2017-2018

Evaluation Plan for Las Cumbres Community Services

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1. Introduction

Since 1971, Las Cumbres Community Services (LCCS) has been dedicated to providing quality services, public awareness, and integrated community support by serving those facing social, emotional and developmental challenges in the rural northern New Mexican counties of Los Alamos, Rio Arriba, Santa Fe, and Taos. Las Cumbres specializes in serving families dealing with trauma, poverty, substance abuse, incarceration, domestic abuse, custody concerns, and parental and infant mental health issues. As the only trauma treatment provider specializing in infant and early childhood mental health in northern New Mexico, many health care providers and educators, along with the Child Protective Services Division of New Mexico, Youth and Families Department (CYFD), refer families to LCCS.

Multiple Las Cumbres programs focus on early childhood development and the well-being of children ages zero to six years old in LCCS's Child and Family Services Department. Among these programs is Behavioral Health, which is the focus of this evaluation. The goal of Behavior Health program is to promote healthy attachment and social-emotional development in children prenatal to age six and their families. Services are delivered both in the home and at the agency, and families are able to access multiple services at once to help cope with stressors such as poverty, substance abuse, incarceration of a family member, CYFD involvement, mental health issues and domestic violence.

This current evaluation fits within the goal of a multi-year evaluation to assess the effectiveness of LCCS's programs and services. The main objective of this evaluation is to determine whether parents feel that as a result of participating in the Behavioral Health program, they are more competent as parents, handle stress more effectively, and are more likely to be raising their children in an environment free of violence. LCCS is also interested in learning about what aspects of the program are effective, and where adjustments can be made to improve services and positive outcomes.

2. Purpose of Evaluation

The purpose of the Evaluation Lab is to build evaluation capacity within partnering organizations. This is the third year LCCS has worked with the Evaluation Lab. In its first year, the Evaluation Lab Team deduced that LCCS clinicians were not consistent in their data collection. This discovery led to a focus group where clinicians disclosed that they were not sure where, on paper or in the EMR system, and with what tool they should track certain aspects of client development and growth. Building on these findings from the first year, the second year of evaluation focused on an analysis of the EMR-Bear system and data to find out what reports, tracking, and information were captured in EMR-Bear for process indicators that measure program outcomes.

This year's evaluation activities will include interviews and focus groups with current or former clients of the Behavioral Health program. The purpose is to ascertain whether parents feel, as a result of participating in the program, they are more competent as parents, have healthier relationships, handle stress more effectively, and are more likely to be raising their children in a stable environment free of stressors and adverse experiences. LCCS is also interested in learning about what aspects of the Behavioral Health program are effective, what could be improved, and what challenges parents have encountered that they wish LCCS had better prepared them for.

The evaluation plan revolves around three primary questions for the Behavioral Health program:

1. Is the program producing its intended outcomes?
2. Where is the program falling short in meeting its intended outcomes?
3. Where and how can the program improve its effectiveness to deliver the intended outcomes?

Using the logic model outcomes as a guide, the evaluation team will develop questions for two interviews and one focus group in order to answer these key questions. The evaluation team will also seek input from behavioral health clinicians to determine what other questions should be included. Two in-depth interviews will be conducted with one current and one former client who have participated in one of the individual behavioral health programs. A focus group will be conducted with current clients who are participating in one of the established group therapy programs. LCCS will reach out to clients regarding the interviews and focus group, and the evaluation team will conduct the interviews and focus group.

Ideally, the interviews will include perspectives from parents who felt that the services they received had a positive impact and parents who were less satisfied with the services they received.

LCCS would like to build toward an evaluation system where the outcomes mentioned above are regularly assessed, and where the Annual Consumer Survey, the Family Feedback Form, and possibly TIPS (Trauma-Informed Practice Survey) are embedded in organizational processes.

