCTF chose to discontinue funding to the ECMHC program for FY 2009. The \$1.5 million loss of funding was made up from a combination of ODMH GRF 404 funds and ODJFS federal Child Care Development Funds. There will be a reduction in funding for FY 2010.

Allocations were provided to local mental health boards to support mental health consultation services for early childhood providers and families of young children. Services and activities targeted to programs serving young children and families include:

- Clinical consultation to early childhood programs, including mentoring, coaching and classroom observation

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- Training and educational sessions, as part of the consultation process, including problem identification, referral processes, classroom management strategies, the impact of maternal depression, substance abuse, domestic violence and other stressors
- Work with parents/families/grandparents/foster parents, as identified through the consultation process, to enhance their ability to create strong, nurturing environments for and relationships with their young children

There are two basic forms of consultation implemented by most programs.

Child and Family-Centered Consultation

- Practiced as the most traditional form of mental health consultation
- Addresses a child's behavior and functioning through the collaborative development of a plan that can be implemented by the staff and family members that interact with the child.

Programmatic Consultation

- Focuses on improving the overall quality of the program
- Assists the program in solving a specific issue that affects more than one child, staff member, or family
- Improves the capacity of the program to respond to the needs of all young children in their care

All 50 Mental Health Boards submitted narrative reports for SFY 2009. Two boards did not submit any data to the ECMHC data collection system.

ECMHC Program Strengths

Consistent themes emerged from the statewide feedback of the program.

- Knowledge and skills of the ECMH specialists – These professionals, many who have been providing such services for 10-15 years or more, are highly skilled and are well trained in their field. They are seen as very dedicated to the children, families and providers that they serve. Many of these programs have employed the same ECMH professional since the beginning of the ECMH initiative creating a great deal of stability of the staff. Families and caregivers voice the benefits of ECMH professionals and their knowledge and skills. This was by far the most common strength noted in the reports.
- Strength-based approaches – Recognizing positive attributes and behaviors with the strength-based philosophies and practices has a greater impact on achieving positive outcomes. Allowing ECMH professionals to serve children who would typically not utilize the mental health service delivery system by allowing providers and families to view mental health as a resource eliminating barriers to service and the stigma often attached to mental health services.
- The use of evidence-based programs – Offering both research and evidence-based programs accounted for success. The quality of the programs is well documented. They desire to improve on existing programs and maintain up-to-date practices.
- Strong community relationships – Many ECMH providers have long-standing positive relationships with the early childhood community and are familiar with the community culture. They are seen as key advocates and valued members of the local early childhood community. They are trusted members of community groups and reliable sources of

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information. These strong ongoing relationships have developed over time leading to collaborative community projects. Strong support from the community has enhanced the actual programming areas. Collaboration with cross-systems has permitted maximizing of resources with limited funding and staff.

- **Flexibility** – Flexibility to adapt to the meet the specific needs of providers, families and children is seen as a key strength to the program. The ECMH professionals are available for evening meetings and trainings. They provide consultation services in the early childhood settings and are also able to visit families in their homes.
- In addition to the \$2.5 million in state and federal funds allocated through ODMH, almost \$2.8 million in local and other funds were dedicated to support local early childhood mental health programs.

“The first strength to share in our ECMH Consultation program is our ability to provide assistance to centers with their long term goals in mind. We firmly believe that lasting change takes time and that it is important to stick with child care centers until they are able to function without our support. We set up action plans with them at the beginning of the school year and revisit these plans throughout the year.

A second strength is that we spend time helping teachers incorporate social/emotional activities into their curriculum. We do not just facilitate social/emotional groups for them but we assist them in integrating these important concepts into what they are already doing with the children. Our consultants focus on creating engaging activities that promote concepts such as sharing, expressing feelings, working as a team, and following directions. These concepts are easily integrated into the day to day curriculum of the classroom. The consultant makes sure that the activities are simple and do not add extra work for the child care providers.

The final strength is that the relationships we build with the centers we work with are so powerful that the child care providers feel that they can count on us. They know who to call when they feel helpless and need to feel empowered. They use us for ongoing assistance and as a trusted training resource. We are known throughout the community as the experts in early childhood mental health and our child care providers feel at ease when we are in their centers.”

Challenges

Challenges and barriers to implementation of the proposed activities also shared many of the same themes.

ECMH programs continue to cite the barrier to providing services as not being able to meet the demand for services due to constraints of insufficient funding and staff. There is simply not enough staff to meet the demand for services. To address these challenges, many programs developed triage plans and focused on those programs that were determined by the communities to be the most in need of consultation services. While the programs enjoy the growth of the community awareness of the program, resources have not been able to keep up. The need outweighs the ability to provide adequate services in a timely manner for many programs.

Providers were asked to address any issues of capacity versus need for ECMH Consultation services in their area. Twelve of the board areas reported that they had a waiting list for ECMH consultation services. While others did have a formal waiting list, they reported that they were not always able to respond to requests for services in a timely manner or not as many services were available as requested. Some simply told those that made requests that they would not be able to serve them due to limited staff and resources. Many also shared they did not promote

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their program and did not participate in public awareness activities. In total, reports indicated that 66 childhood settings requested consultation services for services that were unable to be provided. Most requests were for center based services. There were 47 requests for child specific issues which were not able to be provided most of which were made by parents of children not in center based care.

There are also some providers that are unwilling to allow sufficient time to develop and implement an action plan before asking a child to leave a program. Unrealistic expectations for a “quick fix” of a child’s behavior by the ECMH consultant as opposed to working together to find a solution.

“Another concern is that programs do not have developmentally appropriate expectations about children’s behavior and minimal abilities to handle children with challenging behaviors. Centers want immediate fixes for children and are not willing to consider the reasons for the behaviors. This has been our experience with centers that have a “Zero Tolerance “policy. Often in these centers children are excluded for one instance of hitting. Other centers have “Three bites and you’re out” policies which means children are excluded for 3 instances of biting. The expectation is that children conform to the program rather than programs accommodating to the individual needs of children through the use of intervention plans.”

Another barrier was the extent of early childhood staff turnover in the settings that receive consultation services. It makes it difficult to implement strategies in the classroom and maintain continuity. Caregiver turnover requires continuous training to make sure that new staff are empowered as soon as possible to maintain and improve environments for children. One classroom had 8 different teachers in less than a year. This also creates a challenge for evaluation of a program and outcomes for a child when different teachers are looking at a child through different lenses at different times.

Parent engagement and reluctance to follow through with referrals presented challenges for achieving positive impact for some programs. Transportation issues were also a factor. In-home visits with the families helped to alleviate some of the problem as well as being flexible with time and location of services.

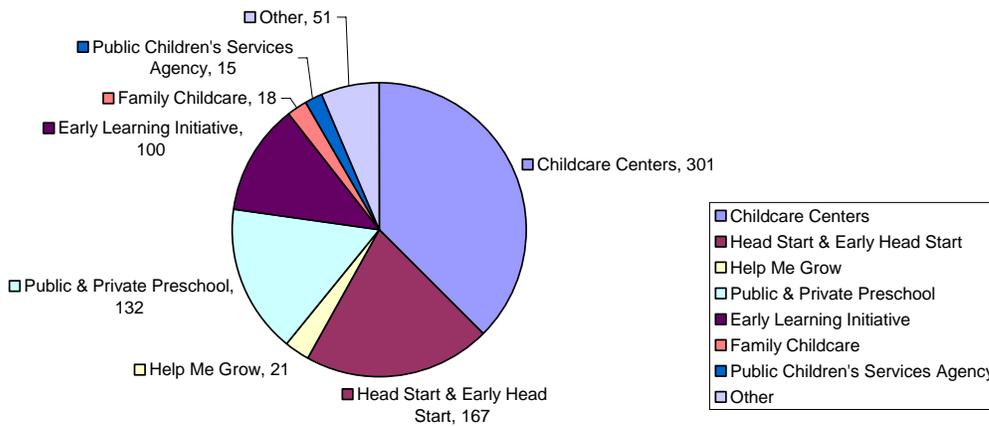
Additional challenges that were cited by the providers included the conflict many early childhood programs were having with being able to schedule non-mandated training that they wanted and needed to serve the children with behavioral issues with the mandated training requirements of Step Up To Quality that do not include Social/emotional issues. Many ECMH consultants have become approved trainers for SUTQ to provide approved training on improving the social and emotional environment as requested.

Collaboration with other providers has been essential to meeting families’ needs. Service coordination/case management linked families to services and supports, including “natural” supports. Inter-systems planning, education, and advocacy provided additional means for addressing these challenges.

Mental Health Consultation Services

- Total of **805** programs/sites received consultation services
- Total of **1471** classrooms received consultation services
- Total of **2931** early childhood providers received consultation services
- Total of **4241** families received consultation services
- Total of **15,196** children in group settings received consultation services
- Total of **3252** individual children received consultation services

Programs: Early Childhood MH Consultation



- Programs/ Sites receiving consultation services
 - Childcare Centers - 301
 - Head Start and Early Head Start - 167
 - Public and Private Preschools - 132
 - Early Learning Initiative - 100
 - Help Me Grow Programs - 21
 - Public Children’s Services Agencies - 15
 - Family Childcare Homes – 18
 - Other – 51

There were **167** Early Childhood Mental Health Specialists reported to be providing consultation services as part of this program during the fiscal year. This included 56 full-time and 111 part-time positions. With the reduction in funding, it is anticipated that these numbers will be less in SFY 2010.

Comprehensive Evaluation of ECMHC

Beginning January 1, 2008, all data reporting was to be submitted in accordance with the Guidelines for the ECMH Consultation Comprehensive Evaluation drafted as part of the Logic

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Model development process completed in December 2007. Development of a web-based data collection system was developed and implemented in FY 2009.

