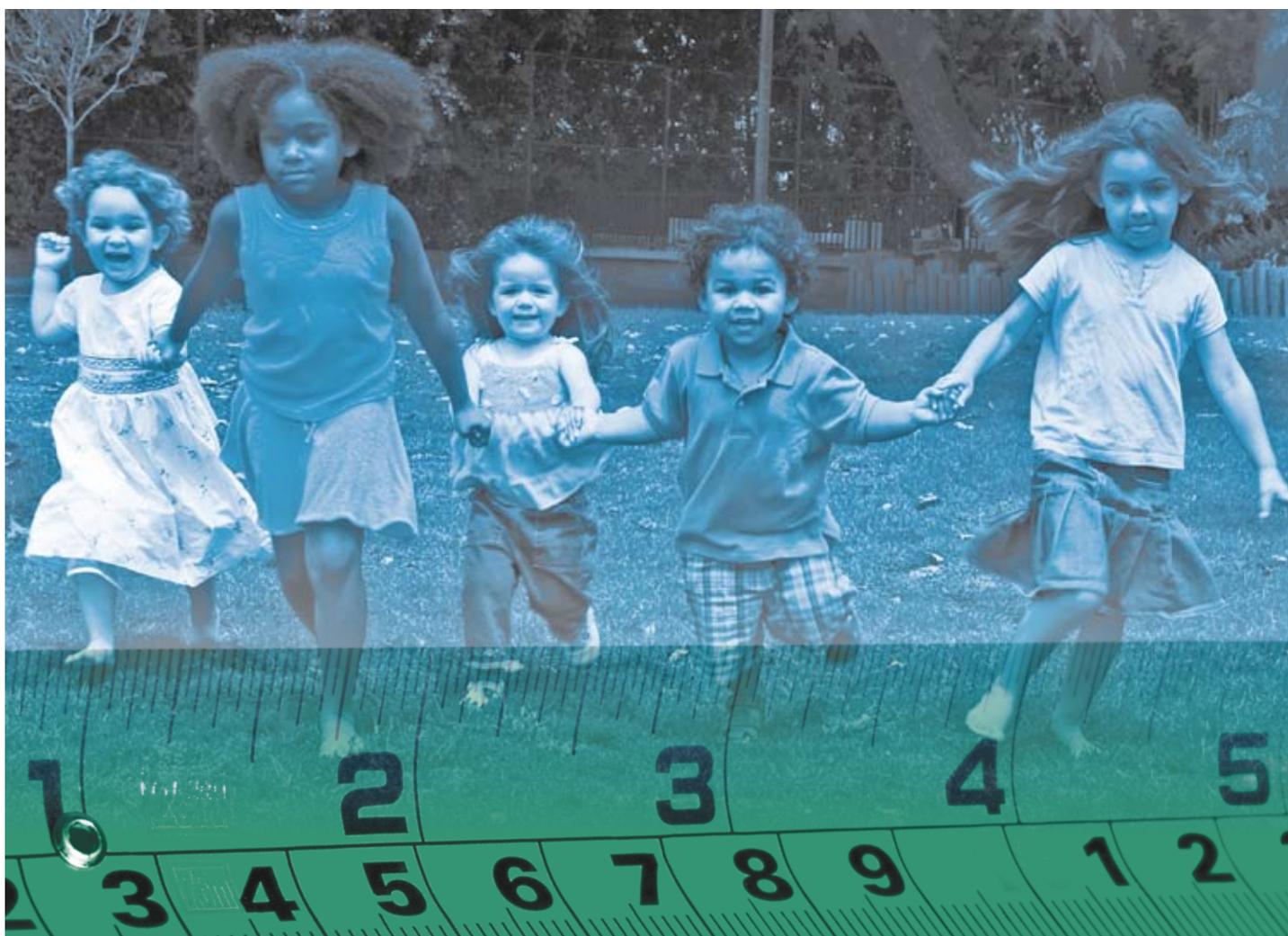


Indicators for Social-emotional Development in Early Childhood

A Guide for Local Stakeholders

Elizabeth A. Isakson | Louisa B. Higgins
Leslie L. Davidson | Janice L. Cooper

November 2009



The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Using research to inform policy and practice, NCCP seeks to advance family-oriented solutions and the strategic use of public resources at the state and national levels to ensure positive outcomes for the next generation. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.

INDICATORS FOR SOCIAL-EMOTIONAL DEVELOPMENT IN EARLY CHILDHOOD A Guide for Local Stakeholders

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Introduction

Social-emotional development in young children encompasses how young children feel about themselves, how they behave and how they relate to people close to them, such as caregivers, teachers, and peers. Although *infant* and *early childhood mental health* are often used in the same way, the term social-emotional development illustrates the importance of prevention and early intervention.¹

There is strong evidence linking social-emotional health in the early childhood years (birth to 6) to subsequent school success and health in preteen and teen years, and to long term health and wellbeing in adulthood.² However, research also shows that effective programs that address social-emotional health early in life can promote resilience and actually prevent mental health problems later in life.³

Objectives

This report is intended to give local stakeholders the information and tools necessary to develop and use indicators for social-emotional development. This set of indicators can support communities in their efforts to implement and assess effective programs that promote young children's wellness.

This report includes:

- ◆ definitions of key concepts related to establishing indicators;
- ◆ seven recommended indicators for social-emotional development;
- ◆ a framework to determine local priorities and “get started” with indicator adoption;
- ◆ resources for finding data at the community level for each indicator; and
- ◆ how to interpret and use data collected for each of the suggested indicators.

It is important for local stakeholders to develop social-emotional indicators at the community level so that they can effectively plan, monitor, and refine programs that promote social-emotional health. To date, few states, cities, and communities have developed and used social-emotional indicators. Implementation of any of these indicators may initially prove to be challenging.

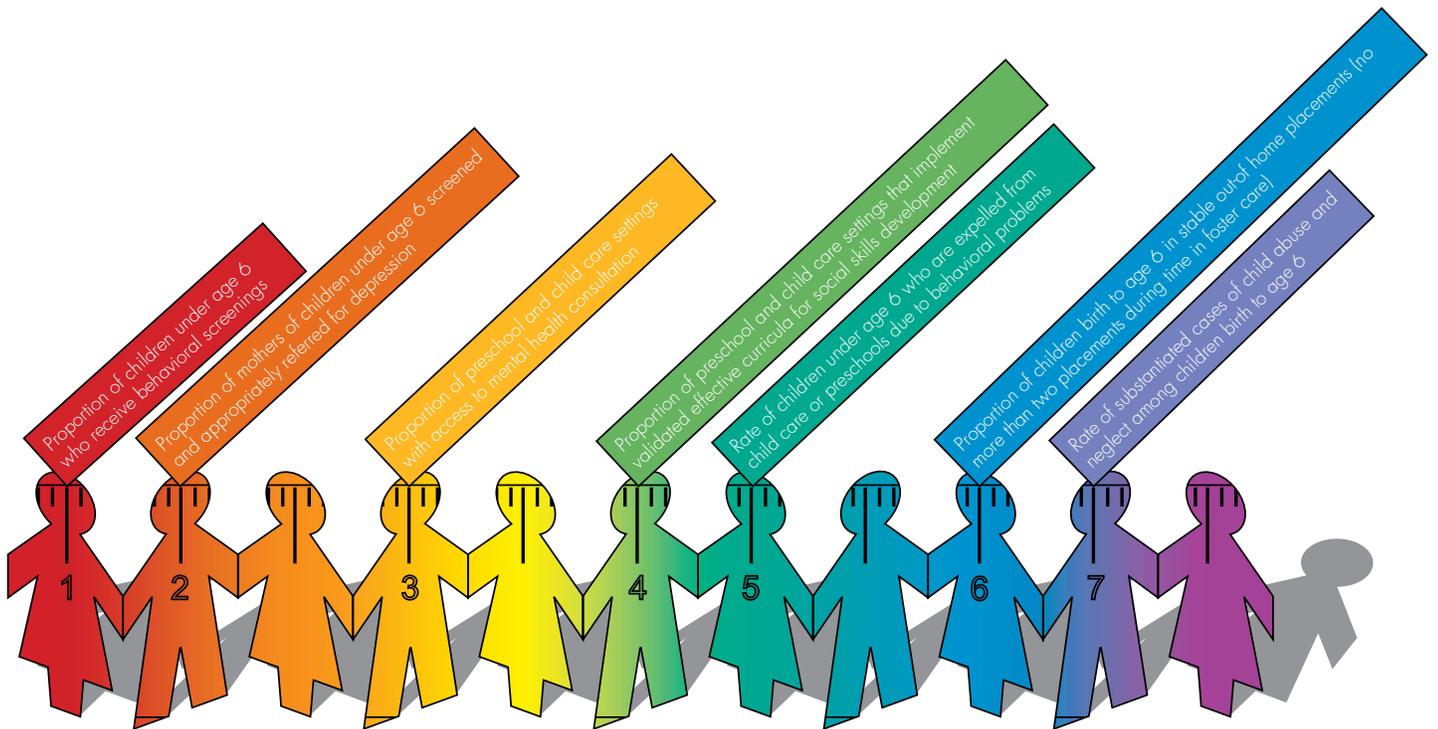
Understanding Indicators: How They Work and How to Use Them