3. Logic Model

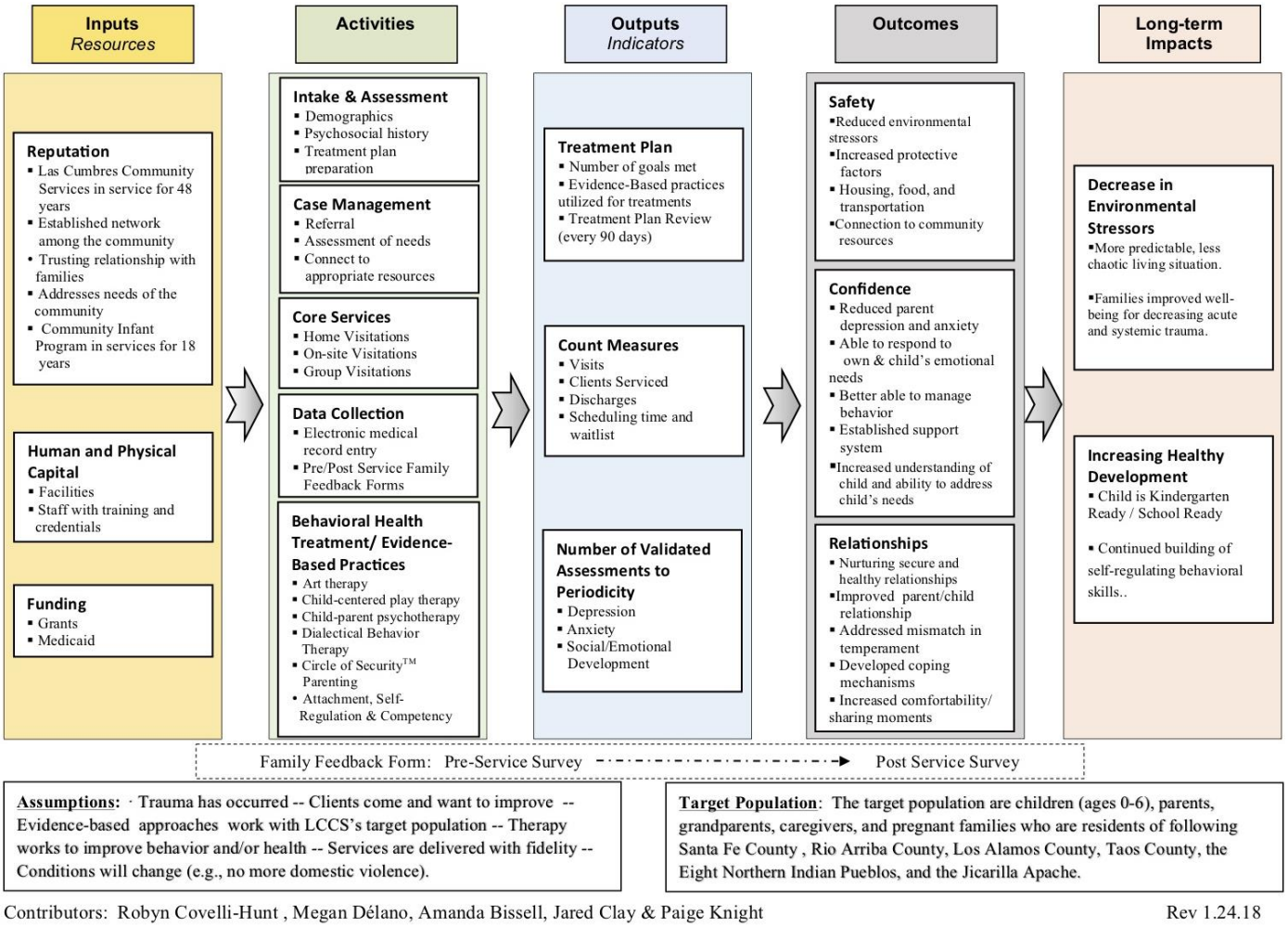
The logic model below provides a schematic of the Behavioral Health program. (See Figure 1.) At intake, clients are assessed and connected to the appropriate in-house services, or referred to external agencies, or other community resources to best address their needs. LCCS collects demographic information and psychosocial history, builds a list of symptoms, and prepares an initial treatment plan. Treatment activities may include one of six evidence-based and evidence-informed therapies:

- Art therapy,
- Play therapy,
- Child-Parent Psychotherapy,
- Dialectical Behavioral Therapy (DBT),

- Circle of Security Parenting© and
- Attachment, Self-Regulation and Competency (ARC).