Ben Kearney, Ph.D., Vice President and Chief Clinical Officer for Berea Children's Home & Family Services (BCHFS) has been responsible for the collection of data and reporting based on his work with the Logic Model and subsequent development of the comprehensive evaluation of ECMH consultation assisted by Lisa Potoma, MSM, Director of Quality and Knowledge Management, BCHFS.

Participants in the Early Childhood Mental Health Consultation Program were required to collect data for center focused outcomes, center focused satisfaction, child focused outcomes, child focused satisfaction, and training evaluation. The following represent data collected for the FY 2009.

Demographics:

- The racial makeup of the classrooms included 79.9% white, 13.1% Black or African American, 3.6% multiple racial heritage, and others accounting for less than 1% each. Race was not available for 2.4% of the respondents. 4.1% of the total clients served were Hispanic or Latino. The gender represented in the classrooms was 47.5% female and 52.5% male.
- The racial makeup of individual children served included 79.3% white, 14.4% Black or African American, 3.3% multiple racial heritages, 2.3% race not available, and others accounting for less than 1% each. The gender of children served was 64.5% male and 35.5% female. 3.6% of the children were Hispanic or Latino.
- The ECMH consultation program has a penetration of serving minority populations greater than the Ohio census populations.

Center Focused Outcomes

BCHFS received center focused outcomes data from **46** different sites representing **692** classrooms. The **692** classrooms had a total of **1650** teachers (an average of **2.38** teachers per classroom) and **14015** students (average of **20.25** students per classroom). **57** students were removed from the classrooms.

The program types that were represented in the 692 classrooms include:

<i>Type of Program</i>	
Childcare Center	25.0%
Early Head Start	0.5%
ELI	10.1%
Family Childcare	0.3%
Head Start	50.8%
Other	1.5%
Preschool Special Education	2.3%
Private Preschool	4.1%
Public Preschool	5.5%

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2316 children were assessed for brief consultation services. There are some programs that offer very brief services to child care centers and are typically offer some form of assessment score review and a few classroom interventions which may be helpful to the teachers. This is different from a more complex consultation model which includes a detailed classroom assessment and action plan.

335 classrooms responded yes to having a written Intervention / Action Plan. Of those responding yes, 28.1% had fully implemented the plan, 25.1% were at least 90%, 19.7% were at least 80%, and 21.8% were at least 70% implemented. 5.49% had implemented less than 70%.

The Reflective Checklist for the Environment is a checklist that can be used to assess the classroom environment. 519 classrooms provided initial scores and 448 classrooms provided closing scores for the Reflective Checklist for the Environment. 414 classrooms provided both initial and closing responses.

The 414 classrooms that provided both initial and closing responses were used to compare the number of “yes” responses from the initial assessment to the last/closing assessment for each of the 18 questions that make up the checklist. Eighteen of the 18 questions had an increase in “yes” responses from the initial assessment to the last. Question number 5 (*Provide a few be-by-myself spaces that are private, but still visible to teachers*) had the highest change in the number of “yes” responses from initial to last/closing with 60.1% of initial responses indicating “yes” and 80.7% of last/closing responses indicating “yes”.

Center Focused Satisfaction

BCHFS received a total of **735** center focused satisfaction surveys from **50** sites. The types of consultation included **279** case consultations, child specific; **290** case consultations, group focus; **18** administrative consultations, program focus; and **148** administrative consultations, staff focus. The satisfaction survey was based on a 5 point scale with a range from 1 representing *strongly disagree* to 5 representing *strongly agree*. The responses to the satisfaction survey indicate an overall satisfaction rate of 96.6%. The satisfaction rate is based on the number of responses that specify agree or strongly agree. This is an increase from FY 2009 rate of 89.25%.

Child Focused Outcomes

BCHFS received child focused consultation outcomes data from **50** different sites representing **2210** children. 2182 of the children were referred for ECMH consultation services. The referral sources include:

Referral Source	Percentage
Child Welfare	3.29 %
Childcare Center	16.56 %
Early Childhood Education Center	3.22 %
Early Head Start	0.58 %
ECMH Consultant	2.71 %
ELI	6.40 %
Family Child Care	0.07 %
Head Start	26.65 %

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Help Me Grow	5.68 %
Other	12.80 %
Parent	6.37 %
Pediatrician	0.61 %
Physician	2.93 %
Preschool Special Education	4.12 %
Private Preschool	3.65 %
UNKNOWN	4.34 %

1121 responses indicated an Intervention / Action Plan was written during FY2009. Of the 1121 responses indicating a plan was written in FY2009, 23.6% had fully implemented the plan, 17.1% were at least 90%, 16.5% were at least 80%, and 21.8% were at least 70% implemented. 21.0% had implemented less than 70%.

373 cases did not open following referral. The reasons the cases did not open included 5.9% of the families moved, 21.7% of the families did not want service, 5.9% of the children were withdrawn from the Center, 7.0% of the families could not be contacted, and 59.5% had other / unknown reasons for not opening after referral.

There were 1659 clients that had a documented status at closure. **87.8% were maintained in the Center at closure**, 5.9% were transferred during services, 5.1% were removed – not participating in childcare, and **1.1% were expelled due to behavior**.

Approximately **1380** children were referred for further mental health and other services as a result of consultation in FY09. The most common referral was for ongoing mental health services and further mental health evaluations with over 900 referrals being made. There were over 120 referrals to public preschools for evaluations. Additionally, referrals were also made to physicians, developmental pediatricians, public children services agencies, special needs preschools, trauma treatment groups, Head Start, Help Me Grow and Family and Children First Councils for service coordination. Children were referred for assessments for medical issues, occupational therapy, speech and language intervention, and developmental testing. Many of these children may have subsequently qualified for other programs as a result of having or being at risk of having a delay or disability. Through the consultation services, programs also reported that several parents were identified as being in need of mental health services and alcohol and drug services, parenting groups, domestic violence shelters and services and were appropriately referred.

Child Focused Satisfaction

BCHFS received a total of 534 child focused satisfaction surveys from 39 different sites. The satisfaction survey was based on a 5 point scale with a range from 1 representing *strongly disagree* to 5 representing *strongly agree*. The responses to the satisfaction survey indicate an overall satisfaction rate of 92.7%. The satisfaction rate is based on the number of responses that specify agree or strongly agree.

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Training Evaluations

Parent and Early Childhood Staff Training

BCHFS received training evaluation data from **39** sites. The sites provided data for **2590** completed evaluations.

The parent and early childhood staff training topics that the evaluations were based on include:

Topic Areas Included	Number of Participants
Behavioral Management	1481
Child Growth and Development	232
Child Observation & Assessment	60
Family and Community Relations	115
Health, Safety, and Nutrition	20
Learning Environment and Experiences	116
Other	92
Professional Development	142
Social/Emotional Processes	332

The parents completing the survey indicated an overall satisfaction rate of 98.4% for the instructor and 95.5% for the learning objectives. The parents reported an understanding of the topic prior to training as 59.9% and an understanding of the topic after training as 94.4%.

The staff completing the survey indicated an overall satisfaction rate of 98.3% for the instructor and 95.8% for the learning objectives. The staff reported an understanding of the topic prior to training as 71.8% and an understanding of the topic after training as 96.9%.

Cross Systems Trainings

BCHFS received training evaluation data from **22** sites. The sites provided data for **463** completed evaluations.

The professionals completing the survey indicated an overall satisfaction rate of 92.9% for the instructor and 88.9% for the learning objectives. The professionals reported an understanding of the topic prior to training as 55.7% and an understanding of the topic after training as 84.7%.

Topic Areas Included	Number of Participants
Behavioral Management	138
Child Growth and Development	75
Child Observation & Assessment	10
Family and Community Relations	7
Learning Environment and Experiences	13
Other	53
Professional Development	45
Social/Emotional Processes	122

Other Activities

“We offer consultation to the County Children’s Services adoption team. When young children (3 and under) have been placed in an adoptive home, the team requests a consultation for the adoptive family to help them meet their children’s special needs. This consultation includes a review of the child’s history, 1-3 visits with the child and their adoptive family, and interview with the caseworker. The caseworker and parents then receive a consultation report with suggestions for helping this child adapt to their new living situation.”

“This past year we conducted a 3 session cross training that provided information on the development and treatment of behavioral disruptive disorders. There was a wide cross section of professionals that attended including early childhood educators, administrators from the school systems, juvenile court probation officers, school counselors, and other behavioral health specialists. The objective was to develop what Ross Greene refers to as a community friendly environment for kids and families.”

Devereux Early Childhood Assessment Program (DECA)

The Devereux Early Childhood Assessment Program (DECA) is a program designed to enhance within-child protective factors while simultaneously decreasing behavioral concerns in young children. A strength based system designed to identify and strengthen children’s protective factors and promote resilience in children ages 2-5, it includes an assessment tool, a standardized, norm-referenced behavior rating scale. Both the standard and clinical forms of the Devereux Early Childhood Assessment (DECA) have been developed as part of a program to focus on protective factors as well as risks and thereby provide early childhood professionals with empirically sound tools for assessing the strength of protective factors and the severity of behavioral concerns in preschoolers. Devereux has also released the Infant/Toddler version for ages birth to 3. Training was provided and providers have begun to use this version also. The Devereux Elementary Student Strength Assessment (DESSA) for children in grades K-8 was released in FY 2009. Some training has been provided in an attempt to educate consultants in order to consider using transitioning children from early childhood settings to Kindergarten settings.