When thinking about indicators that measure social-emotional development, it is useful to envision social-emotional wellbeing and problems as existing along a continuum. At one end, young children experience healthy development and acquisition of needed skills with supportive and sustained relationships; at the other end, young children experience unsupportive and inconsistent relationships, and do not acquire the needed life skills, such as self-awareness, self-regulation, social engagement, emotional understanding, and empathy. The indicators suggested in this report relate to various points along the range of this continuum. The indicators on the left are useful in tracking universal programs for children and the indicators on the right help track programs that serve more vulnerable populations. (See Figure 1.) From a public health perspective, this array of social-emotional indicators drawn from child serving systems is crucial to the formation of a health promotion and disease prevention approach to social-emotional development

that embraces the entire spectrum. By developing these indicators, a community can track progress in program development and implementation over time, providing information to assist in the adoption, quality improvement, and effectiveness of local interventions to promote social-emotional health.

The seven indicators recommended in this report build on earlier work to identify social-emotional indicators for early childhood at the state level by Project Thrive and the School Readiness Project. Much of this work has been informed by Mark Friedman's work on indicator development.⁴ Indicators at the local level will inform and support local program planning and evaluation for young children in a way that state and federal level indicators cannot. The appendix has an information sheet on each indicator with advice on how to define it, possible data sources, pitfalls, and suggestions for how the data might be used.

Figure 1: Indicators along a spectrum of social-emotional well-being



What is an indicator?

From a public health perspective, an indicator is a proportion that measures a meaningful aspect of health or the social care system. It can be collected at the neighborhood, county, city, state, or national level and used in comparative analyses of systems (for instance, within or between counties, states, or countries or over time).

Why are indicators for social-emotional development important?

Indicators may include any of a range of measurements that allow communities to identify areas of need and implement and monitor effective interventions at the family, community and system levels in a coherent and efficient manner.⁵ Indicators of social-emotional development can help communities improve the wellbeing of some of their most vulnerable children.

Why use a proportion?

Proportions allow comparison within communities over time and between communities of different sizes. A proportion consists of a numerator and a denominator. The numerator is the number of events and the denominator is the population in which the events occur. If a locality or a state simply collects numbers of events without simultaneously gathering information about the number of people in the identified service population, the results can be misleading.

For example, one of the recommended indicators for social-emotional health is the number of children expelled from preschool. If one child is expelled from preschool in a community in the first year of tracking the indicator and two children the second year of tracking, it looks as if things have gotten worse. This is a change in the numerator. The denominator in this example is the population of children enrolled in preschool. If the number of children in preschool from year one to year two (denominator) is constant, the proportion of children expelled from preschool has doubled. However, if the number of children in preschool increases from year one to year two, the proportion of children that are expelled is less than double. (See

2009 Project Thrive and NCCP suggested social-emotional indicators

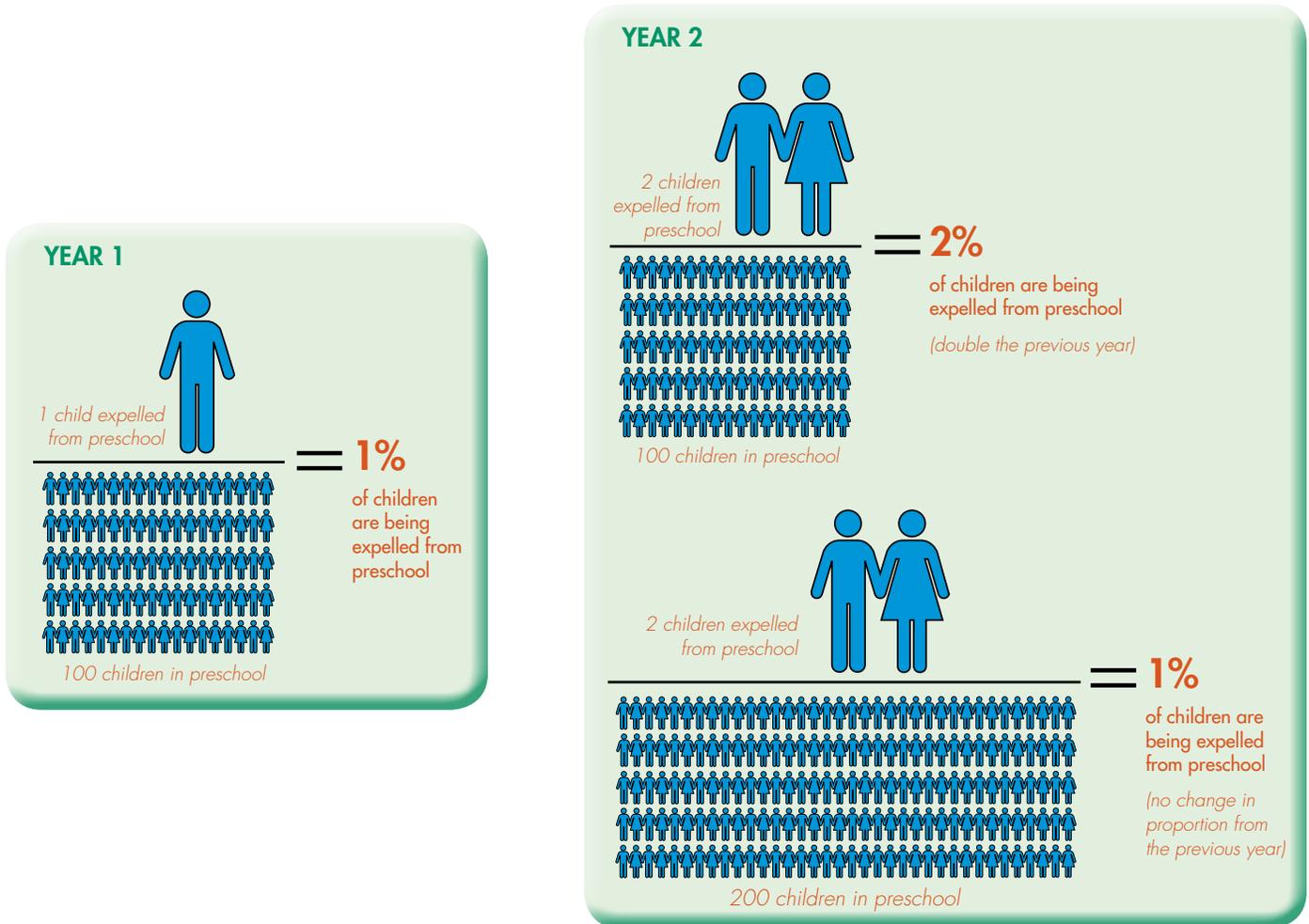
1. Proportion of children under age 6 who receive behavioral screenings
2. Proportion of mothers of children under age 6 screened and appropriately referred for depression
3. Proportion of preschool and child care settings with access to mental health consultation
4. Proportion of preschool and child care settings that implement validated effective curricula for social skills development
5. Rate of children under age 6 who are expelled from child care or preschools due to behavioral problems
6. Rate of substantiated cases of child abuse and neglect among children birth to age 6
7. Proportion of children birth to age 6 in stable out-of-home placements (no more than two placements during time in foster care)

Figure 2). It is insufficient to consider the number of events separate from the population. The use of proportions and rates allows for comparison both over time and between communities.

What is a rate?

A proportion does not necessarily reflect a time period; it may be only a snapshot at a particular moment in time. A rate takes time into account. To express the above example in the form of a rate, it would be said that the rate of preschool expulsion was one percent *per year*, that is both the percentage and how much time it represents must be included. Rates are often expressed in 100 per year notation for common conditions and 1,000 per year notation when occurrences are rare. In the above example, the national rate for expulsion from preschool based on survey results is 6.67 per 1,000 preschool children per year.⁶

Figure 2: Populations and proportions



What is the difference between an indicator and an outcome?