These activities are conducted at home or on-site, and include individual therapy, parent-child dyad therapy, and parenting support groups. Throughout treatment, data are collected through multiple screens and surveys, including a pre/post Family Feedback Form, validated assessment measures conducted at periodically, and client progress tracked by clinicians in an electronic medical record.

Figure 1. Las Cumbres Community Services, Early Childhood Behavioral Health Program Logic Model



The outputs of the programs fall into three areas that include a treatment plan with stated goals and prescribed evidence-based practices; counts of the number of visits, clients served, discharges, canceled appointments, and the number of clients on a wait list; and the screening assessments administered for depression, anxiety. and social/emotional development.

There are three primary desired outcomes: increased safety, parental confidence, and improved parent/child relationship. Safety outcomes include increased protective factors

and safety in housing, transportation, and nutrition. Confidence outcomes include reduced parental depression and anxiety, increased ability to respond to emotional needs and management of behaviors, and the ability to establish a support system between parent and child. Relationship outcomes include a stronger parent/child relationship, better ability to address a mismatch in temperament, the development of coping mechanisms, and an improved level of comfort with sharing parent/child moments.

The expected impact is a decrease in environmental stressors and an increase in healthy childhood development. A decrease in environmental stressors means more predictable, less chaotic living situations and less acute and systemic trauma. An increase in healthy development means the child is ready for kindergarten and the child continues to build self-regulating behavioral skills.

A review of early childhood and developmental literature highlights the need to mitigate the effects of Adverse Childhood Experiences (ACEs) for healthy development by involving caregivers to build a positive parent-child relationship and improve the child's environment. The scientific research on the neurobiological level clearly shows that toxic stress, which refers to strong, frequent, and/or prolonged activation of the body's stress-response systems, and adversity, can have a detrimental impact on brain development. Investment into early childhood programs and trauma-focused infant and child services, such as those offered by LCCS' Behavioral Health program, holds the promise of improving children's life chances. (See Appendix A for a detailed literature review).

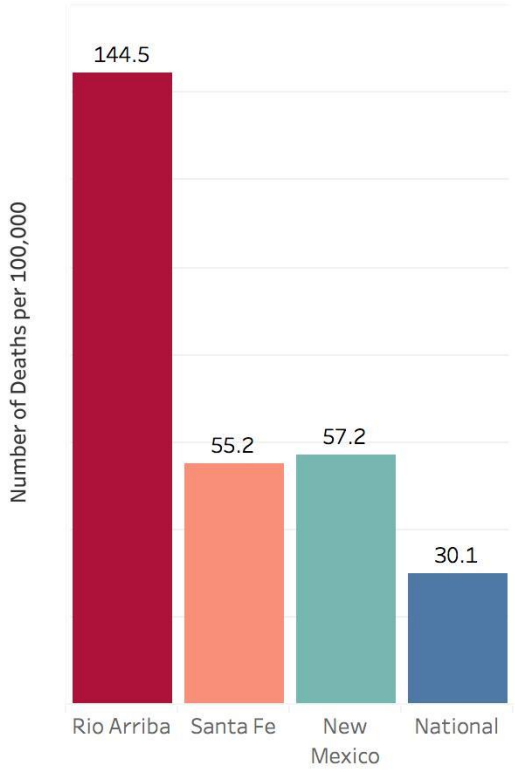
4. Context

Las Cumbres offers its Behavioral Health program in two northern New Mexico counties: Rio Arriba and Santa Fe. Children in these counties are exposed to more trauma and adversity than state and national averages. Data from the New Mexico's Indicator-Based Information Systems (NM-IBIS) and the Annie E. Casey Foundation KIDS COUNT Data Center allow us to explore several indicators of childhood stress and trauma[1]. Comparing these two counties to New Mexico and national averages clearly illustrates why behavioral health programs are needed in this region.

Santa Fe and Rio Arriba counties have high rates of behavioral health-related deaths. Rio Arriba County in particular has an alarmingly high rate of alcohol-related and drug overdose deaths. For the most recent data available, the rate of alcohol-related deaths in Rio Arriba County was 144.5 per 100,000, over double the rate of 55.2 in Santa Fe County and 57.2 for the state as a whole. These rates are well above the national rate of 30.1 per 100,000. (See Figure 2).