Devereux Early Childhood Assessments (DECA) are required to be administered to measure individual outcomes for each child receiving child-specific consultation services. Many programs also use the DECA in the classrooms. To facilitate the collection of statewide data, Devereux and Kaplan have worked with Ohio in tailoring the data collected through the e-DECA system to assist in creating reports that will inform both local communities as well as statewide. With this, we now have the capability of having data on every participating program using the DECA to get a statewide picture of the protective factors and behavioral concerns of thousands of young children in Ohio. As part of this initiative, ODMH has paid for an administrative license for each mental health board and a certain number of child administrations based upon the number of DECA administrations reported by the providers.

During the 2008/2009 school year 26,478 administrations were recorded in e-DECA.

Evidence-based/Research-based/Promising Practices

The ECMH professionals continue to report the Incredible Years Program and the DECA Program as the most used programs for consultation services. Other programs mentioned several times were Conscious Discipline, Second Step, Facing the Challenge and CSEFEL. Providers also reported using techniques from several different programs in the consultation services including: The Developmental, Individual differences, Relationship-based (DIR) Model; Therapeutic Interagency Preschool Program (TIP); PATHS Preschool curriculum (Promoting Alternative Thinking Strategies); Triple P; 1-2-3 Magic; Child Adult Relationship Enhancement Training (CARE); Parent Child Interactive Therapy (PCIT); Trauma Focused Cognitive Behavioral Therapy (TF-CBT); Positive Behavior Supports (PBS) model; Teaching Tools for Young Children with Challenging Behaviors (TTYC); and Trauma-focused Cognitive Behavioral Therapy (TF-CBT)

Positive Impact of the Early Childhood Mental Health Consultation Program

The Early Childhood Mental Health Consultation Program positively impacted children and their families by building protective factors and increasing competencies and skills of parents and providers. This was illustrated in the increase in overall protective factors, decrease in behavioral concerns and positive evaluations of services from providers and parents. Through the consultation model, ECMH specialists provide general classroom observation which affords the opportunity to provide the teachers/staff with needed information regarding social and emotional development of young children as well as commenting on specific children. Services to young children have been made available where in the past they had not. Adults with information about support systems and resources for assistance may also be more likely to reach out for help when they become stressed by the challenges of raising a young child.

One of the most positive impacts is the fact that approximately 88% of the children who were at risk of removal were maintained in the setting as a result of consultation services. The maintaining of children in the childcare setting of their parent's choice clearly benefits not only the child, in terms of stability, but also the family and center, as they are able to maintain work schedules and avoid turn over.

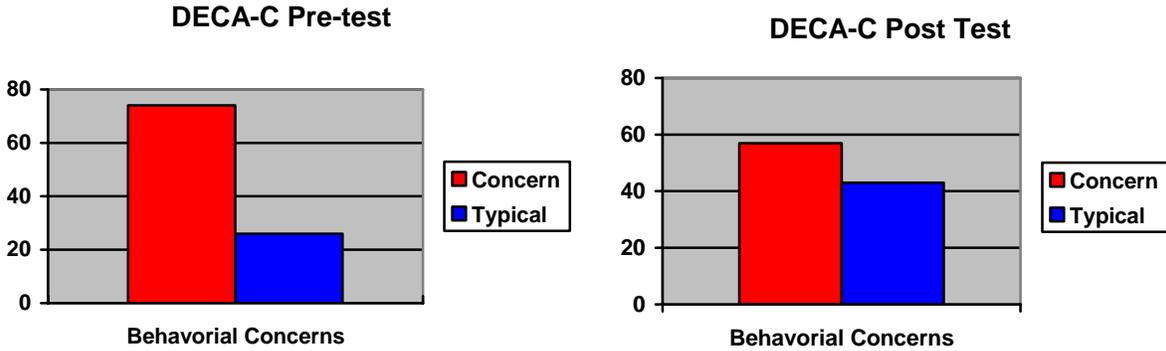
Consultation Examples

Respondents were asked to provide examples of consultation services and to include issues that were addressed, proposed solutions, and the effectiveness of these solutions in the narrative section of the final report. These descriptions provided insight into the process of mental health consultation as well as the diversity and complexity of the issues addressed through consultation services. In addition, the descriptions underscored the importance and value of the collaboration that occurred among professionals, parents, and agencies in generating solutions to problems and achieving positive outcomes for young children, families and/or child-serving staff. These descriptions serve as important illustrations of the highly complex and challenging nature of early childhood mental health consultation. One consistent message from the reports was that improvements in the behavior of children were seen most often when the teachers and the parents were both involved and consistent.

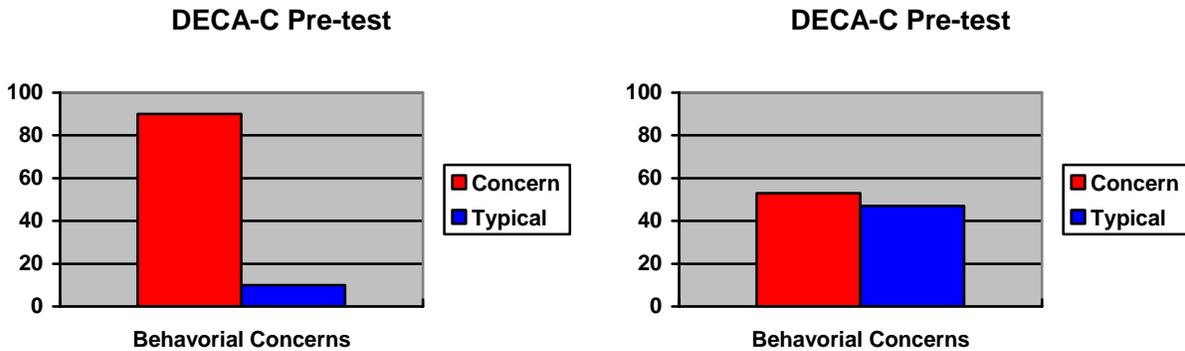
Building Protective Factors

The overall impact of ECMH Specialists on the goal of building protective factors and increasing competencies and skills of parents and providers was significant. There was an increase in protective factors and decrease in behavioral concerns between pre and post testing as shown in the following charts.

TEACHERS



PARENTS



For the **DECA-C**, teachers scored 73.8% of the children scored in the concern range on the pre test and 57.1% scored in the concern range on the post test. Parents scored 90.0% of the children in the concern range on the pre test and 53.3% scored in the concern range on the post test.

Collaboration

Many community collaborations have been strengthened through the ECMH program. Many reported being members of the local Family and Children First Council (FCFC) Early Childhood Collaborative and providing cross-systems training to FCFC member agencies. Local collaborations have been made with many different partners including: hospitals; FQHC; universities and community colleges; physicians; CDJFS; and child care resource and referral agencies. ECMH professionals serve on many committees, participate in community information sessions and collaborate in development of grant applications. Several communities have developed ECMH consortiums to address the social and emotional needs of young children.

Professional Development

During FY 2009, ODMH was able to provide many trainings that had been requested as part of the FY 2008 reports. A total of 25 days of training was provided to 455 participants. Requests for specific training and technical assistance for ECMH were also included in the FY 2009 reports. Plans have already been made or are being developed to provide training on many of these subjects. Regional networks have been formed to allow networking and peer coaching and mentoring for the ECMH specialists.

Peer Supervision and Mentoring

As part of the ECMHC program, regional Peer 2 Peer (P2P) Support group monthly meetings are scheduled and led by trained ECMH Professionals. A Reflective Supervision model continues to be incorporated into the P2P meetings. This practice allows for more in-depth conversation regarding families and the issues that arise when working with them. Members are able to share their stories in a safe environment and listen to others that have struggled with the same issues and share their successes. There are currently 10 peer support groups around the state. Fifty-nine meetings were held that were attended by 398 participants.

Regional Early Childhood Mental Health (ECMH) Consultants meetings were held in September and May. Attendance for the 5 regional meetings was 103 for October and 137 attended in May. In an attempt to provide information to encourage cross-system collaboration, the following were part of the meetings:

- October – 82 attendees
 - Southwest Ohio Early Learning Collaborative: Promoting mental health wellness for children birth to six through Research, Awareness and Action Plans by Jane Sites
 - Play Therapy presentation by George Enfield
 - ODMH updates
 - ECMH Evaluations
- May – 86 attendees
 - Update on ECMHC requirements for FY 2010
 - ODMH updates /data collection
 - Core Competency update
 - Networking/ Round Table discussions

Core Competencies

Early Childhood Mental Health (ECMH) has seen a fast rate of growth over the last decade. This has occurred despite many ambiguities: a definition of ECMH, the professional criteria determining who may practice as an ECMH practitioner, and the basic skills and knowledge required to enter the field. Cohen and Kaufmann (2005), and Donohue, Falk, and Provert (2000) have provided the basic principles of the ECMH field. Many states are attempting to define the competencies needed to meet these principles. In Ohio, these efforts have been primarily led by the Ohio Department of Mental Health's Early Childhood Mental Health Initiative.

Ohio's Early Childhood Mental Health Core Competencies was developed by a passionate, knowledgeable and committed workgroup of ECMH professionals from around the state with a

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broad range of expertise and experience. The document of core competencies is for ECMH professionals who provide consultation and/or treatment. The core competencies included in this manual are written to promote the professional development of knowledge, skills, and attitudes necessary for working with diverse populations. The document serves as an initial effort to articulate Ohio's vision of the competent Early Childhood Mental Health Practitioner.

Since 2000, Ohio has recommended that ECMH practitioners be licensed mental health professionals. This document is not meant to be a formal job description, but attempts to identify shared foundational competencies across disciplines.