An outcome is a measure of the effect of an intervention or program. A specific value can be either an indicator or an outcome depending on the context.

For clarity, here are two examples that are problem based, the first using a situation familiar to most parents, and the second using one of the recommended indicators.

Example 1:

A child is hot to the touch. The problem being evaluated is fever. The parent takes the child’s temperature. It is 102. The indicator is the temperature and the measure of that temperature is 102 degrees. The indicator allows the parent to assess the problem of fever and compare it to known normal temperature and then take action to resolve the problem. The parent gives the medication acetaminophen and retakes the temperature in an hour. The temperature is now 99.8 degrees. The temperature of 99.8 is now an outcome, the result of the intervention of giving acetaminophen to lower the fever. The parent can now compare the initial temperature of 102 and see that it has come down but not yet to 98.6 (normal body temperature) and can continue to monitor the problem of fever by measuring the child’s temperature to guide what further actions to take.

Example 2:

Community leaders are concerned that there is a problem with child abuse and neglect in their community. They identify the rate of substantiated cases of child abuse and maltreatment in their county. The rate is an indicator. They compare their rate to the state and federal rates of child abuse and neglect and find that it is substantially higher. After checking to see that the difference is not simply due to improved levels of reporting, they implement a proven program of home visiting for high-risk families. They follow the indicator over time and to see if it decreases. The indicator can now be used as an outcome in the home-visiting program evaluation. Following the rate of substantiated child abuse over time in this community also continues to be an indicator.

Where does the data for an indicator come from?

Indicators frequently rely on routinely collected data at the local, state, or national level. This is in part because the data is already defined, collected, and summarized, which makes it easier and less expensive than creating new data. For example, since mortality data is legally required to be aggregated and reported by each state, many of the Maternal and Child Health Bureau (MCHB) indicators required for states relate to mortality rates. Less frequently MCHB requires information on non-fatal events to be reported and aggregated, such as immunization rates.

Factors that impact social-emotional development in children exist across multiple disciplines and agencies. These include child welfare, maternal and child health, mental health, child care, and education. The development of a comprehensive set of indicators for social-emotional development frequently requires interaction between more than one discipline or agency to compile the necessary data.

To illustrate this point, we can expand on our example of preschool expulsion by examining how to find out the number of children enrolled in preschool in a given community. Often preschools are required to hold a license to operate; it is this license that gives us an estimated count of how

many preschool children are enrolled in a county. The license can come from the Department of Health, the Department of Health and Human Services, or other entities, depending on the community. The license states how many children each preschool can enroll. Therefore by checking all the licensed preschools at the health department and looking at the capacity it is possible to know how many children can be enrolled in the jurisdiction of the local health department. It is important to think critically when collecting data because it is possible to draw the wrong conclusions when relying on information collected for one purpose (for example, health and safety regulations regarding classroom or building capacity in the department of health) and using it for a different purpose (how many preschool children are enrolled in a county). The information must be looked at in the context of the community. Questions to consider when examining this data include:

- ◆ Are all the preschools fully enrolled? Capacity is different than enrollment. Verification would be needed to check that preschools that can serve 20 children have 20 children enrolled.
- ◆ Are there any cases where the responsible entity is not the Department of Health? Do pre-kindergartens within public schools have the same license requirements as child care settings? If not, more information will need to be gathered from the Department of Education to get an accurate number of all available preschool spots and enrollments.

Professionals, family members, and other community stakeholders working and living within a community may be able to ask the key questions needed to verify the accuracy of information because they know the local landscape and possible pitfalls.

The Appendix of this report contains worksheets on each of the seven indicators to help communities understand the data collection issues surrounding each indicator, including potential problems and possible solutions.

Potential uses of indicators for social-emotional development indicators

Address system functioning: Maternal depression is a well-known risk for children's social-emotional and behavior problems, such as difficulty with self-regulation, poor peer relationships, and aggression. Depressed parents are also less likely to comply with basic safety and health maintenance-related strategies, such as back-to-sleep or car seat recommendations, and consistently making well-child appointments.⁷ Mounting evidence suggests that treating mothers' depression results in a decrease in behavior problems in their children.⁸ Therefore, tracking whether maternal depression is identified and treated is one way to evaluate how the health system is functioning in preventing and reducing social-emotional problems in children. The identification of health system-level problems provides opportunities to address system functioning through program planning and quality improvement initiatives.

Support and assess intervention strategies: Stable relationships are crucial for young children's social-emotional wellbeing, especially for children with histories of abuse who are now in foster care. Indicator 7 tracks how many foster care settings young children are in over time and provides information on whether the state is facilitating stable relationships through placements to support vulnerable children removed from their families. This indicator provides information on one way in which the child welfare system is providing for a child's social-emotional wellbeing. Knowledge of the stability of placement indicator can push program and system assessment and evaluation to improve outcomes for children. It is important to realize the limitations of an indicator – simply knowing how many placements a child has had does not demonstrate the quality of those placements. However, a high rate of multiple placements over short periods of time demonstrates that there is a problem.

Track disparities: Research demonstrates that preschool expulsion rates vary by race and ethnicity. Measuring expulsion rates led Gilliam to find that African-American children and boys from all ethnic backgrounds were expelled more frequently than other groups.⁹ Because preschool education has such a powerful impact on later school success this differential expulsion rate could have a profound impact on educational attainment in minority children.¹⁰ The identification of a disparity can prompt the assessment of the cultural and linguistic competency of programs and systems that serve young children and families.

What is the origin of the seven recommended social-emotional indicators, and why are they used?

Indicators of children's health and developmental status in early childhood have been collected for generations. Child mortality rates, for example, have been gathered since the 17th century.¹¹ Tracking social-emotional indicators is a recent phenomenon. No single indicator suggested here is ideal; rather each is a compromise between what is an ideal marker and what is an available marker. To select seven effective indicators for social-emotional health, we assessed the communication power, proxy power, and data power of each indicator.¹²

The recommended indicators here do not occur in isolation; they are the result of efforts at both the national and state level to identify markers of social-emotional health at the population level. In the last few years the MCHB established two large national surveys that are meant to alternate with each other every two years. The questions in these surveys can provide a national snapshot of children's social-emotional health as seen by their families, who are asked to comment both on need and on barriers to service utilization.*

At the state level, there were two prior efforts to find indicators for social-emotional health in early childhood. The Getting Ready Project and the National School Readiness Indicators Initiative, published in 2005, included social-emotional development as a domain of readiness for school and chose several social-emotional indicators.¹³

Project Thrive at NCCP is the policy support initiative for the Early Childhood Comprehensive Systems (ECCS) grants funded by MCHB. In 2008, Project Thrive suggested six indicators that addressed social and emotional development in *Short Take No. 7: State Indicators for Early Childhood*.¹⁴ Collectively these indicators were a balance of measures that focused on poor family

* The first is the National Survey of Children's Health, and the second is the National Survey of Children with Special Health Care Needs. These surveys of children 0-17 are large. The NSCH can be analyzed at the state level but neither can provide information at a local level. For more detailed information see: <http://www.cdc.gov/nchs/slaits/nsch.htm> and <http://www.cdc.gov/nchs/slaits/nscshcn.htm>

support, substantiated child abuse, preschool expulsion, and multiple out-of-home placements for foster care, as well as others that focused more on identifying positive social-emotional development. Several indicators measured the presence of known effective policies and programs: screening and referring mothers with depression, proportion of children receiving behavioral screening, and the proportion of centers with access to mental health consultation.

Since the publication of *Short Take No. 7* that resulted from these efforts, two of the previous indicators have been divided to allow social-emotional screening to be separated from general development, and a seventh indicator has been added: the proportion of preschool and child care settings that implement validated effective curricula for social skills development.