[1] NM-IBIS is a data and information resource provided by the New Mexico Department of Health. See http://ibis.health.state.nm.us. KIDS COUNT is a project of the Annie E. Casey Foundation to track the well-being of children in the United States. See http://datacenter.kidscount.org.

Figure 2. Alcohol Related Deaths per 100,000, 2011-2015



Alcohol related deaths for each County in comparison to New Mexico and national rates.
Source: New Mexico's Indicator-Based Information System (NM-IBIS), https://ibis.health.state.nm.us

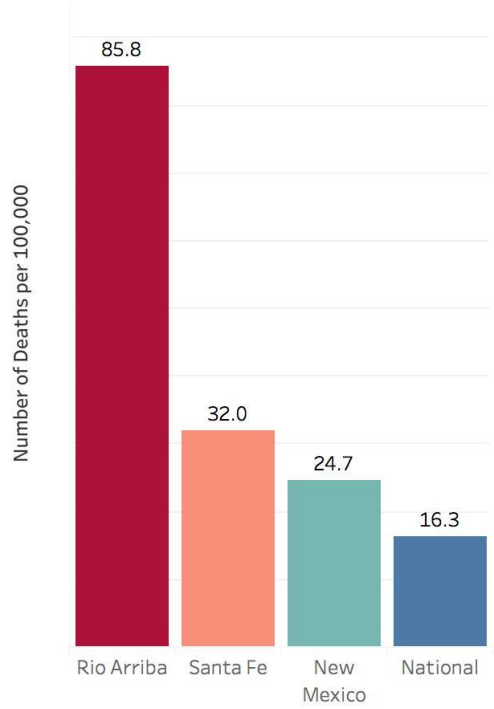
Similarly, the drug overdose death per 100,000 was 85.8 in Rio Arriba County and 32.0 in Santa Fe County. This compares unfavorably with lower rates of 24.7 in New Mexico and 16.3 nationally. (See Figure 3).

State and local suicide deaths were also above the national average. The rate of suicide deaths per 100,000 was 27.5 in Rio Arriba County, 20.0 in Santa Fe, and 19.8 in New Mexico, compared with only 13.3 nationally. (See Figure 4).

These figures suggest that Rio Arriba and Santa Fe counties are clearly challenged by behavioral health issues.

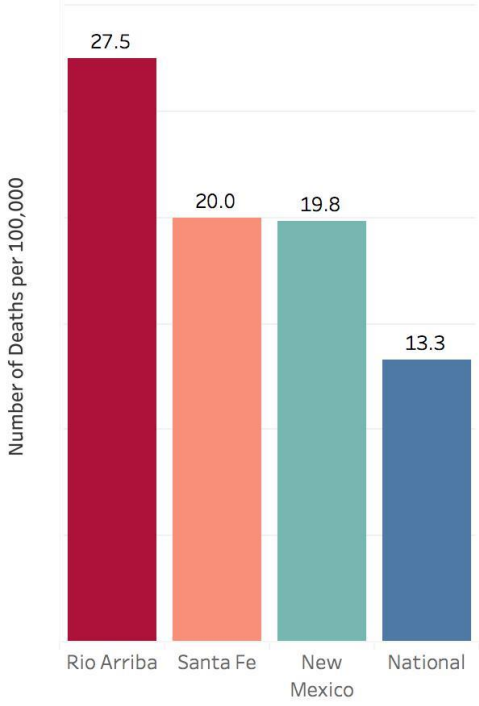
Rio Arriba and Santa Fe also face extreme rates of child neglect or abuse. The incidence of substantiated child abuse or neglect was 58 per 1,000 children in Rio Arriba County, six times the national rate of 9 per 1,000 children. In Santa Fe County and New Mexico as a whole, the rate was 25 per 1,000 children. (See Figure 5).

