2015-2016 Evaluation Plan for
Las Cumbres Community Services

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Organization Overview

Las Cumbres Community Services (LCCS) provides both center-based and home-based services in a 6,000 square mile area, encompassing Los Alamos, Rio Arriba, Santa Fe, and Taos counties. Services span multiple specialties including behavioral health, early childhood programs, and respite care for caretakers of adults with disabilities. Families referred for services are often dealing with multiple stressors such as poverty, trauma, drug abuse, incarceration, custody concerns, parental mental health issues, and domestic violence. Families are referred to Las Cumbres from health care providers, educators, or the Child Protective Services Division of the New Mexico Child, Youth and Families Department (CYFD).

The behavioral health services program offers a range of services for families with children ages birth to six who have social and emotional vulnerabilities, and special developmental needs. The early childhood programs include traumatized child treatment programs and the Family Infant Toddler (FIT) program which provides services to families with children at risk of developmental delays, with a focus on physical, emotional, social, and cognitive development. LCCS's infant team also works with children under 3 years of age and those who have been removed from their home. The behavioral health services provided to children in the Community Infant Program (CIP) are the focus of the evaluation.

CIP seeks to provide home-based and center-based support focused on the mental health of infants from birth to age six. The goals are to ensure a safe environment for families, decrease caregivers' stress levels, and improve caregivers' relationship with their child or children. CIP works with families referred for services due to concerns about the parents' or caregivers' ability to provide a secure and trusting relationship with their children, or are at risk for abusing or neglecting their children.

Evaluation Focus

The eventual goal is to create a multi-year evaluation plan that meets the needs of the organization. To do so requires investigation into the current status of the organization through the use of focus groups, interviews, data collection, and a review of academic literature that supports the goals and logic model of the organization. The collaboration between the Evaluation Lab and LCCS encourages sharing of evaluation plans, program models, logic models,

community statistics, literature reviews, and instruments developed by or in conjunction with the Lab. The final report generated at the end of the evaluation process are the intellectual property of the organization. The Evaluation Lab will not publish any of the document on its website or any other format without the written permission of the director for LCCS.

CIP offers five therapeutic models: art therapy for children, child centered play therapy, Circle of Security parenting curriculum, parent-child therapy, and dialectical behavioral therapy (DBT) for parents. This evaluation process will explore the effectiveness of care coordination among LCCS's child and family services programs and investigate how to measure short and long term outcomes of their clients. This includes looking at the quality of the data collected by the organization, as it is important for LCCS to monitor the efficacy of its program.

Major economic and social problems are linked to low levels of skill and ability in society.[1] Cognitive abilities, socio-emotional skills, physical and mental health, attention, motivation, and self-confidence all contribute to the ability to function and perform in society at large.[2] Family environments of children are an important influence on their ability to function as an adult and the seminal Adverse Childhood Experiences (ACE) study showed that the effects of adverse childhood experiences follow children into adulthood.[3] If children and families in distress receive early intervention, that intervention can improve the cognitive, socio-emotional, and physical health of children, and improve their life chances.[4]

The literature on play and art therapy attests to their positive impacts on children with behavioral and emotional problems. Both therapies allow children to explore their feelings through imagination and creative outlets. Child-centered play therapy does not attempt to control or change the child, and is based upon the theory that a child's behavior is caused by the drive for self-realization.[5] Play therapists do not force children to address a specific problem or issue, rather they allow children to play out their experiences and feelings.

Art therapy focuses on the creative process using media for non-verbal communication. An individual's experiences, feelings, and thoughts can be expressed through art therapy which can result in self-awareness, growth and resolution of conflict.[6] From the literature, we can conclude that both therapies are appropriate and should provide benefits to children. Research shows children under 8-years of age receive greater benefits from Child-centered play therapy,

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[1] Heckman, James J. 2008. "Schools, Skills, and Synapses," *Economic Inquiry*, 46(3):289-324.

[2] Ibid., 290.

[3] Felitti, Vincent J. et al. 1998. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults," *American Journal of Preventive Medicine* 14(1):245-258.

[4] Heckman, 290

[5] Landreth, Garry L. 1993. "Child-centered play therapy." *Elementary School & Guidance Counseling,* 28(1): 17-29.

[6] ibid.

as do African American and Hispanic children.[7] Children who have broad-spectrum behavioral problems, self-esteem, and caregiver-child relationship stress appear to benefit the most from this form of therapy. One study found marked reductions in the frequency and severity of many behaviors, including poor concentration, hyperactivity, fighting, defiance, manipulation, poor motivation, unusually fearful, overeating, withdrawn, bedwetting, and nightmares.