Document Goals

- To define how ECMH is similar to and different from other related disciplines.
- To provide existing ECMH practitioners in the state with a common language which can be used for advocacy efforts.
- To serve as a foundation for new professionals entering the field.
- To give a road map for professional development among Ohio's ECMH practitioners.
- To build capacity in Ohio by assisting institutions of higher learning in the development of programs to train additional providers.

Guiding Philosophy

This document is guided by the philosophy that consultation and treatment are built on the same foundation. That's why the five ECMH domains address both practices without giving priority to either one. Each domain has the capability to stand alone yet builds upon the other. This results in some duplication of knowledge, skills, and abilities. However, this purposeful replication only helps to strengthen ECMH professional development.

The five domains are:

- 1 Social-Emotional Growth & Development
- 2 Family & Community Relations
- 3 Assessment
- 4 Interventions
- 5 Professional Development

Ohio's Core Competencies for Early Childhood Mental Health Professionals can be found on the ODMH website at:

<http://b9962ed140049a571a710839f1f71c989aaf09ce.gripelements.com/pdf/what-we-do/provide/children-youth-families/core-competencies.pdf>

Moving Forward

For FY 2009, consultation services were allowable to any early childhood setting that the providers chose to serve. This will change for FY 2010. The Social and Emotional Workgroup of the Early Childhood Cabinet recommended that allowable consultation activities for FY 2010 funding be narrowed in focus to provide consultation services in low income and high risk areas and would include only subsidized child care and Head Start settings. Children identified as being at risk of expulsion from an early care setting will remain a priority. Providers reported that over 85 % of the child care and head start centers served in FY 09 will continue to be

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eligible to receive services in FY 2010. However, FY 2010 funds will not be permitted to be used to provide consultation services to other early childhood settings and providers such as Help Me Grow, public and private preschools not licensed by ODJFS, Public Children Services Agencies, and other entities. This includes at least 186 settings that were reported as being served in FY 2009. While these funds may not be used to serve this other population, the providers may choose to use other available funding sources to continue to provide services.

Resource Directory

The resource directory that lists all of the participating ECMHC providers has been updated and shared with other agencies as appropriate and is also available on the ODMH website at:

<http://b9962ed140049a571a710839f1f71c989aaf09ce.gripelements.com/pdf/what-we-do/provide/children-youth-families/early-childhood-mh-provider-list.pdf>

II. EARLY CHILDHOOD MENTAL HEALTH TREATMENT

Therapy – Direct service utilizing therapeutic interventions including formal child mental health diagnostic evaluations, direct therapeutic services; therapeutic play groups, and one-on-one individual child support.

Background Information

Funds were earmarked in the state budget for FY 08-09 for ECMH Treatment. An RFP process resulted in 11 boards being recommended to receive funds for an 18 month project. Additional funds were allocated and 2 additional boards were funded for FY 09.

The grant's purpose was the implementation of evidence-based practice in Ohio through increasing availability and penetration of early childhood mental health treatment. This grant sought to support and enhance a significant public investment in the health and education of Ohio's youngest children and their families.

Goals

- To meet the treatment needs of young children and their parents identified through the early childhood mental health consultation process.
- To further develop the local system of care for young children.
- To acquire data on treatment access and outcomes for this target population.

Objectives

- To employ effective and promising practice models of ECMHT.
- To share results and encourage replication of successful ECMHT approaches.

The target population of the initiative was children birth to age seven and their families identified through ECMH consultation services as being in need of further assessment, diagnosis and treatment beyond those services available through ECMH consultation.

The expected Outcomes of the project included:

- Demonstrated effective treatment and support interventions for the target populations that are culturally competent.
- Enhanced local system of care for young children and their families.
- Implemented best practices and evidence-based treatment approaches that offer a model for other providers of ECMHT services;
 - reduces the number of children removed from early care and educational settings due to behavioral health concerns; and that
 - increases access to ECMHT.
 - for those young children served increases in protective factors and decreases in behavioral concerns are anticipated.

All thirteen of the funded project boards provided narrative reports of their grant activities from receipt of notice of award through June 30, 2009.

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There were several best practices and evidence-based treatment approaches implemented as part of this project. The most frequently cited include:

- Play therapy
- Filial therapy
- Trauma-focused Cognitive Behavioral Therapy (TF-CBT)
- PCIT – Parent Child Interactive Therapy
- Incredible Years Dina small group therapy

Participants reported **1185** children and their families have received ECMH treatment services from the beginning of grant activities through June 30, 2009. This significantly surpasses the estimate of serving up to 650 children.

The children receiving treatment ranged in age from an average of one year, 11 months up to six years, 2 months with the average being 4.6 years of age.

The most cited reasons for children seen for treatment were aggression, trauma, attachment issues and disruptive behaviors.

Approximately 69% of the children receiving treatment services were determined Medicaid eligible. Over 80% of the services provided were billable to Medicaid. The most often cited reasons for services that were not Medicaid billable were that the child was under age 3; service coordination and consultation with other professionals, family support and education and planning with parents for treatment interventions. Travel and other expenses associated with in-home services were also noted.

The average cost per child was \$1280. This was within the projected range of \$1078 and \$1350. ODMH data for FY 2008 showed 11084 children birth to age 5 being served by all 50 boards with an average cost of service per child of \$1214 for all diagnoses and types of services.

Eighty-nine early childhood mental health professionals provided treatment services as part of this project.

Strengths

Many strengths were recognized in relation to the implementation of the ECMH treatment grant. The most consistent response categories included:

Early Childhood Mental Health Professionals

- The expertise, knowledge, quality, skills, and commitment of providers.
- Increased staff to reach more families
- Increased knowledge of treating young children and their families

Services specific to Early Childhood Mental Health issues

- Filling a void when it comes to specialized early childhood mental health treatment
- Improving the mental health of the an underserved population
- Helping families recognize a child's strengths
- Ability to providing family-focused services including spending time with parents providing education, linkages and supports
- Flexibility in the services offered and where including providing in-home services

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- Meeting the needs of at-risk children earlier
- Using evidence-based practices
- Expansion of an existing program

Collaboration

- Collaboration within the community to serve these children
- Informing the community of early childhood mental health issues and best practices
- Linkage and referral process
- Increased referrals from physicians
- Increased coordination of services and programs within and among agencies
- Increased access of families to mental health services

The biggest strength of the Early Childhood therapists was being able to offer therapy services in a variety of settings, including the client's home, the client's school or child care, and a traditional outpatient office. Early Childhood therapists were able to collaborate with school personnel and appropriate early childhood staff on a regular basis in order to provide quality services to children receiving treatment. As part of the outpatient team, the Early Childhood therapists were able to make necessary referrals for additional services quickly, as needed (i.e., case management, group therapy, parenting groups, and psychiatric services). Having a primary core of three full time therapists dedicated to the spectrum of early childhood mental health services, including prevention, consultation, and treatment, allowed for delivery of more intensive services to children and families as needed.

Challenges

The most often cited challenges related to implementing the ECMHT grant involved:

Working with families

- Engagement and consistent participation of families
- Multiple and serious family difficulties and the lack of acknowledgement of families of their own problems
- Complexity of working with families involved in the child welfare system
- Large number of trauma cases and the extent of a child's traumatic experiences

Current and future funding

- The need outweighs the availability of providers
- Inability to bill Medicaid for services for children birth to age three
- Finding providers appropriately trained and educated to treat the early childhood population or the funds to provide the necessary training
- High level of demand that exceeds available capacity

Community Involvement

- Educating the community that this services exists
- Developing relationships with the early childhood community

A data collection form was developed and was added to the established ECMH web-based data collection system managed by Ben Kearney, Ph.D., Vice President and Chief Clinical Officer for Berea Children's Home & Family Services (BCHFS) assisted by Lisa Potoma, MSM, Director of Quality and Knowledge Management, BCHFS.

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The following is a summary of the data collected for the Early Childhood Mental Health Treatment Program for FY2009 (July 1, 2008 – June 30, 2009). This report is based on early childhood mental health treatment data that was reported through August 7, 2009 on the ECMH data collection website.

Referral Information

The primary referral sources to ECMHT services included:

- ECMH Consultant 13.6%
- Child Welfare 13.4%
- Physician/pediatrician 12.2%
- Parent 10.8%
- Childcare Center 5.6%
- Head Start/Early Head Start 5.6%
- Help Me Grow 3.4%
- Other 23.8%

When other was selected as the referral source, additional information was collected. A summary of how the “other” referral sources were defined is listed below.

<i>Other Defined</i>	<i>% of Other</i>
family member / guardian / family friend	21.6%
clinician / therapist	32.8%
school	14.7%
community referral / center / shelter / network / church	19.0%
hospital / clinic / insurance	6.0%
other / unknown	6.0%

Demographic Information

The racial makeup of the children served included 72.1% white, 15.7% Black or African American, 9.5% multiple racial heritage, 1.9% race not available, and others accounting for less than 1% each. The gender of children served was 67.2% male and 34.8% female. 97.5% of the children were not Hispanic or Latino, 2.4% were Hispanic or Latino.

Outcomes

Written Intervention /Action Plans were captured in the data submitted during FY2009. Of the responses indicating a plan was written in FY2009, 22.8% had fully implemented the plan, 14.1% were at least 90%, 17.4% were at least 80%, and 22.8% were at least 70% implemented. 26.6% had implemented less than 70%.

There were 266 clients that had a documented status at closure. Of the clients that had a closure status by the end of the grant, **90.6% were maintained in the Center at closure**, 3.4% were transferred during services, 4.1% were removed – not participating in childcare, and **only 1.9% were expelled due to behavior**. 121 referrals were made at closure.