Figure 3. Deaths due to Drug Overdose per 100,000, 2011-2015



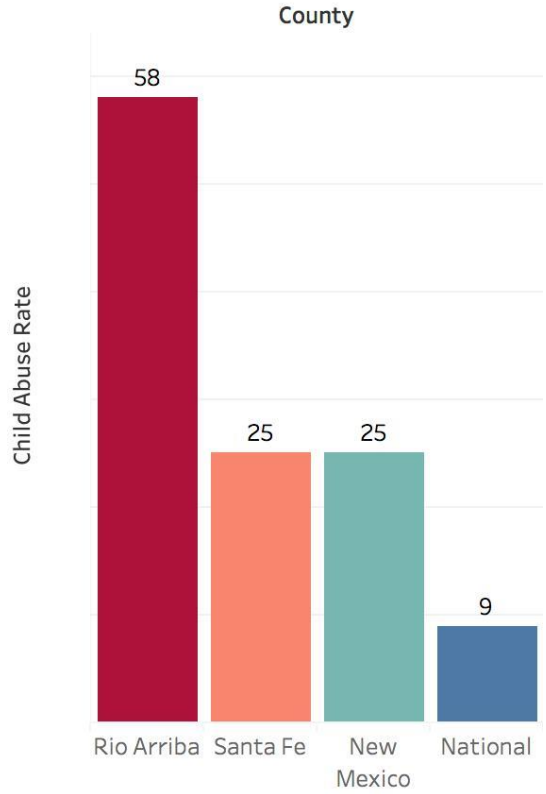
Drug overdoes related deaths for each County in comparison to New Mexico and national rates.
Source: New Mexico's Indicator-Based Information System (NM-IBIS), https://ibis.health.state.nm.us

Figure 4. Deaths due to Suicide, 2011-2015



Deaths due to suicide for each County in comparison to New Mexico and national rates.
Source: New Mexico's Indicator-Based Information System (NM-IBIS), https://ibis.health.state.nm.us

Figure 5. Child Abuse Rate: Number of substantiated child victims per 1,000 children (SFY 2017)

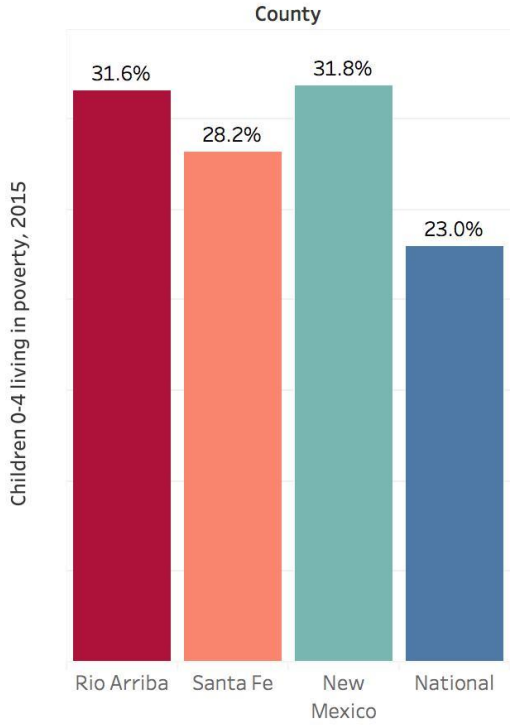


Sum of Child Abuse Rate for each County. Color shows details about County in comparison to New Mexico and the United States.
Source: The Annie E. Casey Foundation, KIDS COUNT Data Center

Finally, the child poverty rate in Rio Arriba and Santa Fe counties, as 32 and 28 percent, respectively, is much higher than the United States rate of 23 percent, but similar to the 32 percent rate for New Mexico. (See Figure 6).

The data show that rates of behavioral health-related deaths, child abuse and neglect, and child poverty in Rio Arriba and Santa Fe counties far exceed the adversity experienced nationally. These depressing statistics demonstrate the critical need for LCCS' Behavioral Health program.

Figure 6. Children 0-4 Living in Poverty, 2015



Child poverty rate for each County. Color shows details about County in comparison to New Mexico and the United States.
Source: The Annie E. Casey Foundation, KIDS COUNT Data Center

Although the Behavioral Health program only operates in Rio Arriba and Santa Fe counties, LCCS offers services for disabled adults in Los Alamos, and to remediate developmental delays for infants in Los Alamos and Taos counties. Los Alamos is the wealthiest county in New Mexico (and the 6th wealthiest in the United States)[2]; Taos is quite similar to Santa Fe. Data for all LCCS-served counties are presented in Appendix B.