Evaluation History

Las Cumbres has conducted evaluations in the past. The last formal evaluation took place in 2007-08, but was determined by the organization to not be substantially valuable. In 2011 a staff training was held to learn how to collect the right metrics for evaluation purposes. Follow up training in the consistent collection processes have not taken place since then. At present, Las Cumbres does not know if the survey instruments they use to collect data are administered and informative enough to be useful for program evaluation. Additionally, it was suggested that time constraints and buy-in from therapists may be barriers to continuing evaluation efforts.

Some funding sources require periodic reporting on demographic information, improvement in maternal health outcomes, and treatment outcomes for clients who receive services funded by specific grants. LCCS creates these reports by assigning an office manager to go through client files to draft reports on an as-needed basis. An automated process would allow records to be consistently and reliably entered into a database, thus streamlining the reporting process. By creating a sustainable record keeping plan for Las Cumbres, the organization will be able to easily and regularly generate evaluation data which can be used for program improvement and reporting to funding sources.

Evaluation Plan

The long-term goal of this plan is to create a self-sustaining system for Las Cumbres to conduct program evaluations for the early childhood behavioral intervention programs. The quality and frequency of information LCCS collects from clients must be evaluated and improved before moving on to an evaluation of their programs. An initial file audit will determine if viable data collection instruments are in place and whether these instruments are used consistently among clinicians. Las Cumbres has both a hard copy file system and an electronic medical records system. The organization has reported inconsistent transcription of notes and instrument findings between the paper and electronic systems.

There are a number of instruments used by therapists at LCCS to monitor client progress. If an instrument is found to be collected more than once, the second evaluation activity will be a sample analysis to determine the quality and reliability of the instrument for use in pre-post- testing. Quality is defined as accurately measuring intended outcomes of the program while reliability will determine if feedback from respondents is accurate and realistic. For

[7] ibid.

example, if 100 percent of respondents show improvement in all areas, the instrument may not be reliable. This analysis will begin with 50 cases selected for testing. The team will use an electronic format to allow for statistical analyses. It is vital to determine the reliability of the instrument to determine if the data is accurate. For example, if an instrument based upon self-reporting by clients shows all respondents have improved in all categories, the results should be considered suspect. Should the sample analysis reveal a viable and consistently collected instrument is currently used, a subsequent larger analysis of approximately 150 cases will constitute the third aspect of evaluation.

The last step of the evaluation plan will be to hold a focus group with the therapists at Las Cumbres. The therapists have first-hand knowledge of the processes for the selection and administration of the various instruments used by the organization. By understanding which instruments are selected, whether or not the instruments are used as part of the therapeutic process, and what barriers to consistency between the paper and electronic records exist, valuable recommendations can be made as a result of this evaluation. The development of policies on when and how tools are used will be an outcome of the focus group in order to increase consistency in the CIP process among clinicians. Lastly, should the findings from the previous activities indicate a different assessment instrument may be needed, research into determining if such a tool is available or the development of one for LCCS will be completed.

Evaluation Timeline

The file audit will take place in early December to determine if patient files include more than one iteration of the following forms: Parent Stress Indicators (PSI) which provides quantitative pre and post data, Ages and Stages Questionnaire (ASQ) examining child development, or LCCS's own quantifiable Feedback Form (FF). The ASQ and the PSI are administered more than once. The ASQ is used to determine if the child is meeting developmental milestones appropriate to their age. The PSI is the only pre- and post- administered assessment that provides quantitative feedback. The feedback form is administered at the end of services, in an effort to collect information on client satisfaction with services. Other forms, in addition to these, are listed in Appendix C. A summary report of the patient files and consistency of measurements found will be completed by December 18, 2015. Should one or more of the instruments (PSI, ASQ, FF) be completed regularly and more than one time during reception of services, a sample analysis will be done to determine the quality of data collected through the questionnaires.

Collection of the instrument (from the files), data entry, analysis, and drafting a report of the findings will occur from January through March of 2016. Recommendations on the use of assessment instruments will also be made. If one or more instruments are found to be collected regularly and provide reliable information, a larger statistical analysis will be done to evaluate the quality of Las Cumbres' early childhood behavioral intervention programs. The PSI and FF

would be used to evaluate aspects related to parents, either parent stress or parent satisfaction. Should the ASQ be used, the impact on children will be evaluated in terms of meeting developmental benchmarks. Data collection, entry, analysis will take place beginning February 15, 2016 with a report of the findings completed by March 25, 2016.