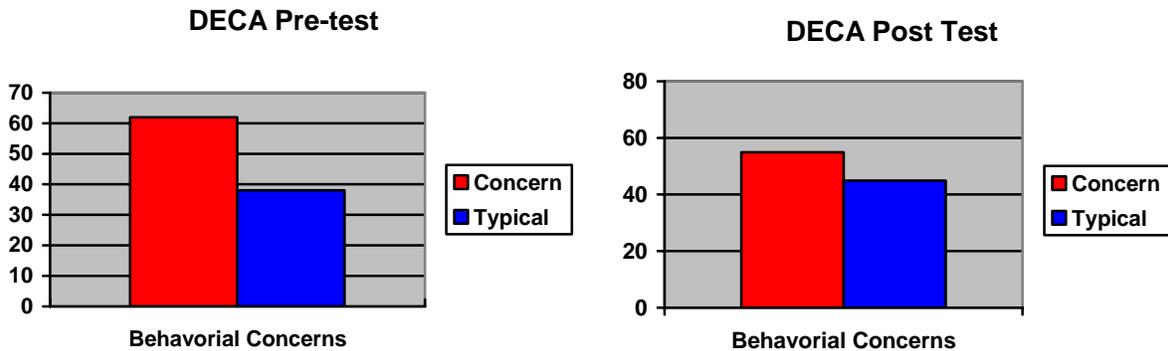
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DECA

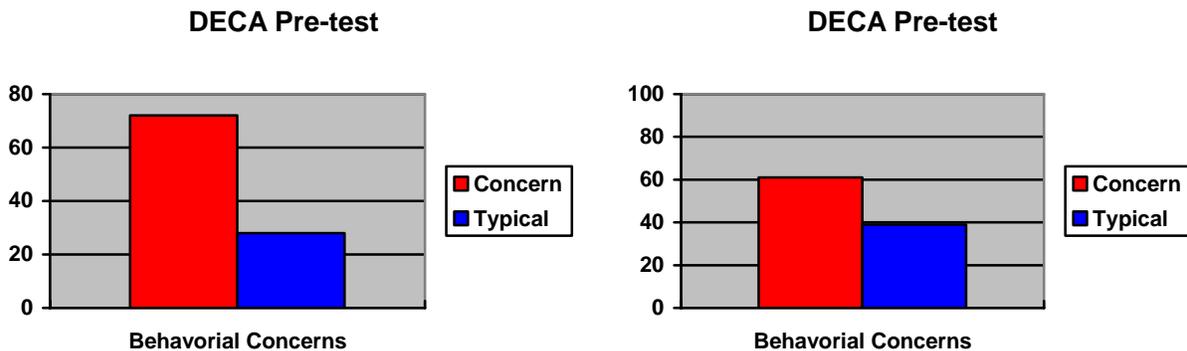
On the Overall Protective Factor Scale, teachers reported an overall mean on the DECA of 45.04 for the pre test and 51.85 on the post test and this change was statistically significant. 30.8% of the youth were in the atypical range on the pretest and 19.2% were in the atypical range on the post test. Teachers reported that 11.5% youth starting in the atypical range had clinically significant improvement between the pre and post tests. Parents reported an overall mean of 31.40 on the pre test and 46.80 on the post test, this change was statistically significant. 100.0% of the youth had scores in the atypical range on the pre test and 0% had scores in the atypical range on the post test. Parents reported that 80.0% of the youth starting in the atypical range had clinically significant improvement between the pre test and the post test.

On the Behavioral Concerns Scale, Teachers had an overall mean on the DECA of 62.00 for the pre test and 55.42 on the post test, this change was statistically significant. 69.2% of youth scored in the atypical range on the pretest and 42.3% on the post test. Teachers reported that 38.5% of the youth starting in the clinical range had clinically significant improvement between the pre and post tests. Parents had an overall mean of 72.00 on the pre test and 61.20 on the post test, this change was statistically significant. 100% of youth scored in the atypical range on the pre test and 60.0% on the post test. Parents reported that 80.0% of the youth starting in the clinical range had clinically significant improvement between the pre test and the post test scores.

TEACHERS



PARENTS

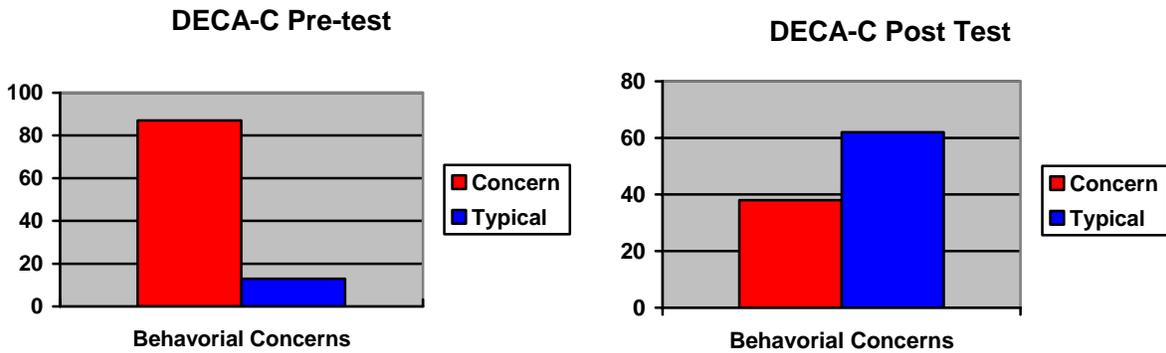


DECA C

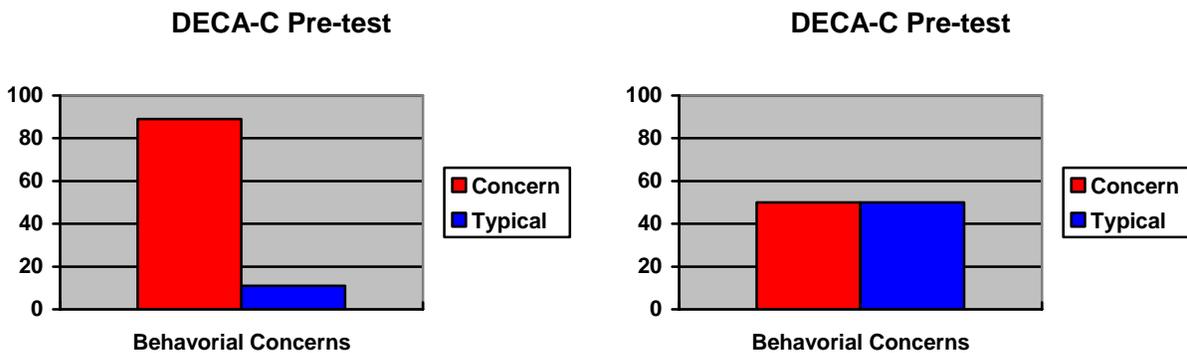
Teachers reported an overall mean of 37.56 on the pre test and 47.24 on the post test for Overall Protective Factor Scale on the DECA-C, this change was statistically significant. 76.4% of the youth scored in the atypical range on the pre test and 10.9% scored in the atypical range on the post test. Teachers reported that 55.6% youth starting in the atypical range had clinically significant improvement between the pre and post tests. Parents reported an overall mean 33.38 on the pre test and 45.17 on the post test, this change was statistically significant. According to the parents, 85.3% of the youth scored in the atypical range on the pre test and 52.9% scored in the atypical range on the post test. Parents reported that 52.9% of the youth starting in the clinical range had clinically significant improvement between the pre test and the post test scores for the DECA-C.

For the DECA-C, teachers had an overall mean of 66.56 on the pre test and 58.75 on the post test for Behavioral Concerns Scale on the DECA-C. 87.3% of the youth scored in the atypical range on the pre test and 38.2% scored in the atypical range on the post test. Teachers reported that 56.4% of the youth starting in the atypical range had clinically significant improvement between the pre and post tests. Parents overall mean was 68.70 on the pre test and 58.30 on the post test. 88.9% of the youth scored in the atypical range on the pre test and 50.0% scored in the atypical range on the post test. Parents reported that 77.8% of the youth starting in the atypical range had clinically significant improvement between the pre test and the post test scores.

TEACHERS



PARENTS



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The ECMHT grants ended June 30, 2009. For the next biennium, Early Childhood Mental Health Treatment will be part of a component of Ohio Family and Children First (OFCF) Cabinet System of Care (SOC) initiative. The emphasis will be for ADAMH/CMH/ADAS Boards in partnership with their Family and Children First Councils (FCFCs) to support Early Childhood Mental Health Treatment and Intensive Home-Based Treatment, with trauma-informed practice. This is the former ABC 404 Base allocation which will continue to be allocated to the ADAMH/CMH/ADAS Boards at the same allocation level as SFY 2009. The Children's Community Behavioral Health (CCBH) component of the SOC focuses on the provision of effective community treatment services needed to maintain children and youth (ages 0 through 17) in their homes and communities. The priority population is children and youth who have intensive behavioral health needs and/or who are at risk of removal from an early care and education setting, or are at risk of removal from their homes or communities due to behavioral health issues.

The CCBH funds can support clinical intervention and treatment, and clinical programs that address gaps in treatment services. Services provided with CCBH funds can include: clinical intervention and treatment for children and youth ages 0-17; early childhood mental health treatment; Intensive Home Based Treatment; co-occurring mental health and substance abuse treatment; substance abuse treatment; trauma-informed care; and clinical programs that address gaps in treatment services.

III. THE INCREDIBLE YEARS PROGRAM FOR PARENTS, TEACHERS AND CHILDREN

Goal: Expand research-proven parent and caregiver training and education to prevent abuse, neglect and severe behavioral, emotional and developmental problems in children. Facilitate thorough training and education designed to enhance the knowledge, skills and confidence of parents and other caregivers.