5. Evaluation Team and Other Stakeholders

The parties involved in this evaluation process are Las Cumbres Community Services and the UNM Evaluation Lab. The Evaluation Lab students are Jared Clay, Ph.D. candidate in Political Science, and Paige Knight, MA candidate in Public Policy, under the mentorship of Amanda Bissell. Amanda holds a Master in Public Health degree and is an Evaluation Lab Team Lead.

The representatives for LCCS are Robyn Covelli-Hunt, the Director of Development and Communications, Megan Délano, Chief Operations Officer, and Stacey Frymier,

[2]Lerner, Rebecca. "The 10 Richest Counties In America 2017." Forbes Magazine, July 13, 2017. Accessed on December 17, 2017 at https://www.forbes.com/sites/rebeccalerner/2017/07/13/top-10-richest-counties-in-america-2017/#3f7a96d42ef3.

Director of Child and Family Services. Robyn also serves as the Evaluation Coordinator.

6. Evaluation Activities and Timeline

The evaluation activities will take place from September 2017 through March 2018, with report presentations and revisions April to May 2018.

September

- Meet with organization to review timeline, discuss Statement of Work, and review the logic model Solicit suggestions for relevant literature

October

- Further review Statement of Work and make necessary revisions to logic model
- Review the relevant literature

November-December

- Finalize and confirm Statement of Work and logic model with organization
- Formulate interview and focus group questions

January

- Schedule interviews and focus groups
- Finalize interview and focus group questions with organizations

February

- Conduct interviews and focus groups
- Code and organize findings
- Begin drafting final evaluation report

March

- Draft evaluation report to organization to include report on data and measures and results from interviews and focus groups
- Organization receives report

April

- Meeting with LCCS to present and discuss evaluation report
- Evaluation report revisions
- Present poster at annual Evaluation Lab Workshop

May

- Final evaluation report that incorporates organization comments

Appendix A: Literature Review

Las Cumbres Community Services provides trauma-focused infant and early childhood mental health services across four counties in Northern New Mexico, a region where young children are disproportionately exposed to Adverse Childhood Experiences (ACEs), toxic stress, and significant environmental risk factors compared to state and national averages. ACEs are traumatic events such as abuse and household dysfunction that are experienced during childhood. Toxic stress refers to strong, frequent, and/or prolonged activation of the body's stress-response systems. The Annie E. Casey Foundation's 2015 Data Book of state trends in child well being ranked New Mexico 49th overall when considering economic well-being, education, health, and family and community factors.

Six evidence-based and evidence-informed models are used at LCCS: Child-Parent Psychotherapy (CPP), Attachment, Self-Regulation and Competency (ARC), Circle of Security Parenting© (COS), Dialectical Behavior Therapy (DBT), Child-Centered Play Therapy (CCPT) and Art Therapy. This array of programs promotes healthy attachment and social-emotional development in children prenatal to age six and their families.

One of the most important studies identifying the relationship between adult health risks and childhood exposure to emotional, physical and sexual abuse is the Adverse Childhood Experiences (ACE) study. The ACE study found a strong relationship between adverse childhood events and multiple health risk factors for adults. A questionnaire on childhood experiences was mailed to 9,508 adults who had just completed a standard medical evaluation. Seven categories were studied: psychological, physical, or sexual abuse, violence against mother, and living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned (Felitti, 1998). These seven categories were then measured against 10 risk factors (smoking, severe obesity, physical inactivity, depression, suicidal, alcoholism, drug abuse, parenteral drug abuse, numerous sexual partners (>50), and a history of STDs. Researchers found that prevalence of these health risks, and corresponding health issues, increased as the number of ACEs increased.

ACEs are thought be linked to risk factors such as smoking, alcohol and drug abuse, overeating, and risky sexual behaviors that survivors adopt as coping mechanisms for dealing with chronic stress that is a legacy of abuse, domestic violence, and general household dysfunction (Felitti, 1998). Thus ACEs lead to significant and costly health issues in adulthood.

To truly understand the gravity of ACEs and the effects they can have from childhood into adulthood, it is helpful to have an understanding of how these adverse events influence the developing brain. The brain plays a critical role in stress management, and it is both vulnerable and adaptable. Shonkoff *et al*. (2009) explains that the brain:

> interprets and regulates behavioral, neuroendocrine, autonomic, and immunological responses to adverse events, serves as a target of acute and chronic psychosocial and physical stress, and changes both structurally and functionally as a result of significant adversity (2254).