Short Take No. 7 in 2008 recommended that states track the proportion of children under age 6 receiving developmental and behavioral screenings.¹⁵ Since the reaffirmation of the American Academy of Pediatrics (AAP) policy on developmental screening in 2006, there has been greater use of validated multi-domain developmental screening tools in child health providers' offices.¹⁶ Because of this welcomed increase in tool-based validated developmental screening, it has become apparent that the combining of developmental and behavioral screens in one indicator would not be specific enough to differentiate whether children are receiving both screens. Some of the multi-domain screens contain social-emotional components while others do not. Separate social-emotional screens also exist. A specific comparison of the multi-domain and the specific social-emotional screens is not available.¹⁷ Therefore, in this report we have emphasized social-emotional screening which could either be part of a multi-domain screen or a separate social emotional screen.¹⁸

In addition, the indicator "Children birth to age 6 in out-of-home placements that had no more than two placements in a 24 month period," from the *Thrive Short Take* and the School Readiness Project, was altered slightly in this publication to mirror the existing Placement Stability indicator from the federal Administration for Children and Families'

(ACF) Child and Family Service Reviews.¹⁹ Making the recommended indicator compatible with federal guidelines allows indicators to be compared across localities, states, and at the national level. The broadening of the indicator to the ACF definition took into consideration that the median stay in foster care is 15 months.²⁰

The addition of a seventh indicator on implementing evidence-based curricula for social-emotional learning in early childhood settings reflects:

- ◆ evidence that curricula for social skills improves children's functioning and peer interactions;²¹
- ◆ a public health orientation on health promotion and disease prevention since this indicator fits along a continuum of systems function with the other two measures of child care quality: mental health consultation and preschool expulsion rates; and
- ◆ a practical way for communities to implement promising strategies for promoting social-emotional developmental wellbeing through assessment of an effective strategy.

All of the indicators recommended here for social-emotional development are measurable. Some are routinely available and some will require development, including coordination and prioritization, to collect. The process of prioritizing and agreeing on the indicators will take time and require cooperation among many different government entities and key stakeholders. Though information for an individual indicator may derive from a single agency, collectively, they cross multiple agencies and systems: health, social welfare and education. An added benefit may be that the required cross-agency work on prioritizing and adopting indicators may result in enhanced cross-agency functioning.

Community Indicators: Getting Started

In NCCP’s survey of states’ progress on the development of social-emotional indicators, ECCS coordinators frequently reported two key barriers to implementing their list of indicators: 1) that the data are all held by different agencies, and 2) that there are no funds or mechanisms to bring promote cooperation among agencies. Local communities will likely face the same challenges. Bringing data to bear on problem solving from a range of agencies and stakeholders often requires prioritization, planning, and commitment.

Prioritizing the Indicators

It is unlikely that a community will be able to implement all seven indicators at once because of resource constraints. Prioritizing is a challenging but necessary step. It requires collaboration between community leaders, professionals, family members, and advocacy groups. The prioritizing process also benefits from understanding the efforts and priorities of early childhood initiatives at the state level. Choosing where to start will be informed by availability of data, what the data show about the key needs of children and families, what communities see as the most important areas to address, and the likelihood of initial success in establishing an indicator.

The seven indicators can be broken into three useful categories for prioritizing:

- ◆ health care system promotion and prevention: screening mother and child for mental health and social-emotional development;
- ◆ early education system promotion and prevention: supporting social-emotional development in young children; and
- ◆ child welfare system promotion and prevention: prevention of abuse and providing a stable environment for children in foster care.

By applying the following framework communities can start to think about which indicators to start with.

Finding the Data: Building Access to Information

As mentioned above, in NCCP’s survey of states’ progress on the development of social-emotional indicators, ECCS coordinators cited challenges in measuring chosen indicators because so many different agencies held the necessary data and negotiating data sharing and data management is difficult.

Figure 3: Flowchart of indicator use at the local level

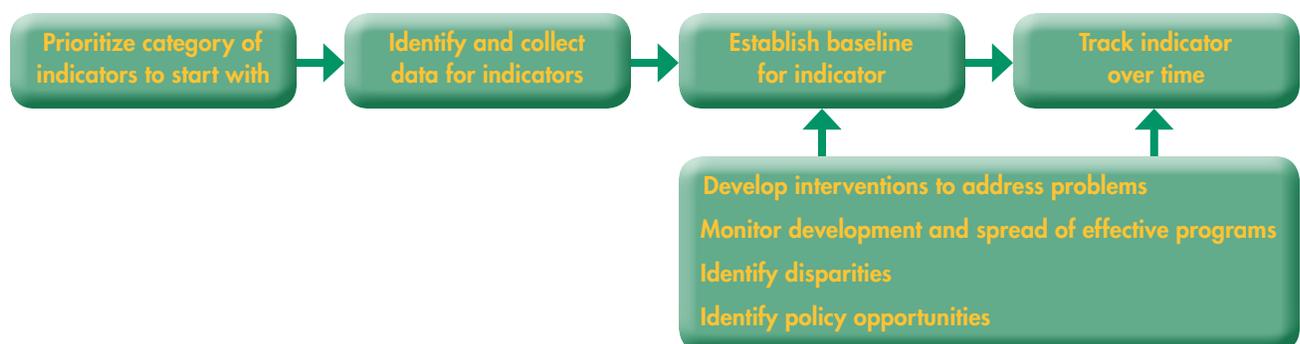
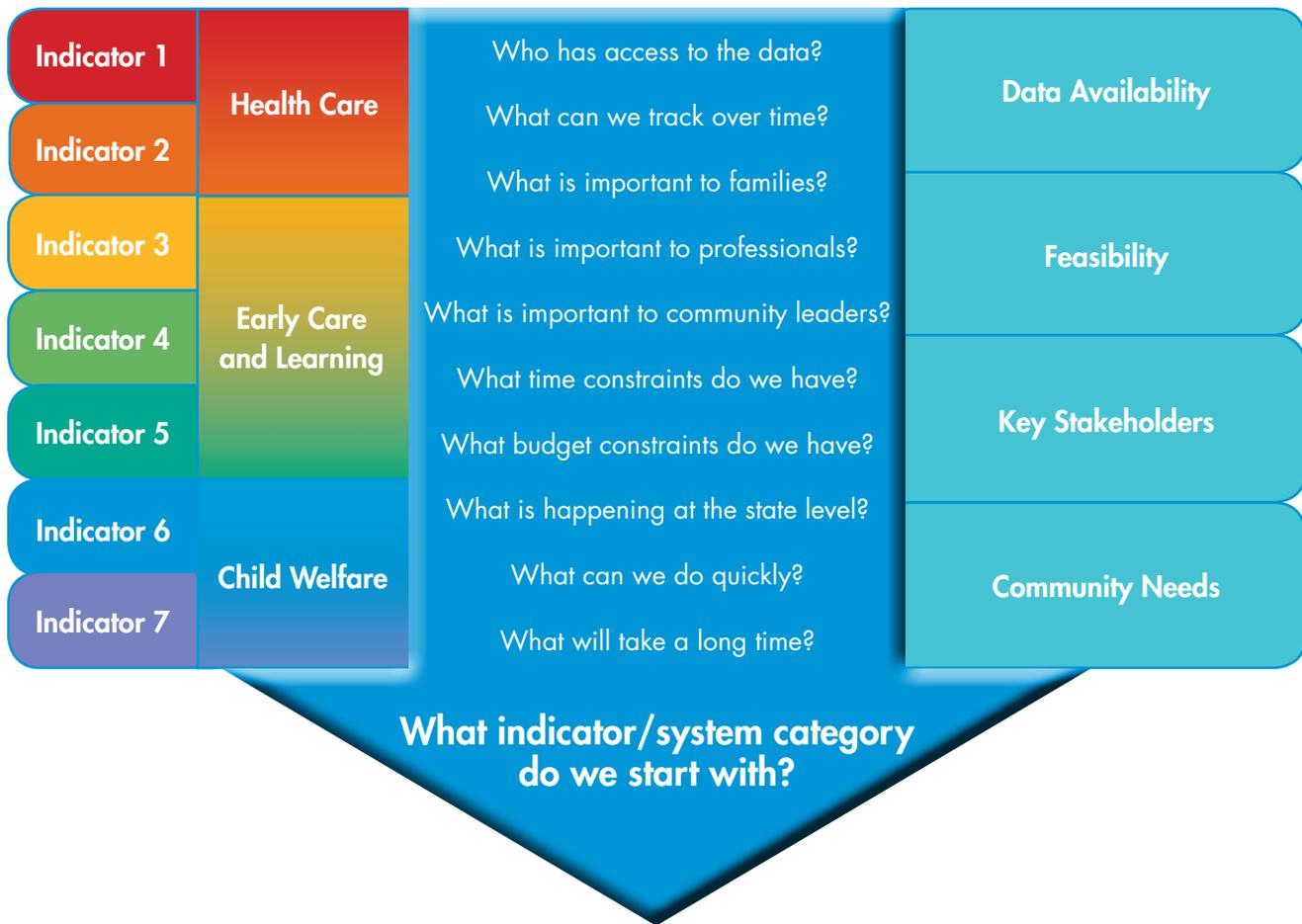


Figure 4 : Framework for getting started



Access to information and data sharing will be built upon community buy-in and participation in the development of the indicators. Local leaders will need to navigate and negotiate with key stakeholders (such as agency personnel, tribal groups, parent groups) and state agencies to move forward with data collection. It is crucial that all parties involved see the value and need for the collection and sharing of data. The creation of a common vision among local stakeholders may be challenging but will lay the groundwork to address other potential obstacles in this process.