The Incredible Years Program (IYP) is an award-winning parent training, teacher training and child social skills training series selected by the U.S. Office of Juvenile Justice and Delinquency Prevention as an "exemplary" best practice. IYP was also selected as a model program by the Center for Substance Abuse Prevention. The series has been subject to numerous evaluations by independent groups, demonstrated excellent effectiveness and attained high overall ratings. The American Psychological Division 12 Task Force recommended the IYP as a well-established treatment for children with conduct problems.

The Incredible Years Parents, Teachers, and Children Training Series has two long-range goals. The first goal is to develop comprehensive treatment programs for young children with early onset conduct problems. The second goal is the development of cost-effective, community-based, universal prevention programs that all families and teachers of young children can use to promote social competence and to prevent children from developing conduct problems. The program targets parents, caregivers and children, ages 2 to 12.

Funds were allocated to local mental health boards to support parent education groups, as well as teacher training and child social skills education sessions. The funds were to be used for:

- Parenting skills education groups
- Teacher and early childhood provider education sessions
- Classroom Dina sessions
- Small Group Dina Sessions (not funded through other sources)

The Incredible Years was piloted in 13 board areas as part of the ABC Initiative in FY 2007. For FY 2008, through an RFP process, this was increased to 23 boards. An additional 5 boards participated in FY 2009, for a total of 28 boards. For FY 2009, forty-one (41) boards reported that they were currently using the Incredible Years as part of their ECMH services. The following chart was reported from the 41 boards.

Program Types	# of groups	# of sessions	# of total participants
Parent	111	846	1168
Teacher	11	53	304
Dina Classroom	263	4355	4199
Dina Small Group Therapy	26	315	289

Participating providers that received funding specific for implementing the IY programs were required to collect data to demonstrate the effectiveness of the program in Ohio. Training was

also provided on an ongoing basis. In addition, ongoing monthly mentoring sessions were conducted by certified mentors and other qualified group leaders.

All 28 participating boards submitted narrative reports for SFY 2009.

Strengths

Many strengths were noted related to implementing the Incredible Years program. The most commonly cited strengths were:

- the collaboration among community organizations and the strong partnerships that were developed
 - *The quality of child care in our community is positively impacted by our ability to regularly offer the Teacher Training series at no charge. Our relationships with local daycare centers are also strengthened through this initiative as we have more opportunities to interact and share information through the classes.*
 - *Providers are very receptive to participation in Dina School, because it is a free service that offers “hands-on” assistance for teachers in addressing behavior challenges in their classroom. As a result, teachers participate in the Dina sessions where positive guidance is modeled and they receive coaching in positive reinforcement and incentives. Teachers also receive formal instruction through participation in the teacher training curriculum.*
 - *Taking collaboration another step further was the inclusion of Head Start. They were willing to donate their facilities in order to provide an environment that the families were comfortable in and could feel welcome. This provided a setting in which the families were familiar, while decreasing their reluctance to attend out of fear of being stigmatized as a result of their child receiving services from a mental health center. This collaboration also help reach an at- risk population as many of the families also attend the Head Start program.*
- The ability to provide other supports to enable parent participation such as transportation, meals, gas and child care
 - *When a meal was provided for the participants, attendance was improved. Participants also received a gas card each time they attended a group which also improved participation.*
- the curriculum and materials and that the program is strength-based and an Evidenced-based best practice
 - *The curriculum is laid out with instructions on how to implement the session. The puppets are instant attention-getters, and the children easily respond to the puppets.*
 - *For the parenting classes, the materials are simple, easily understood by the parents, and allow for lots of discussion of the topics. The parent format is very easy to follow.*
 - *When parents attended the program on a consistent basis, they reported many successes at home, including playing with their children more and handling behavior issues more appropriately.*
 - *At first, many parents were skeptical of the sessions regarding play, but as they completed their homework and spent time playing with their children, they began understanding and endorsing the benefits of playing with their children.*

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- *The vignettes were very helpful in explaining and demonstrating the key elements in a session. Also the vignettes gave the parents an opportunity to show their knowledge and make them feel good about their own parenting as they pointed out things the parents in the vignettes did wrong and did right.*
- The programs were also found to be appropriate to be used successfully with various cultural populations, e.g., Hispanic, deaf and hard of hearing and Amish.

Challenges

There were also some challenges related to implementing the Incredible Years program. The most commonly cited changes to implementation were:

- Discontinuation of identified funding
- Maintaining attendance and participation rate of parents
 - *Overall, attendance was a challenge. Although incentives were used and did help with attendance, many of the families in the program had other issues (i.e., abuse/neglect issues, domestic violence, mental health issues, inconsistent living arrangements etc.), which prevented them from attending on a regular basis.*
- Logistics of finding a suitable facilities and transportation issues for parent groups
- scheduling for schools
 - *Difficult challenge of scheduling dinosaur school to fit the availability of teachers' and facilitator's schedules and classroom time due to the preschool curriculum requirements that continue to get more rigorous requiring teachers to spend more time teaching academics and testing students and less time supporting social and emotional development*
- Demand for services far exceeds capacity

There were many success stories highlighting the use of the Incredible Years program shared. Examples of these may be found in the appendix.

Twenty-three of the 28 participating boards submitted to Berea Children's Home & Family Services data for collection of statewide analysis, summary and reporting. The following is a presentation of the Incredible Years Program data that was submitted to BCHFS for FY 2009.

OUTCOMES

Basic Parent Groups

Basic Satisfaction

The satisfaction survey was based on a 7 point scale with a range from 1 (*no satisfaction*) to 7 (*very satisfied*). The responses to the satisfaction survey indicate an overall satisfaction rate of 95.43%. The lowest satisfaction rate was related to the degree to which the Incredible Years program helped with other personal or family problems not directly related to the child (question 4) at 90.12% and the highest satisfaction rate was related to the parent indicating that they would recommend the program (question 7) with 99.22%. The satisfaction rate is based on the number of replies that specify the top three satisfaction responses. A summary of the satisfaction rate for each question of the survey is listed in the table below.

Parenting Scale

Families participating in a Basic Parent Group were asked to complete the *Incredible Years Parenting Scale* prior to and at the conclusion of group sessions. “The Incredible Years Parent Scale is designed to measure dysfunctional discipline practices. The scale targets specific aspects of parental discipline practice rather than providing a global measure of such attitudes and beliefs. The measure contains three sub-scales: Laxness, Over-reactivity and Verbosity. Responses are made using a 7-point scale anchored between two alternative responses to a situation, where a score of 7 represents the highest score in terms of *ineffectiveness* and a score of 1 represents the lowest score in *effectiveness*.” (Arnold, O’Leary, Wolff & Acker, 1993) According to this definition, lower scores indicate effective discipline practices.

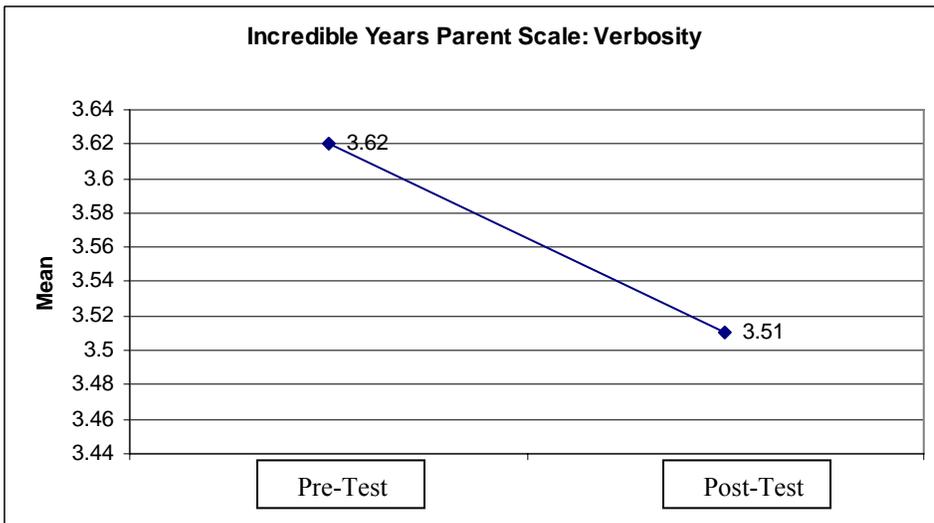
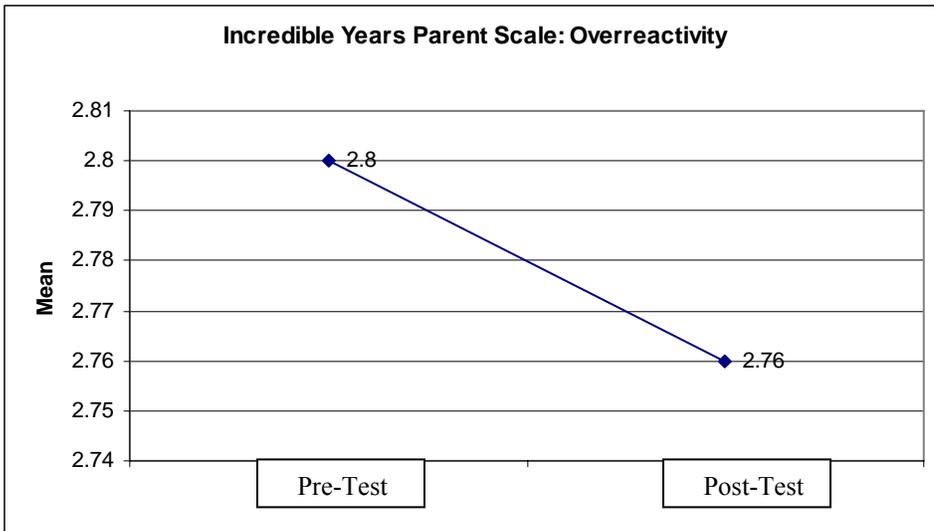
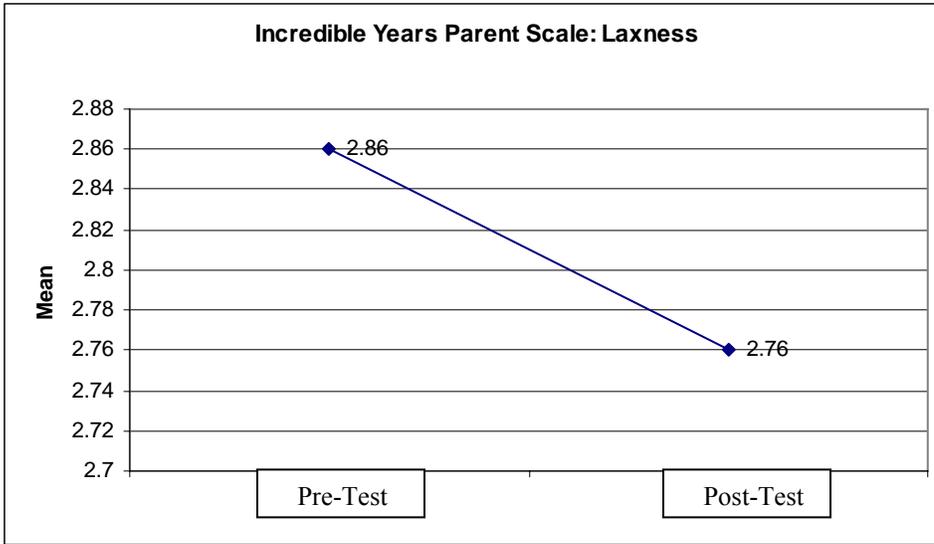
The Laxness factor includes 11 items related to the way in which parents give in, allow rules to go unenforced, or provide positive consequences for misbehavior.