Brain development is especially important in early childhood, and when a child experiences toxic stress, the impacts can be detrimental to developing proper brain architecture. Extreme poverty, recurrent abuse, chronic neglect, and family violence are major risk factors (Shonkoff *et al.* 2009). These biological findings underline the importance of reducing toxic stress in early childhood.

A report from the Center on the Developing Child at Harvard University (2016) further consolidates key scientific concepts regarding early childhood trauma. Experiences early on "affect the nature and quality of the brain's developing architecture by influencing which circuits are reinforced and which are pruned due to lack of use" (5). Toxic stress can trigger genetic instructions that can disrupt the proper development of these neural systems, making it more difficult to respond to adversity later in life.

Both studies give recommendations for policies and practices that can help mitigate the long-term effects of adverse childhood experiences. Early childhood programs are key to elevating educational achievement and studies have shown a significant return on investment when low-income children receive early childhood intervention, such as greater economic productivity, decreased welfare dependence, and lower rates of incarceration (Shonkoff *et al.* 2009).

The Harvard report argues that positive early experiences can help counterbalance the consequences of adversity. The Conjunto Therapeutic Preschool at LCCS is one example of how the organization is able to provide nurturing, capacity-building experiences that can tilt the health and development in a positive direction. The report provides further opportunities to apply developmental science to child welfare programs, suggesting that child welfare systems can be simplified and streamlined in order to reduce demands on their clients. LCCS adheres to this principal by offering multiple services in one place at one time. An additional focus of the report was the importance of relationship building. LCCS is a trusted community partner in Rio Arriba county, where it has operated for more than four decades. This is a strong position from which to build relationships with clients.

Finally, the Harvard report focuses on the development of two foundational core capabilities: self-regulation and executive function. The report deems these as essential to both effective parenting and meaningful participation in the workforce and community later on in life. Acquiring these capabilities is one of the most important and challenging tasks of early childhood years, and strengthening these capabilities is critical for healthy development through adolescence and into adulthood. The report recommends prioritizing approaches that focus on active skill-building, and exploring approaches designed to target elements of executive function and self-regulation, like teaching people to "re-focus attention away from potentially negative and threatening aspects of their environment and toward those that present positive opportunities; to recognize and interrupt automatic responses; and to identify goals that are important to them and make realistic plans" (14). Adults need to build these skills so that their children can also develop the same capabilities.

One of the behavioral health programs that LCCS offers is Child-Parent Psychotherapy (CPP). CPP involves treatment sessions where the child and the primary caregiver participate together. The goal is to enhance the caregiver's ability to provide safe and

developmentally appropriate care to the child. Lieberman *et al*. (2005) recruited 75 mother-child dyads for a Randomized Control Trial (RCT) of CPP. Dyads were eligible if the child was 3-5 years of age and had witnessed domestic violence. Mothers were recruited via referrals from family court, domestic violence service providers, medical providers, pre-schools, child protective services and other government agencies, and then randomly assigned to one year of CPP or to a control group that received case management and referrals to other forms of therapy. Seventy-three percent of the mothers in the control group, and 55 percent of their children received individual therapy. The study took place in San Francisco and participants were predominately Latino.

Fifty dyads—27 in the CPP group and 23 in the control group—were available for a follow-up study six months following treatment. Lieberman *et al.* (2006) found that preschoolers who participated in CPP had fewer behavior problems six months after CPP, compared with those in the control group. Mothers had significantly lower scores in the global severity of their symptoms than those in the control group. The effect sizes for the study were moderate: child symptomatology was 0.41, and maternal symptomatology was 0.38.

Ippen *et al.* (2011) reanalyzed the Lieberman data to whether children with more adverse childhood events would experience greater benefits from CPP. Children who had experienced more than four ACEs in the CPP group showed dramatic improvements in PTSD and depression symptoms and significantly fewer behavioral problems, compared with their peers in the comparison group. Mothers also had reduced symptoms of depression and PTSD, compared with those in the comparison group. The differences were quite dramatic: in the children's intent-to-treat sample, effect sizes for PTSD, depression, and behavior problems were of 1.5, .8 and .7, respectively. For mothers' PTSD and depression, effect sizes were .9 and .8. Children with fewer than four ACEs also experienced benefits, with effect sizes in the .2 to .4 range; effect sizes for their mothers' PTSD and depression were .7 and .6.