Finding the Data: Collecting the Numbers

When referring to indicators, we are defining data as the numbers that are to be collected. These numbers will then be interpreted to aid in the

understanding of the social-emotional wellbeing of children in a given community. Compiling data for each indicator will require the collection of two numbers: the numerator, or the number of occurrences, and the denominator, the total population who could potentially have an occurrence. Careful consideration must be given to establish parameters for data collection. Examples of parameters include:

- ◆ defining community boundaries (e.g. zipcode vs. school district);
- ◆ age range – establishing a starting and cut off point for each indicator (e.g. birth to 5 vs. birth to 8); and
- ◆ time range – establishing time range in which to look at each indicator (e.g. calendar year CY 2001-2002 vs. fiscal year FY 2003-2004).

Finding the Data: The Importance of Confidentiality

A potential challenge of collecting data at the local level can be maintaining confidentiality in communities with small populations. Some of the recommended indicators involve circumstances that may be sensitive, such as, child abuse, maternal depression, parental substance use disorders, or expulsion from preschool. Confidentiality must be preserved in the collection of data so that it cannot be used to identify individuals but only the systems serving young children. No personal data is required to collect this information; only the number of occurrences is needed. To ensure confidentiality when the number of events is small, localities can include a larger geographic area, such as a number of counties instead of only one, or they can include a larger time period, for instance the past five years versus just one year.

No information collected that could potentially identify an individual or family should be included in any report on indicators or health outcomes in such a way that could lead to the identification of a person or family.²²

For example, if a mother of triplets has a positive depression screen and is referred for evaluation in a small community, the data should not be presented in a report that separates single births and multiple births. The information that she is a parent of triplets may be enough for community members or others to identify her.

Finding the Data: Screening

The goal of screening is to identify risk and detect problems early so that appropriate referrals and interventions can occur. Ensuring that all children in a community are being screened for health and mental health wellbeing is a good prevention strategy. Ideally, these screenings should be conducted at well-child health visits with a child health provider. At first, information may not be accessible on the number of children screened. Communities may need to start by contacting child health care providers to see to what extent they have incorporated validated screening for behavioral development and maternal depression into their

practices (as recommended for EPSDT screening). The first step in creating the indicator could be the percentage of providers screening for social-emotional problems and maternal depression with validated screening tools rather than the percentage of children screened. Then by working with the providers communities can assess the best way to measure the proportion of children who are getting screened for social-emotional development and mothers getting screened for depression, to guide their efforts towards universal screening.

It is important for communities to encourage their state to recommend the use of a validated screening tool for social-emotional development in addition to validated developmental screening in their early periodic screening, testing, and diagnosis (EPSTD) standards.²³ EPSTD standards are set by either the state Medicaid office or the Medicaid Managed Care contract holder, depending on the state.

If health provider data is not available on all children or all mothers, a local community can begin with children enrolled in Head Start. Head Start is contracted to administer a developmental, sensory, and behavioral screens within 45 days to all children entering a Head Start program and yearly thereafter.²⁴ By partnering with local Head Start providers, a community can document the screening tests being used in that setting and find the data for children enrolled in Head Start. Head Start can also provide mental health support that may include services for the parents.²⁵ This would provide information on screening within a segment of the children in preschool.

Finding the Data: Early Education

Early education encompasses a variety of settings. Typically, these settings are classified as center-based child care, home-based family day care or group care, and informal family, friend and neighbor care. Early education can also include formal preschool, whether Head Start, community based, private, or state run. The settings for early education that are common in a given area will determine what data is available and how to collect it.

As described earlier, local and state Department of Health licensing information on child care providers is a good source for data already collected

on child care settings. At the very least, the location and number of each facility will be available.

Child care coordinating councils and child care resource and referral organizations in a given community may be additional sources of information. Input from these types of organizations will be very important in understanding local child care conditions.

Many states have rating systems for child care providers. The rating systems may contain a social-emotional component that provides information on consultation and curriculum.²⁶

The state Department of Education may be a good source of information depending on how prekindergarten is administered locally. Usually the Department of Education does not have sanction of children younger than 5. However, with the growth of prekindergarten and special education populations they may have information on services for children as young as 3 years old.

Lastly, there is relevant information in Head Start Performance Information Reports. These are reports Head Start administrators submit on all aspects of their program, including enrollment, curriculum, and consultation. The limitation of using this dataset for social-emotional indicators is that it is only for children enrolled in Head Start and not the whole population of children in a given area. However, it may be a good place to begin.

Finding the Data: Child Welfare

The Administration for Children and Families (ACF) currently reviews how states' child welfare agencies function by administering a Child and Family Service Review (*Children's Bureau Website - Child Welfare Monitoring*). Each state is required to submit data for this review. By coordinating with state welfare agencies, localities can follow the structure of the Child and Family Service Review and deepen their understanding of how their local child welfare system is functioning. A wealth of information is available in the reviews, including assessments of how the child welfare system is promoting children's well-being from both the physical and mental health perspectives.²⁷

For children under tribal jurisdiction, state and tribal agreement based on the Indian Child Welfare Act of 1978 will need to be reviewed to understand the reporting of cases between the state and tribe.²⁸

Defining a community's geographic borders – using ZIP codes, county boundaries, tribal lands, for example, is critical for accurate data collection. Location is important in child welfare information because a child may live in one county, experience abuse in another, and receive foster care related services in yet a third. A plan that sets a standard for data collection will be important for each locality. Most child welfare system data is collected from birth to age 18, and it is compiled on an individual level, so it will be possible to request data by specific age groups.

For the placement stability indicator that is part of the Child and Family Service Review, the states did not receive specific data on this indicator in the initial review, which occurred from 2001- 2004. However, the states will get specific information regarding this indicator in the second round of reviews scheduled for 2007 - 2010.²⁹

Establishing a Baseline

Once data has been collected and analyzed for a new indicator, a baseline for that indicator can be established. The baseline serves as a point of comparison for all data collected in the future. An accurate baseline may not be easy to determine. In some instances it may be necessary to combine data from several years into an average to get a stable estimate. This typically happens when collecting data on uncommon occurrences (See Appendices for indicator-specific baselines).

Tracking Change Over Time

Once the baseline exists, the indicator can be followed at intervals determined by stakeholders. It is important that any change be interpreted with care. For example, it may not be clear whether an increase in the number of substantiated cases of child abuse indicates progress in abuse identification or an increase in the actual amount of abuse occurring. Any indicator proportion must be interpreted by the local community as their perspective

is required to make sense of the data. Critical thinking is necessary to understand changes in data over time.

Interpreting and Using the Findings

Similarly, when interpreting the results of the indicators, the number itself is not enough. Critical thinking about what that number means in a community and in relation to the other indicators is the most important part of the effort to establish local indicators of social-emotional wellbeing.

Social and emotional development indicators can be used by local communities in several ways to shape key questions about children's wellbeing.

- ◆ To track the size of a problem: How many children are entering foster care in our community and how does it compare to the state and country as a whole?
- ◆ To identify disparities: Why are African-American children expelled more often from preschool?
- ◆ To identify areas of improvement for the systems, agencies or providers that serve young children: How can we improve the permanence of placement for children in foster care?
- ◆ To identify areas for needed policy changes: Is the use of a standardized screening tool with a social-emotional component required by the state Medicaid under EPSDT?
- ◆ To provide evidence for advocacy in discussion with state and federal decision-makers: Our rates of maternal depression are much higher than at the state level so we need more home visiting programs compared to other areas of the state.
- ◆ To measure outcomes of program implementation at the local level: Our daycare centers have all recently implemented mental health consultation, has it made a difference in expulsion rates?

Experiences at the State and County Levels

A number of states are successfully using some of these social-emotional indicators.