A focus group with Las Cumbres' therapists will allow for further evaluation of the data capturing processes. By interviewing the therapists in a group setting, we hope to capture collective perspectives on the processes for data collection, specific instrument preferences, and other suggestions regarding outcomes tracking. The focus group questions will be drafted, vetted by the Evaluation Team, and finalized by February 24, 2016. The focus group will take place during the week of February 29, 2016 at the LCCS's main office in Espanola with a summary report completed by March 18, 2016.

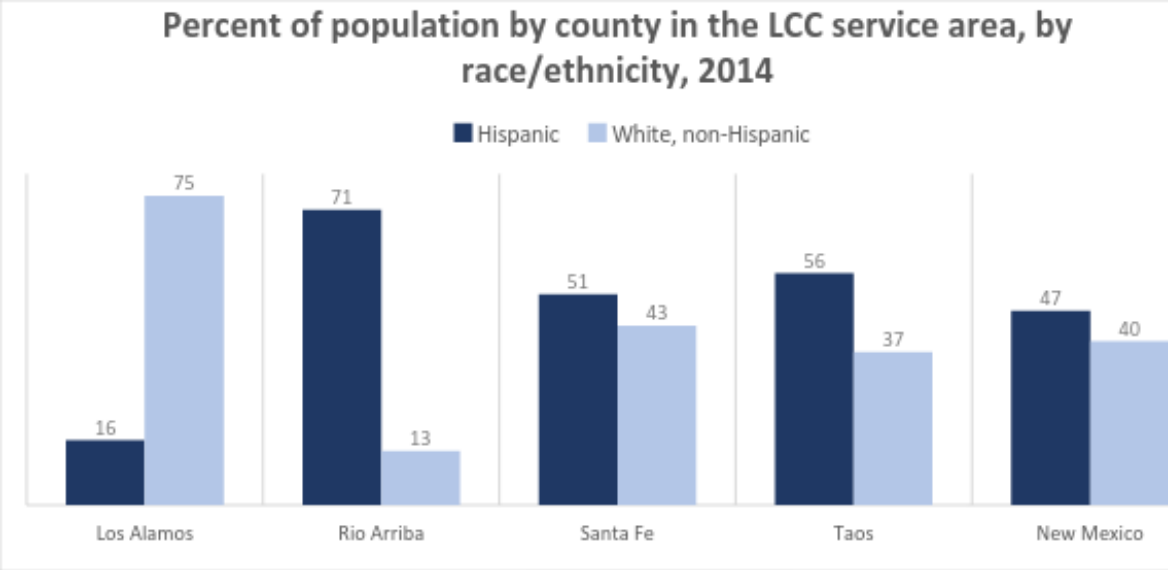
Should it be necessary, a new instrument will be found or developed as the final evaluation activity for this year. This instrument could be a modification of the FF currently used or may be a completely new instrument. This instrument needs to provide data specific to the evaluation goals of Las Cumbres, reasonably simple to complete, and compatible for entry into the EMR system for ease of report generation. The mode and frequency of implementation of this instrument needs to be flexible to fit the needs of the organization. The new instrument will be found or completed by April 13, 2016.

Appendix A: Logic Model for Las Cumbres

Goals	Activities	Process Measures	Short Term Outcomes	Long Term Outcomes
Increase child and family resiliency	Art therapy	Number of referrals	Positive changes in child behavior	Maintain reduction in symptoms
Reduce trauma risk factors within the family system and the environment	Child-centered play therapy	Number of families served	Reduction in child symptoms of dysfunction	Sustain new behaviors
Improve parent-child relationships	Circle of Security (12 week parenting curriculum)	Frequency of sessions	Increased social-emotional development in child	Prevent child from needing increased levels of service
Resolution of systems related to trauma	Child-Parent Psychotherapy	Multiple services provided	Reduction in parent stress	
Decreased recidivism	Dialectical Behavior Therapy	Parent stress levels	Increase parent capacity to meet child's needs	
Prevent child abuse and maltreatment	Case Management of external activities (WIC, housing, Medicaid, SNAP)		Resolution of maternal depression	