The Over-reactivity factor includes 10 items which address mistakes in discipline such as displays of anger, meanness, and irritability.

The Verbosity factor includes 7 items which address lengthy verbal responses and reliance on talking even when talking is ineffective.

The following Tables and Graphs summarize the statistics and the responses of the pre and post tests for the three subscale factors: Laxness, Over reactivity, and Verbosity (lower scores indicate higher effectiveness).

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DINA (Small Group) Treatment Program

Parents of children participating in the DINA Small Group therapy were asked to complete a DECA assessment prior to the start and at the conclusion of small group sessions.

On the Total Protective Factor Scale, the parents had an overall mean of 40.82 on the pre test and 46.16 on the post test, this change was statistically significant. 38.7% of the youth had scores in the atypical range on the pre test and 24.7% had scores in the atypical range on the post test. Parents reported that 47.2% of the youth had clinically significant improvement between the pre test and the post test.

On the Behavioral Concerns Scale, parents had an overall mean of 63.90 on the pre test and 58.69 on the post test; this change was statistically significant. 73.1% of the youth scored in the atypical range on the pre test and 46.2% scored in the atypical range on the post test. Parents reported that 16.2% of the youth had clinically significant improvement between the pre test and the post test scores.

Classroom DINA Program

The satisfaction survey was based on a 5 point scale with a range from 1 (*not at all*) to 5 (*very*). The responses to the teacher satisfaction survey indicate an overall satisfaction rate of 96.89% for the Classroom Dina Program. Parent involvement was not an integral part of the classroom program in 23% of the responses. 65.67% of the responses indicated that the program enhanced academic skills of the children.

Teacher Classroom Management Program

Teachers that received training were asked to complete the *Teacher Workshop Satisfaction Questionnaire* at the conclusion of the series of trainings or workshops...The satisfaction survey was based on a 7 point scale with a range from 1 (*lowest satisfaction level*) to 7 (*highest satisfaction level*). The responses to the teacher satisfaction survey indicate an overall satisfaction rate of 98.14%. The satisfaction rate is based on the number of replies that specify the top three satisfaction responses.

State GRF Funds in the amount of \$273,354 were allocated to the 28 boards for FY 2009. An additional \$261,117 in other funds was reported also being used to implement the IY programs in these local communities.

The Ohio Children's Trust Fund released a Request for Grant Applications (RFGA) for the Community-Based Child Abuse Prevention Project. The purpose of this RFGA is to engage qualified Ohio organizations to develop and implement new community-based programs or expand existing community-based programs based on the Incredible Years (IY) program. In order to avoid duplication of state funding efforts, ODMH will not be providing specific allocations to support the IY program in the next biennium.

IV. MATERNAL DEPRESSION PROGRAM

Ohio's mental health service providers are working diligently to increase awareness of the effects of maternal depression through general training for early childcare providers and by identifying and linking services for at-risk families. Ohio's Maternal Depression Program (MDP) implements screening programs through a collaborative effort involving county Help Me Grow systems and community mental health (CMH) providers. Identified mental health professionals in each local program provide consultation and accept referrals for services as appropriate.

The Ohio Department of Mental Health (ODMH) Maternal Depression Program (MDP) was originally developed by Dr. Amy Heneghan at Case Western Reserve University in 2004 and transferred in July 2006 to Dr. Frank Putnam at Cincinnati Children's Hospital Medical Center (CCHMC). The project originally began as a pilot consisting of two main components: 1) a maternal depression awareness training for health professionals serving mothers and children – primarily pediatricians; and 2) a project to evaluate the feasibility of large scale screening for maternal depression by Help Me Grow workers in 7 pilot counties in Ohio. As part of ABC, the pilot was expanded through an RFP process to 15 MH boards and 17 counties in Ohio.

MDP objectives include:

- Increasing the number of mothers screened for maternal depression
- Increasing the number of mothers referred for further services to treat maternal depression
- Increasing the percentage of mothers referred for further service who follow up and participate in such services

Participating MH Boards were allocated \$10,000 per fiscal year to be used in a variety of ways and for multiple uses including but not limited to: MDP direct costs, mental health consultation services to the participating local Help Me Grow providers regarding referrals for services; accommodation for mothers without financial means to participate in services; and family supportive costs related to assuring family participation. A total of \$150,000 of ODMH GRF was allocated in FY 2009 to the 15 participating mental health Boards.

The reports indicated that most of the funds were used to provide consultation services to the HMG program. While most mothers were found to be Medicaid eligible, some funds were used for those moms that did not receive Medicaid, for insurance co-pays, and other services not billable to Medicaid. Other activities included:

- Participating in the MDP conference calls, meetings and follow up on referral data and other non-billable activities
- Providing in-home therapy to moms
- Purchased therapist time that would be available 2-3 hours per week to take referrals for identified moms.
- Establishing parent support groups for moms experiencing postpartum depression
- Providing gas cards, transportation and child care to enable moms to participate in therapy

Help Me Grow providers administer the Edinburgh Postnatal Depression Scale (EPDS), a widely used 10-item perinatal depression screening form with good sensitivity and specificity, to

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mothers ages 18 years or older with infants between 4-20 weeks of age as part of their standard services. Mothers who score in the clinical range (≥ 12) on the EPDS and/or endorse item 10 (suicidal ideation) at ≥ 2 on the EPDS are referred to a partnering county mental health provider for further evaluation and treatment.

The project introduced a web-based data reporting and referral system in Jan 2008 that has greatly facilitated tracking and improving screening and referral performance. A training DVD was created in the spring of 2008. Copies of this training were distributed to each participant county in July 2008 and a streaming video is available on the Maternal Depression Screening Project page of www.OhioCanDo4Kids.org. The DVD has also been sent upon request to HMG programs and mental health providers that are interested in participating in the MDP or who are screening for maternal depression as part of their agency's protocol.

According to the FY 2009 Annual report prepared by Dr. Frank Putnam, a total of 1218 screens that fit the established MDP protocol were submitted for FY 2009. Data indicate that the current practice of using the EPDS with a positive threshold of 12 is yielding a rate similar to national data and not unduly increasing the burden on the mental health system by referring a large number of false positives. 13.5% of mothers screen positive for depression on the EPDS, which is in line with national epidemiological studies of maternal depression. About two thirds (65.3%) of the mothers screening positive accepted a facilitated mental health referral and nearly half of those accepting a referral (47.6%) actually kept their appointment with the 90-day surveillance period. This is a relatively high rate of completion when compared with other maternal depression screening and referral models. The median time between the referral and completed appointment was 14 days.

In addition to the ongoing data submitted, each county participating in the Access for Better Care MDP was required to submit a joint agency report with input from both mental health and Help Me Grow agencies. One county submitted 2 separate reports for mental health and Help Me Grow and another county only submitted a report from mental health. The rest submitted joint reports.

Strengths

Several consistent themes emerged from the reports describing the strengths related to implementing the screening for maternal depression with families.

- The collaboration between HMG and mental health was increased and strengthened. It allowed the opportunity in many instances for HMG to connect with the adult mental health system in the community
- Using the Edinburgh as the screening tool enhanced a consistent statewide screening effort. It was described as easy to administer, user-friendly, easy to understand and explain, convenient, inexpensive, and provided a systematic way to approach moms about maternal depression and engage moms to accept and transition to mental health services.
- The screening opened the door for discussion with new moms about post partum depression and facilitated engagement of moms in to treatment who otherwise would not have sought services. It helped families feel more comfortable with accepting mental health services and served to reduce the stigma sometimes associated. Using EPDS was

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helpful not only in identifying possible concerns, but also in reassuring mothers that what they were feeling is typical and learning that was very reassuring to new mothers.