North Carolina, one of the 17 School Readiness States, has adopted several social-emotional indicators and is developing others.³⁰ These include:

- ◆ the number (not proportion) of children age 0-5 with substantiated reports of abuse and neglect at the state and county level since 2001;
- ◆ maternal depression: They do not use the EPSDT Medicaid data for maternal depression, but since 2000, they have used regional data from the Pregnancy Risk Assessment Monitoring System to periodically assess the percent of mothers who report that they were moderately to severely depressed in the months after birth;³¹ and
- ◆ the state is also trying to develop an indicator to measure “the percent of children with developmentally appropriate skills and behaviors in the emotional/social emotional domain.” In this case, they plan to aggregate information from their Kindergarten Health Assessment required of all children entering kindergarten.



Nebraska included data on social-emotional indicators in the Report to the Governor on the Status of Early Childhood in 2008.³² These include:

- ◆ rate of substantiated child protective service cases per 1,000 Nebraska children age 0-8 years. This measure has been used since 2005 and the state has set a target for the state; and
- ◆ maternal depression: They are using their PRAMS data and the proportion of children eligible for Medicaid between 2004 and 2007 who received mental health treatment. The PRAMS data are generally not suitable for use at a local level though they provide rich data at the state level.

At the local level, some communities with active state early childhood initiatives have started to measure indicators for social-emotional health.



Northwest Counties of California's First Five reported on the number of social emotional screenings, of parental depression screenings and treatment, and the training of child care staff on mental health issues. These are not presented as proportions and no plan is in place for continued monitoring, however it is commendable that these were tracked and compiled to assess progress made by First Five in their communities.³³



Guilford County in North Carolina produced a pilot report card in 2007 which included county level data for maternal depression and substantiated risk for child abuse as well as many other general health indicators for school readiness.³⁴

Conclusions

Localities, counties, and states must plan how they will embrace a comprehensive approach to social-emotional developmental health. Communities can affect local change through the development of social-emotional indicators. By working with leaders and providers from health, education, and child welfare sectors in the community to develop these indicators, stakeholders can understand where systems struggle to appropriately serve young children and how systems are successfully supporting social-emotional development. Linking the seven recommended indicators can lead to important insights into building cohesive system responses in a local area. The most common social-emotional indicator in current use at the state level is the number or the rate of substantiated cases of child abuse. This is an important measure, but alone it focuses on only one end of the spectrum of social-emotional development. In order to assess the full spectrum of social-emotional developmental wellbeing for young children, other indicators must be implemented. There is an urgent need for indicators which address the systems involved in promoting social-emotional developmental wellbeing in children – the child welfare system, the health system, and the early education system.

A group of seven indicators has been proposed which act across the spectrum, and the appendix provides information on how to develop and interpret them. Through collaboration with state level initiatives these indicators can support state efforts and also document the need to increase resources back to the local community. The most difficult step for local communities will likely be the cross agency negotiation to prioritize and then to share and link data. Local communities will need to choose wisely to start where success is achievable in a timely manner. Early success in establishing an indicator will provide momentum and energy to complete the seven indicators over time. It may be necessary to start with a preliminary measure within a subgroup (such as the Head Start population) and then move on to provide information on the whole population.

It is clear that efforts to track these indicators will assist communities in better understanding how to nurture the social-emotional development of their children, how to initiate and evaluate effective programs, and how to work with other stakeholders locally and at the state level.

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Proportion of children under age 6 receiving social-emotional screening with a validated screening tool

Definition

A screen for social-emotional well-being or behavioral well-being may be a component of a multi-domain developmental screen which includes a social-emotional component or may be a separate validated screen specifically for social-emotional development (see references below).

Importance to social-emotional development

- ◆ Use of a validated screening tool in health or preschool settings can facilitate early identification of almost all children who will have behavioral problems in school.¹
- ◆ Early identification of behavioral difficulties allows for early intervention.
- ◆ Targeted early interventions are effective in reducing behavioral and school problems. The interventions in early childhood can be family oriented or school based.²

Assign local priority

High Medium Low

Does state ECCS track it?

Yes No

Outcome

Percent of children who were screened with an appropriate tool during a well child visit.

Numerator

Number of children screened during a well child visit.

Denominator

Number of children who received well child visits in the past year.

Age range

Children from 0-6 years of age.

Possible sources of data

- ◆ Will need to work with local child health practitioners to find out what is current local practice regarding screen for social-emotional health.
- ◆ Developmental screening, including social-emotional screening, during well child visits has a Current Procedural Terminology (CPT) code that may allow tracking through billing. The code is 96110 Developmental Testing, limited.³ However the code is not always reimbursed by private insurers so some practitioners may not be using it. Medicaid does reimburse for the code. Discussion with practitioners and the state Medicaid office may help determine how widely this code is used. This will make it clear if it can be used initially or if data development work must take place.
- ◆ Depending on the number of providers that serve a community, a medical record or chart review may be the only means of assessing the percentage of children being screened. Providers may be auditing screening themselves. This would be very difficult if a community has many small providers in small offices, but easier if one big community health center serves the population.
- ◆ All children entering Head Start must have a development assessment within 45 days of entering. By contacting Head Start programs, grantees can find out what validated tool they are using and if it has a behavioral component. If it does, this indicator can be used with a Head Start denominator. If not, it becomes a data development issue.

Possible pitfalls

- ◆ Although EPSDT requires mental health screening at well child visits for all children enrolled in Medicaid, the use of a validated tool for this screen in young children is neither universally required by state Medicaid programs nor embraced by all practitioners.⁵ Therefore it may be that choosing this indicator will require discussions with providers regarding the development of a screening program that includes a validated social-emotional component within the community.
- ◆ Even where state Medicaid requires the use of a validated tool, there may not be a code that distinguishes this validated screen in the administrative data.
- ◆ Head Start may be the most readily available source of information but relying solely on it means tracking only children enrolled in Head Start. It would however, represent a beginning of systematic collection of an important social-emotional indicator.

How can the state or tribe help?

- ◆ EPSDT requires mental health screening for all children under 18 covered by Medicaid.
- ◆ States set their own EPSDT standards, and can require use of a validated screening tool for mental health within an age group. For more information on validated screening tools for social-emotional development see:
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Baseline

Can be established once data is collected.

Tracking

Would depend on how information is obtained.

Using the Data

- ◆ If validated screens are not being used, stakeholders can work with providers to facilitate the adoption of evidence-based screening tools.
- ◆ If providers are not coding correctly they are not getting paid appropriately by Medicaid. By working on coding properly communities can improve provider reimbursement for a needed service and establish a means of following developmental screening in the future.

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Proportion of mothers of children under age 6 screened and appropriately referred for depression

Definition

This indicator has two components that require defining:

1. Screening Component: Screening for depression requires a standard validated screen given to all mothers which assesses risk for depression (PHQ-9, PHQ-2, Edinburgh, Beck).
2. Referral Component: Results of a positive screen should be followed up with referral for assessment to confirm a diagnosis and treatment by an adult health or mental health care provider.

Importance to social-emotional development

- ◆ The use of validated screening tools enhances the detection of depression.¹
- ◆ Maternal depression has significant deleterious effects on a child's social-emotional well being and maternal depression is readily treatable.²
- ◆ Treating the depression has been shown to improve child behavioral outcomes.³
- ◆ Identifying and treating depressed mothers is an important marker of a health system that supports the social-emotional development of a community's children.

Assign local priority

- High Medium Low

Does state ECCS track it?

- Yes- both, screen and referral
 No-neither
 Yes-one, screen or referral

Which one? _____

Outcome

1. Screening Component: Percentage of mothers attending a well-child visit who received a validated screen for depression in the past year.
2. Referral Component: Percentage of mothers who have a positive screen that receive treatment.

Numerator

1. Screening Component: number of mothers screened at well child visits by child health care provider.
2. Referral Component: number of mothers who screened positive that received treatment.

Denominator

1. Screening Component: number of children who received at least one well child visit in the past year by a child health care provider.
2. Referral Component: number of mothers who screened positive.

Age range

Women of child bearing age.

Possible sources of data

1. Screening Component:
 - ◆ Certain states have initiatives for screening of maternal depression. If your state has a screening initiative, the information they have gathered to set up the initiative may help you at the local level.
 - ◆ Pregnancy Risk Assessment Monitoring System, (PRAMS), a national survey that often asks questions about peri-natal depression symptoms or screening. Question can vary per state so need to contact state PRAMS administrator and

see if they have information on peri-natal depression and if it can be used at the local level. This is not the exact context we are looking for because PRAMS only looks at depressive symptoms during pregnancy and in the first 6 weeks after pregnancy, but may be a place to start.