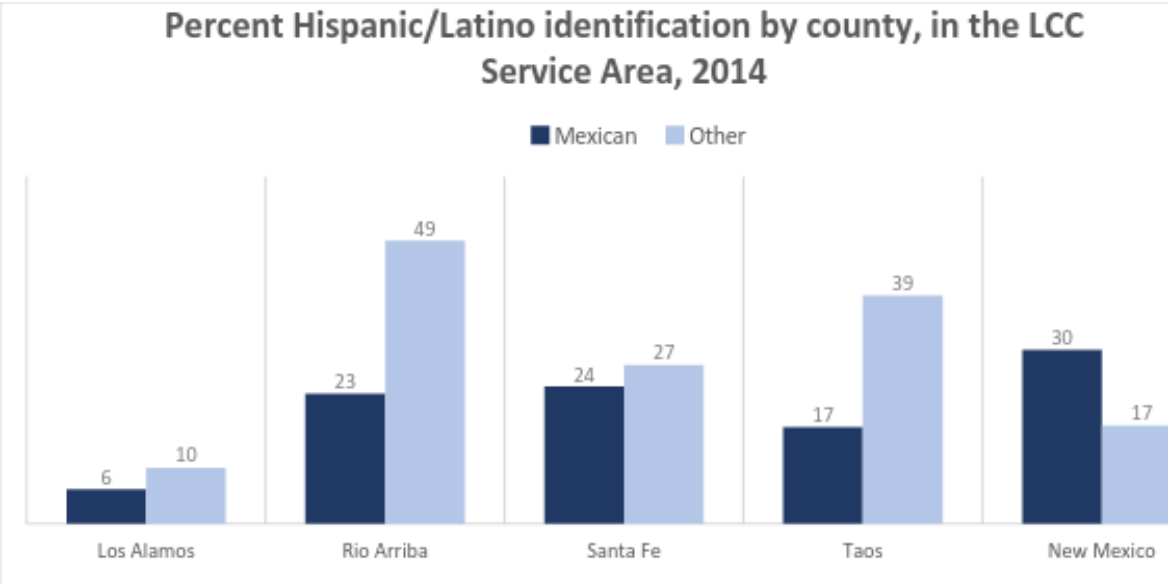
Internal Factors	External Factors
Staff turnover	Funding
Data collection processes	Limited number of service providers
Lack of service coding	Transportation to provide services
	Mental health stigma

Appendix B: Demographics of area served by Las Cumbres Community Services

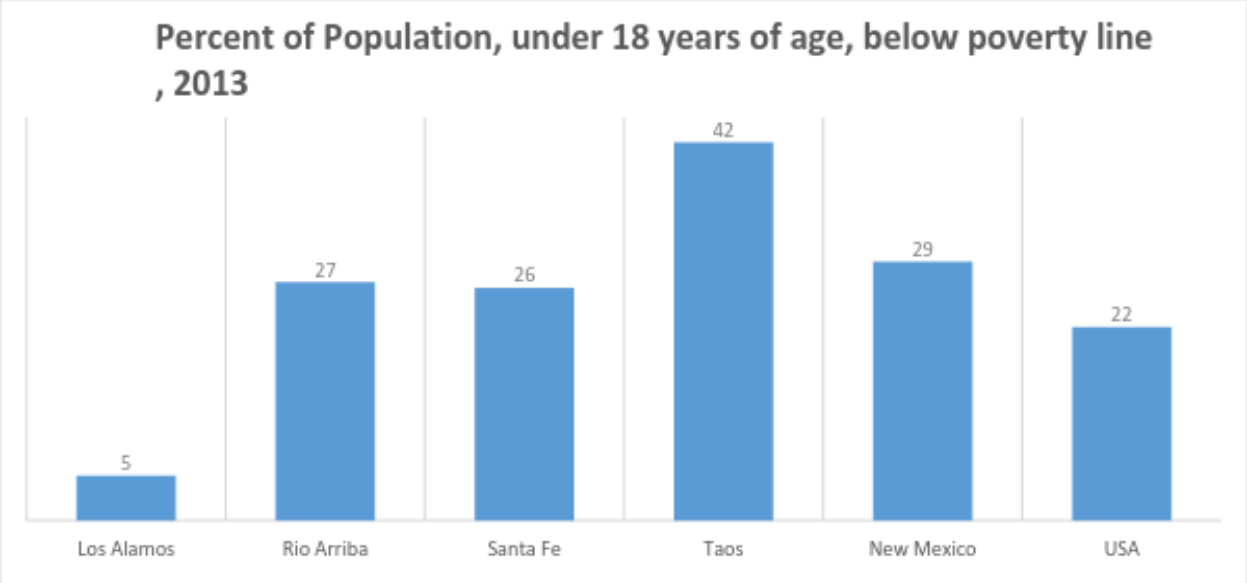


Source: 2014 American Community Survey, by county and state.