- The funds allowed for mental health to provide in-home services which enabled greater engagement and increased participation in mental health services. Having a designated mental health provider to receive referrals provided very timely access to services to moms who otherwise might have been put on a waiting list for services.
- The ongoing training, support and technical assistance provided by Dr. Putnam and staff at CCHMC. The participants found the monthly conference calls to be very helpful.
- For some counties, participating in the MDP led to engaging local physicians, bringing awareness to community organizations and participating in local conferences. One local FCFC approved funds to continue the program locally.

”Another component of our program, not funded by the grant, was to integrate our clinical practice in a pediatric practice within our County. This integrated behavioral and physical health practice not only looked at the issue of maternal depression, both prenatal and post delivery, but also integrated early childhood interventions. This practice will enter its second year, incorporating more fully the maternal depression project. We hope to expand this project to more pediatric practices and continue our work with Help Me Grow and/or other entities within the county.”

Challenges

Several consistent themes for the challenges/barriers related to implementing the screening for maternal depression were also described.

- HMG staff turnover and having to train new staff was a significant challenge. With many HMG programs laying off staff due to projected budget cuts for FY 2010 and the change in the HMG program eliminating newborn home visits, this will be an even greater challenge than in the past. Some reported closing the HMG program in the county before the end of the fiscal year due to anticipated budget cuts.
- Some HMG staff were not comfortable providing EPDS screenings and discussing mental health issues and chose not to screen moms they served. This led to a difference in the numbers of screenings between staff in some counties and difference among participating counties.
- There were also some changes to the identified mental health provider that delayed the start of services for a few mothers.
- The limitation of the established protocol presented a challenge for some HMG staff. For counties that chose to only allow the NHV nurses to administer the EPDS, many times the visits took place in the first couple of weeks after birth of the infant, outside of the allowed 4-20 weeks postpartum established time frame. . There was also concern that teen moms were not part of the protocol due to the research nature of the program.
- While the screening helped many moms to engage in mental health services, some were reluctant to be diagnosed with depression due to a fear of the local children services agency becoming involved.
- There was also reluctance for some moms to engage in mental health services due to the perceived stigma associated. Some moms agreed to be referred but then failed to follow through with scheduled appointments. Having in-home visits by the mental health provider helped with this issue in some counties.

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There were several success stories highlighting the identification of a concern related to the use of the maternal depression screening that can be found in the appendix.

There were many lessons learned and several recommendations shared that could facilitate a smoother statewide implementation of the maternal depression screening protocol

- Staff consistency is important and counties should assure there are several people trained in understanding the issues of maternal depression, administering the EPDS and referring to mental health services. Then, when there are turnovers in staff, an experienced EPDS screener could help train new staff.
- Continue to provide ongoing TA and training and have the resources available that are part of the OhioCando4kids website. The training DVD is a great tool and should be made available to all counties.
- Continue to have monthly conference calls. A suggestion was made to reserve some of the time during the phone calls for counties to share ideas, suggestions, or “tips” around common implementation issues. Sharing “best approaches” is an excellent learning tool for all participants.
- Incorporate into training a panel of new mothers who have experienced postpartum depression who could discuss ways providers can be more helpful or effective in the referral process. These women may provide valuable insights for engaging new mothers in nonthreatening ways and facilitating access to care.
- Integrate maternal depression screening, data collection, training and referrals into Help Me Grow’s existing infrastructure (i.e., Screening policy, Early Track data collection, ODH training, Help Me Grow website) vs. maintaining separate data system, website, and training.
- Provide training for all mental health providers on maternal depression. Many mental health clinicians do not have experience in treating maternal depression. Specifically, maternal depression is more acute than chronic, and has an impact on child development and the family system.
- The roles of the contact person for HMG and mental health need to be clearly defined and ongoing communication is a key to success.
- Encourage counties that have participated successfully in the MDP to mentor other counties just beginning to implement the EPDS screening program. Many can be ambassadors for the program on the strengths of the program and importance to serving HMG families.
- Obtain suggestions from counties with a high success rate of effectively linking moms to mental health intake appointments.
- Expand the parameters of the established program protocol to include a broader range of ages of infants, prenatal screening and teen moms.
- The database works well and reports can be tailored to meet county needs.
- Encourage moms to talk with their OB/GYN at follow up postnatal visits.
- Making an appointment for mom with mental health immediately on completion of the screening increases chances of follow through with services.
- It is very important for not only HMG but the mental health provider to observe the mom and infant interacting together.

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- Make sure any future training focuses on how to approach the mom in administering the tool and how to process concerns and responses while going through the screen. This could be part of the mental health partner role to assist service coordinators in their comfort levels on administering the screen.
- Data needs to be entered on an ongoing basis instead of entering a batch at a time which has caused referrals to mental health to be not done at all or all at once. It also affects the data for amount of time between screening and referral and when the appointment is made. It is more efficient for the SC to enter their own screening data instead of a data entry person.

As previously addressed, sustainability of the MDP for SFY 2010 will be difficult for some counties.

- HMG providers in ten of the counties indicated they planned to continue with the established MDP. The rest were dependent upon local budget issues being resolved before they would know if they would continue to provide screening or for some, any HMG services.

“Current Help Me Grow staff have not been trained in maternal depression or screening (tool and protocol). We plan to wait until ODH finalizes its policies to determine whether or not Maternal Depression screening will be required and training offered before continuing participation.”

- While public mental health services will continue to be available in the counties to accept referrals and provide services, the majority will not continue to have a designated mental health professional available to provide consultation and more immediate services to new moms who show maternal depression symptoms. There will also be fewer or no in-home visits made to provide mental health services. Most mental health providers will also cease to participate in the ongoing conference calls, meetings and any other non-billable activities.

“We will no longer have an expedited process of getting mothers into assessment and treatment. Our existing mental health system will be able to provide timely services, but not the expedited process developed for this project. In addition, mental health services will shift from home-based to office-based. Home-based staff are usually utilized within the agency for at-risk children over the age of 3. The mental health agency staff was temporarily utilized for this project. Mothers will be faced with the need to find transportation to the facility, and child care so they can focus on themselves during the allotted treatment time.”

Changes that will be needed in procedures and/or staff for FY 2010 for mental health and for Help Me Grow were addressed.

- Several programs chose to only have the newborn home visiting nurses administer the EPDS. For these programs, service coordinators will now need to be trained on maternal depression, administering the EPDS and referring to services when indicated.
- Integrate the MDP database into Early Track 3.0 to eliminate two separate data systems.
- The training that was provided to the program participants needs to be incorporated into the ongoing training curriculum required by ODH.

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- Offer specific training for Service Coordinators on maternal depression (definition, prevalence, impact on child development, screening and referral).
- Counties need to engage local physicians, especially OB/GYN and family physicians.
- HMG and community mental health programs need to work more closely together,
- Establish family therapy/parent child therapy as a billable Medicaid service.
- With the changes to HMG (elimination of newborn home visits and changes to at-risk eligibility), we should expect fewer moms to be screened and therefore, fewer referrals to mental health services in the continuing counties.
- HMG Staff reductions will require a change for many in what personnel administer the EPDS and enter the data. HMG Staff reductions will require a change for many in what personnel administer the EPDS and enter the data.
- It will be important to establish a process for referral to other resources such as support groups, physicians, FQHC and other community services when moms are not able to get immediate access to mental health services.

HMG policy has been introduced that will expand screening as a requirement statewide in the next biennium. While the current state budget crisis poses considerable challenges for the statewide expansion of the program, the flexibility built into the design of the program should accommodate the many different county-level implementations of Help Me Grow and possibly help the program adapt to these new challenges. The program is well positioned to provide training, data collection, and technical assistance to HMG programs using the EPDS to screen for maternal depression whether or not they have an identified mental health partner. The program received national recognition when it was selected by the Institute of Medicine as a promising program for addressing the serious public health problem of parental depression.

For SFY 2008-09, the ODMH Maternal Depression Program provided a total of fifteen ADAMH/CMH financial awards of up to \$10,000 per board to support services to identified mothers who were screened and referred through Help Me Grow. Over the course of the coming biennium, the planning will be for maternal depression to become a component of the Help Me Grow system. From a state and local perspective, it will be essential to strengthen and/or establish ongoing collaboration between the mental health and Help Me Grow systems to ensure that referrals are made as indicated and community-based services are available for identified mothers. Consistent with the SFY 2010 policy intent to eliminate smaller pilot programs, ODMH will not be providing specific allocations to boards to support maternal depression services in the next biennium. ADAMH/CMH boards were encouraged to make local decisions regarding state and local funding to be directed for supporting maternal depression services.

ODMH General Revenue Funds (GRF) and Transformation State Incentive Grant (TSIG) funds have been used to support the continued development of the program for the past few years including: development of the web-based data collection system, ongoing training for HMG and MH providers, monthly conference calls with participants, semiannual face-to-face meetings with the program participants and ongoing technical assistance. For FY 2010, ODH will contribute funding to be combined with ODMH TSIG funds to continue the work of Dr. Putnam and his staff at CCHMC. Eventually, it is envisioned that this work, including the data system, will be incorporated into the HMG system as part of the Center for Early Childhood Development.

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Information including reports on the Maternal Depression program and the training video can be accessed at OhioCanDo4Kids.org.

For more information about all of Ohio's ECMH program components please visit the ODMH website at:

<http://mentalhealth.ohio.gov/what-we-do/provide/children-youth-and-families/early-childhood/index.shtml>