- ◆ Communities or tribes may need to first determine how many providers are screening mothers to get an idea of what is happening. Child health care providers that are screening mothers for depression are of particular interest.
2. Referral Component:
 - ◆ If screening is happening, it is important to then find out if referral and follow-up is in place.
 - ◆ If your locality has a large number of mothers on Medicaid and Prenatal Care Assistance Program (PCAP), the state Medicaid office may be able to report on all mothers who gave birth in the past 5 years and the number who have had a diagnosis of depression.

Possible pitfalls

- ◆ Screening mothers for depression during well child care is becoming part of standard care in pediatrics but is not yet universal. Therefore in individual communities, this may be something that providers are not yet doing systematically.
- ◆ Use of validated screens is very important. A provider “looking for” maternal depression without use of a validated screening tool is not optimal for the identification of depressed mothers.

How can the state or tribe help?

States that have mandated screening for maternal depression or increased reimbursement for depression screening can help their local communities by enforcing these mandates and supporting efforts to seek reimbursement.

Baseline

1. Screening Component: Baseline can be established soon after gaining a means to track screening.
2. Referral Component: Baseline will require 2-3 years to establish depending on the rate of maternal depression in the community or tribe.

Tracking

Can be done by consistently reviewing data sources. Complexity and inconsistency can be increased by the need to track screening and referral from different sources.

Using the data

1. Screening Component:
 - ◆ The goal is for all mothers of young children to be screened (100 percent). If the value is less than that, action can be taken to move a community closer to the goal.
2. Referral Component:
 - ◆ Multiple values are needed to assess community progress toward screening and referral goals.
 - ◆ Over time the community will be able to see if they are identifying depression adequately and events/problems that either increase or decrease the number of women diagnosed.
3. General uses for Indicator 2:
 - ◆ Information on Maternal Depression on the local level can be used to seek state reimbursement for routine screening of parents in health care settings.
 - ◆ The impact of programs that effect parental wellness, Nurse Family Partnership, Parents as Teachers, can possibly be measured at the community level.

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Proportion of preschool and child care settings that have access to mental health consultation

Definition

Mental health consultation is a broad term. NCCP supports the definition provided by the Georgetown University Center for Child and Human Development: "A problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more caregivers, typically an early care and education provider and/or family member. Early childhood mental health consultation aims to 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."¹

Importance to social-emotional development

- ◆ Early treatment of behavior and emotional problems can prevent more serious long term consequences.²
- ◆ Mental health consultation in child care and school settings prevents expulsions.³
- ◆ Mental health consultation can improve the overall quality of the child care environment by working with staff and parents to understand children's challenging behavior.⁴

Assign local priority

High Medium Low

Does state ECCS track it?

Yes No

Outcome

Percentage of preschool/child care settings with access to mental health consultation.

Numerator

Number of preschool/child care settings with mental health consultation in a community.

Denominator

Total number of preschool/child care settings in a community.

Age range

Children from 0-5 years of age.

Possible sources of data

- ◆ Department of Health licensing information for source of total number of preschool child care settings.
- ◆ License forms may ask about mental health consultation.
- ◆ It may be necessary to call each child care and preschool and ask if the location has access to mental health consultation and how the location defines "access."

Possible pitfalls

- ◆ It is important to explore with early education providers that do have mental health consultation how the process is actually used in practice.
- ◆ The accuracy of the denominator (total number of preschool or child care settings) is dependent on the quality of record keeping. If the number of settings is not accurate the proportion cannot be interpreted.

How can the state or tribe help?

The state or tribe can set basic requirements and list best practices for mental health consultation in early learning settings.

Baseline

Baseline can be established in first year of data collection.

Tracking

- ◆ The frequency of data collection will depend on what actions are taken in response to baseline results.
- ◆ Those collecting baseline data may wish to establish procedures to make it easier to track data in the future, such set procedures for self reporting and licensing renewal.

Using the data

- ◆ Investigate the causes of unexpected results to better inform interventions.
- ◆ Mental health consultation for child care is shown to improve the quality of care. Linking mental health and child care through accurate data can inform and improve local intervention.
- ◆ Localities can work with their health department to require mental health consultation access as a requirement for licensing.
- ◆ Localities can approach state to seek further funding for small local child care entities to be able to afford access to mental health services.
- ◆ In absence of consultation, localities can link mental health providers with groups of small child care providers to “share” the cost of consultation.

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Proportion of preschool and child care settings implementing validated effective curricula for social skills development

Definition

Social and emotional evidence based curricula are universal prevention oriented interventions aimed at child care and preschool classrooms as a whole. The curricula are designed and tested to promote young children's decision-making, pro-social behavior, impulse control and emotional-problem solving. Often the curricula embed proactive classroom training as a condition for successful implementation of a curriculum.¹

Importance to social-emotional development

- ◆ Social and emotional skills can be taught and reinforced in a curriculum that builds resilience in the population.²
- ◆ Curricula targeted to the general population are a means of promoting social-emotional development, not just preventing problems.³

Assign local priority

High Medium Low

Does state ECCS track it?

Yes No

Outcome

Percent of early education settings implementing such curricula.

Numerator

Preschool and child care settings with validated effective curricula in place.

Denominator

Total number of preschool and child care setting in the community.

Age range

Children from 0 -6 years of age.

Possible sources of data

- ◆ Department of Health licensing of preschools or child cares providers can be a source of number for denominator.
- ◆ License forms may ask about social-emotional curricula.
- ◆ It may be necessary to call each child care/ preschool and ask whether they use a validated effective curriculum.

Possible pitfalls

- ◆ Validated effective curricula may not be in place, but the setting may do a good job in promoting social-emotional health. However, to assure consistent quality over time and among different settings, it is important to have an actual curriculum in place. This issue must be carefully and constructively addressed with different early education settings.

How can the state or tribe help?

- ◆ The state or tribe can promote knowledge of effective curricula.
- ◆ The state or tribe can help educators offer and standardize effective curricula.

Baseline

Data will be available immediately after collection.

Tracking

Data sources should be reviewed consistently over time.

Using the data

- ◆ Use data to position a community to optimize promotion and adoption of effective curricula.
- ◆ Bring data that shows a need for greater implementation of effective curriculum to the attention of the state, the local officials in charge of licensing early education centers, and the parents in order to make the case for expanded implementation.

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Children under age 6 who are expelled from child care or preschool due to behavioral problems

Definition

Children that are enrolled in child care or a preschool who are asked not to return due to behavioral problems encountered by child care or preschool staff.

Importance to social-emotional development

- ◆ Expulsion is a missed opportunity to intervene to prevent social-emotional problems.¹
- ◆ Escalation of problem in a preschool or child care setting to the point of expulsion demonstrates a lack of appropriate skills or resources to address difficult behavior.²
- ◆ Difficult behavior left unaddressed does not go away, and can become much more problematic for children in later school and family life.

Assign local priority

High Medium Low

Does state ECCS track it?

Yes No

Outcome

Rate of preschool expulsion.

Numerator

Number of expulsions in the past year.

Denominator

Total number of children in early education settings, child care and preschool.

Age range

Children from 24 months to 6 years of age.

Possible sources of data

- ◆ Department of Health licensing of preschools or child care providers will be source for denominator.
- ◆ It may be necessary to call or survey each child care provider or preschool and ask them about enrollment and expulsions. It is important to guarantee them that the data will remain anonymous.

Possible pitfalls

- ◆ Confidentiality may be a source of difficulty because expulsion is uncommon. Publicly available data must not include the identity of individuals. Localities can collect data from many years or a larger geographical area to ensure that no one can conclude the identity of the individual from the results presented.³
- ◆ The accuracy of records of the number of early education settings and their current enrollment is essential and will depend on local record keeping.

How can the state or tribe help?

- ◆ The state or tribe may already have information on expulsion from child care providers or preschools.
- ◆ The county, state, or tribe may be able to provide access to appropriate services for expelled students.

Baseline

If expulsion is rare in a community it may be that the baseline is zero. Concluding this will take a few

years of observation. If expulsion is a more frequent occurrence in a community then an average of 2 or 3 years will establish a baseline.

Tracking

Data sources should be reviewed on an annual basis.

Using the data

- ◆ Use information to change local practice through program and training. For instance, mental health consultations and a social emotional curriculum can be required if not already universal.
- ◆ By comparing local data with state and national rates of expulsion, in the event that local rates are significantly higher than the state or national rates, powerful argument for state attention to local need can be made.
- ◆ Approach the state to seek further funding for small local child care entities to have access to mental health services.
- ◆ Investigate possible reasons for unexpected results to better shape interventions.