American Indians or Alaskan Natives make up 14% of the population in Rio Arriba County, 5% in Ta 2.3% in Santa Fe, and 1% in Los Alamos, while representing 8.5% of the state population. Individua identifying as African American make up less than 1% of the population in all counties represented above, and 1.8% of the population statewide. Asian and Pacific Islanders make up 6.4% in Los Alam 1% or less in the remaining counties, and 1.3% of the total state population.



Source: 2014 American Community Survey, by county and state. Other includes individuals who identify as Puerto Rican Cuban, which ranged between 0 and .4% in each county.



Source: 2013 American Community Survey, by county. http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Child Abuse Investigations, 2012-2013 by County				
County	Accepted Reports	% of Substantiated Reports	# of Substantiated Victims	# of Child Victims per 1000
Los Alamos	65	14	4	0.9
Rio Arriba	NR*	NR	42	4
Santa Fe	946	27	360	14
Taos	315	24	152	20
New Mexico	18,197	25	7,788	13

*Information not reported by county.

Source: 2012-2013 Community Health Profiles.
http://www.nmhealthcouncils.org/Resources/Pictures/LosAlamosProfile06072014.pdf
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http://www.nmhealthcouncils.org/Resources/Pictures/RioArribaProfile060702104.pdf

Appendix C: Las Cumbres Existing Instruments

Adverse Childhood Experiences (ACE)
Ages and Stages Questionnaire (ASQ)
Ages and Stages Questionnaire: Social-Emotional (ASQ-SE)
At-Risk Severe Emotional Disturbance Criteria Checklist (SED)
Circle of Security Assessment and Treatment Plan Organizer
Family Feedback Form (FF)
Life Stressor Checklist
Mental Status Exam
Parent Stress Indicator (PSI)
Psychosocial Assessment (PSA)
Traumatic Events Screening Inventory

Appendix D: Literature Review

This literature selection for the Las Cumbres evaluation focuses on the effectiveness of the therapy models used by the organization in their early childhood behavioral health services. The primary forms of therapy used by Las Cumbres, child-centered play therapy (CCPT) and art therapy, are reviewed in order to assess their respective impacts.

Play Therapy

According to Landreth (1993), CCPT does not attempt to control or change the child, and is based upon the theory that a child's behavior is caused by the drive for self-realization. Play therapists do not force children to address a specific problem or issue, rather they allow children to play out their experiences and feelings. Landreth argues play is serious business for children in that it builds up their confidence for dealing with their environment. Since language development lags behind cognitive development, the use of play therapy allows children to communicate their awareness of their environment while remaining safe from their feelings and reactions. The children are able to use symbolic language to express themselves in a safe environment.

Landreth presents the eight basic principles that should guide therapists' interactions with children (Landreth 1993, 20). According to these principles the play therapist:

1) is genuinely interested in the child and develops a warm, caring relationship.
2) experiences unqualified acceptance of the child and does not wish the child were different in any way.
3) creates a feeling of safety and permissiveness in the relationship, so the child feels free to explore and express him- or herself completely.

4) is always sensitive to the child's feelings and gently reflects those feelings in a manner that the child develops self-understanding.
5) believes deeply in the child's capacity to act responsibly, unwaveringly respects the child's ability to solve the personal problems, and allows the child to do so.
6) trusts the child's inner direction, allows the child to lead in all areas of the relationship, and resists the urge to direct the child's play or conversation.
7) appreciates the nature of the therapeutic process and does not attempt to hurry it.
8) establishes only those therapeutic limits that help the child accept personal and appropriate relationship responsibility.

The child is the focus. It is not a problem-focused or prescriptive approach.

Lin and Bratton (2013) conducted a meta-analysis of studies on CCPT and find that children who received CCPT interventions improved from pre-treatment to post-treatment by almost half of a standard deviation from children who received no treatment at all. Their study combined small-n studies on CCPT (controlled studies that were or were not peer reviewed, and both published and unpublished studies). Their meta-study found that the effectiveness of influenced by the child's age, child's ethnicity, caregiver involvement, and the presenting issue of the child. Children under 8-years of age receive greater benefits from CCPT, as do African American and Hispanic children. The best results are also found for children who have broad-spectrum behavioral problems, self-esteem, and caregiver-child relationship stress.