Endnotes

1. Gilliam, W. S.; Shahar, G. 2006. Prekindergarten Expulsion and Suspension: Rates and Predictors in One State. *Infants and Young Children* 19: 228-245.
2. Gilliam, W. S. 2005. *Prekindergarteners Left Behind: Expulsion Rates in State Prekindergarten Systems*. New Haven, CT: Yale University Child Study Center.
3. Brady, H.E.; Grand, S.A.; Powell, M.A.; Schink, W. 2002. Access and Confidentiality Issues with Administrative Data. In Ver Ploeg, M.; Moffitt, R.; Citro, C. (Eds.), *Studies of Welfare Populations: Data Collections and Research Issues*: National Research Council.



Rate of substantiated cases of abuse and neglect among children birth to age 6

Definition

Substantiated cases of abuse and neglect are cases that have been reported to child protective services, investigated, and found to be actual cases of abuse or neglect.

Importance to social-emotional development

- ◆ Children who experience abuse and neglect are at high risk for social-emotional problems and later development of mental health problems.¹
- ◆ Knowledge of the rate of abuse and neglect will allow communities to plan for promotion of social emotional well-being within the affected population and make use of appropriate interventions to prevent, and mitigate the effects of, abuse and neglect.
 - Evidence has shown that targeted interventions can help prevent child abuse before it occurs.²
 - Evidence exists to show that mental health interventions with children who have experienced child abuse are effective.³

Assign local priority

High Medium Low

Does state ECCS track it?

Yes No

Outcome

Number of cases per 1000 children per year (rate of cases).

Numerator

Number of cases substantiated.

Denominator

Total population of children from 0-6 years of age.

Age range

Children from 0-6 years of age.

Possible sources of data

- ◆ All states must report child abuse data to the federal government. (http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can).
- ◆ May need to request the state department of children's services (ACS, DCFS, etc) to extract the local data and give it to you.

Possible pitfalls

- ◆ Confidentiality must be maintained. Looking at multiple years or multiple locations may address this concern. For example, looking at the previous 5 years for a small population or examining number of bordering counties at once can ensure that the identity of the children and families involved remains confidential.
- ◆ Defining the age range may be an issue because traditionally data for child welfare is for all children 0-18. It may be necessary to work with local child protective agencies to promote understanding of the importance of early childhood social-emotional health and plan to collect data for the appropriate age range in the future.
- ◆ Defining the community may be difficult. All stakeholders must come to consensus on how to deal with geographic issues of reporting.

How can the state or tribe help?

State child welfare agencies have experience with the child and family services review, so developing a close working relationship with the state to look at this measure can be helpful.

Baseline

It may take a number of years to establish a baseline depending on a given community's population size.

Tracking

Data tracking should be coordinated with the state's review process.

Using the data

- ◆ Determine what changes in the numbers mean. With this indicator it is important to look critically at the numbers and ask questions about what can the indicator really show. For example:
 - If the number goes up, this may be:
 - a negative finding, because it indicates more abuse and neglect taking place; or
 - a positive finding, because it indicates that more abuse and neglect is being identified and stopped.
 - If the number goes down, this may be:
 - a positive finding, because it indicates less abuse and neglect taking place; or
 - a negative finding because it indicates less abuse and neglect is being identified and stopped.
 - Look at these numbers in context and use common sense. For example:
 - if the child protective agency staff was just cut by 25% because of budget woes and the rate of abuse goes down that may not be because of less abuse but less abuse being identified; or
 - if the child protective agency has been working for years to improve prevention services and now has universal home visiting for at risk families, then reductions in abuse may be real.
- ◆ Changes in the rate can then be used to identify:
 - Need for further serviced
 - Effective programs and actions

Endnotes

1. McCarthy, J.; Marshall, A.; Irvine, M.; Jay, B. 2004. *An Analysis of Mental Health Issues in States' Child and Family Service Reviews and Program Improvement Plans*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.
2. Eckenrode, J.; Ganzel, B.; Henderson, C.R. Jr.; Smith E.; Olds, D.L.; Powers, J.; Cole, R.; Kitzman, H.; Sidora, K. 2000. Preventing Child Abuse and Neglect with a Program of Nurse Home Visitation: The Limiting Effects of Domestic Violence. *JAMA - Journal of the American Medical Association*. 284(11):1385-1391.
3. Fisher, P.A.; Gunnar, M.; Dozier, J.; Pears, B.; Pears, K. 2006. Effects of Therapeutic Interventions for Foster Children on Behavioral Problems, Caregiver Attachment, and Stress Regulatory Neural Systems. *Annals of the New York Academy of Sciences*. 1094: 215–225.



Proportion of children birth to age 6 in foster care for long periods of time whose living situations are stable

Definition

“Permanency and Stability of Placement” is defined by the Federal Child and Family Services Review as having four parts, We are focusing only on the fourth part, permanent stability, for indicator 7. This does not undermine the importance of the other three, which are timeliness and permanency of reunifications, timeliness of adoptions, and permanency for children in foster care for long periods of time.

Please see website for full description: <http://www.acf.hhs.gov/programs/cb/cwmonitoring/index.htm>

Importance to social-emotional development

- ◆ Children that have been placed in foster care are already at significant risk for social-emotional development problems.¹
- ◆ Foster care presents an opportunity to promote social-emotional well-being and prevent further experiences that may be detrimental to mental health.²
- ◆ Healthy relationships are crucial in the early childhood years in developing social-emotional skills, so ensuring the stability of relationships during time spent in foster care is a crucial marker of how the child welfare system is promoting social-emotional development for high risk children.

Assign local priority

High Medium Low

Does state ECCS track it?

Yes No

Outcome

Placement stability consists of three measures:

- ◆ Percent of the total number of children who were served in foster care during the year and who were in foster care at least 8 days but less than 12 months who had two or fewer placement settings.
- ◆ Percent of the total number of children who were served in foster care during the year and who were in foster care for at least 12 months but less than 24 months who had two or fewer placement settings.
- ◆ Percent of the total number of children who were served in foster care during the year and who were in foster care at least 24 months who had two or fewer placements.

The three outcomes should be tracked individually.

Numerator

The number of children in each of the relevant denominator groups with more than 2 placements in the year under review.

Denominator

Varies depending on the specific outcome:

- ◆ Number of children in foster care more than 8 days but less than 12 months.
- ◆ Number of children in foster care more than 12 months but less than 24 months.
- ◆ Number of children in foster care more than 24 months.

Age range

Children from 0-6 years of age.

Possible sources of data

- ◆ Each state participates in Child and Family Service Reviews of their states child welfare programs done by the Children's Bureau of the Administration for Children and Families of the US Department of Health and Human Services. Each state's review can be viewed at: http://basis.caliber.com/cwig/ws/cwmd/docs/cb_web/SearchForm.
- ◆ Working closely with the state child welfare agency localities may create opportunities to review the state information on how a specific locality is doing.

Possible pitfalls

- ◆ All states are required to collect this data at the state level as part of their Child and Family Service Reviews. Collecting the same data at the local level will require close work with the state welfare agency to obtain summary data on foster placements by specific locality or county.
- ◆ As in substantiated cases of child abuse and neglect (indicator #6) special attention must be paid to issues of confidentiality.
- ◆ The boundaries the specific locality will need to be well defined as in indicator #6.
- ◆ The age range will need to be consistent across all three measures.
- ◆ States do not report data by age group in the Child and Family Services Review so breaking the data down by age will be important.

How can the state or tribe help?

Because state's child welfare agencies have experience with the Child and Family Services Review localities should develop a close working relationship with them to look at this measure at the local level and learn from their experience.

Baseline

It may take number of years to establish a baseline depending on population size and rate of foster care placement in the community.

Tracking

Data tracking should be coordinated with the state's review process.

Using the data

- ◆ An increase in the proportion of children having fewer placements during their time in foster care is good trend.
- ◆ If the score for placement stability goes down the child welfare system needs to work on stability of placement for children in long term foster care.

Endnotes

1. O'Connell, M.E.; Boat, T.; Warner, K.E.; (Eds.). 2009. *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities*. Washington, DC: The National Academies Press.
2. McCarthy, J.; Marshall, A.; Irvine, M.; Jay, B. 2004. *An Analysis of Mental Health Issues in States' Child and Family Service Reviews and Program Improvement Plans*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.