Art Therapy

Arguments supporting the effectiveness of art therapy have relied heavily on qualitative case study research. Art therapy focuses on the creative process using media for non-verbal communication. An individual's experiences, feelings, and thoughts can be expressed through art therapy which can result in self-awareness, growth and resolution of conflict. Art therapy is often used when acknowledgement or verbalization of feelings is difficult. Saunders and Saunders (2000) present a quantitative art therapy program evaluation model. Data were collected on 94 youth between the ages of 2 and 16 for a period of 3 years. Behavioral outcomes and therapeutic processes were evaluated in addition to the impact on subgroups including gender and age. A pre/post-test model was used to assess the amount of change in client (child) behavior from intake to exit. For each client child/family problems were recorded, 24 common symptomatic behaviors of life stressors were recorded in terms of frequency and severity, and goals were identified and recorded.

Saunders and Saunders found positive changes in the therapist-client relationship to be significant. The relationship indicators were eye contact, trust, accepting redirection and limits, and expression verbally, nonverbally, and visually. Age and gender were not significant in terms of engagement in the therapeutic process, however, the correlation of number of therapeutic sessions attended was significant and positive. Declines in symptomatic behavior from intake to exit of 24 stress-related behaviors were significant for both frequency and severity. These behaviors included poor concentration, hyperactivity, fighting, defiance, manipulation, poor motivation, unusually fearful, overeating, withdrawn, bedwetting, and nightmares among others. No statistical difference between genders or among age was found. A majority of children exiting had met their therapy goals with 65% meeting their first goal, 58% meeting their second, and 57% meeting their third therapy goal. However, without a control group, the findings lack comparison.

Conclusion

The articles reviewed support the program of CCPT and art therapy offered by Las Cumbres' child therapists. Post-Traumatic Stress or Trauma and Loss spectrums are two examples of broad-spectrum disorders that Las Cumbres counselors encounter. Further, Las Cumbres works with children from predominantly Hispanic counties in the state, between 0 to 6 years of age. Additionally, the results of Saunders and Saunders (2000) analyses illustrates art therapy has significant positive impact on children. While the study covers a youth age group broader than Las Cumbres serves, the authors did not find statistical significance on the impact of therapy among age comparisons meaning it was equally effective from clients age 2 to 16. These factors indicate that the CCPT and art therapy programs run by Las Cumbres should have a significant, positive outcome for the children receiving services. It may be possible to use the principles and messages outlined by Landreth (1993) and the survey indicators presented by Saunders and Saunders as points for evaluation of the services provided by Las Cumbres.

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Appendix E: Further Reading

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Appendix F: Las Cumbres Community Services Evaluation Plan Timeline

Activity	Description	Period	Notes
1) File Inventory	Gain access to files and electronic records	Completed by Nov 30	Confidentiality agreement required
	Determine if the Parent Stress Indicators (PSI) form has been completed more than once Determine if the Ages and Stages Questionnaire (ASQ) has been completed more than once Determine if the Feedback Form (FF) has been completed more than once	Completed by Dec 11	
	File inventory report	Completed by Jan 15	
2) Sample Analysis*	Analyze instruments (PSI, ASQ, and/or FF) with pre- post-information to test quality of existing data	Data entry Jan 25-29 Analysis Feb 1-5 Writing Feb 8-12	*Only if PSI, ASQ and/or FF are found to be collected more than once per client
	Sample analysis report	Completed by Feb 12	
3) Focus Group	Secure UNM Institutional Review Board approval	Completed by Feb 26	Submitted by Dr. Binder and the Evaluation Lab
	Prepare focus group questions	Questions drafted by Feb 19 Questions finalized by Feb 26	Draft questions submitted to Evaluation Team (Melissa, Jeff, and LCCS) for review
	Interview lead clinician	Completed by Feb 26	
	Focus group with therapists	Week of Feb 29 - Mar 4	

	Focus group report	Completed by Mar 18	
4) Full Analysis*	Larger-n analysis on PSI, ASQ, and/or FF in the same manner as the sample analysis	Data entry Feb 15 - Mar 4 Analysis Mar 7-18 Writing Mar 21-25	*Only if PSI, ASQ and/or FF are found to be viable instruments in the sample analysis
	Full analysis report	Completed by Mar 25	
5) New Instrument(s)*	Modification of FF or generate a new form	Completed by Apr 1	*If needed
	Streamlined reporting system for therapists	Completed by Apr 1	Potentially administered once per month