The literature reviewed here clearly supports the programs and services that Las Cumbres provides. ACEs have a significant impact on the long-term health and well-being of adults. The scientific research on the neurobiological level clearly shows that toxic stress and adversity can have a detrimental impact on brain development. Investment in early childhood programs and trauma-focused infant and child services, such as those offered by LCCS, are critical for healthy child development and healthier, happier, and more productive outcomes in adulthood.

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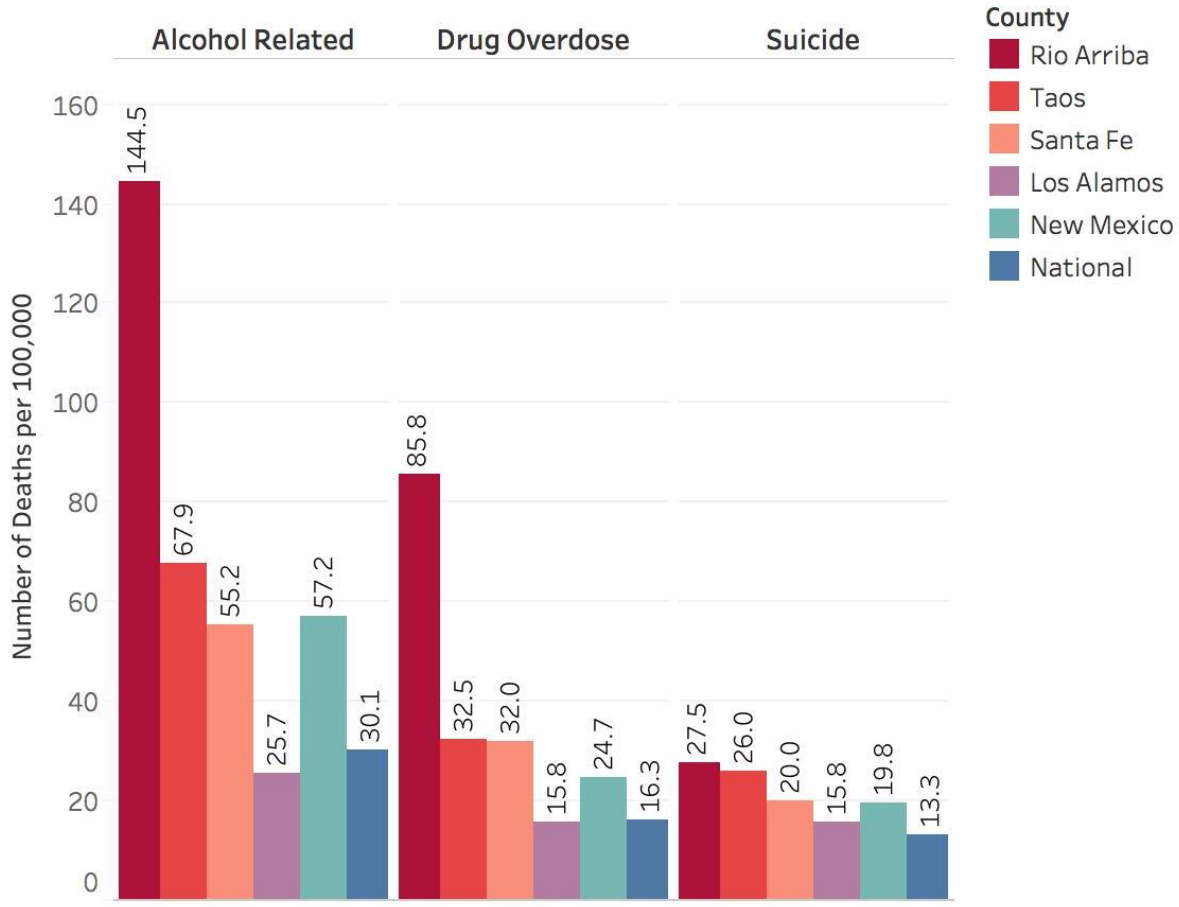
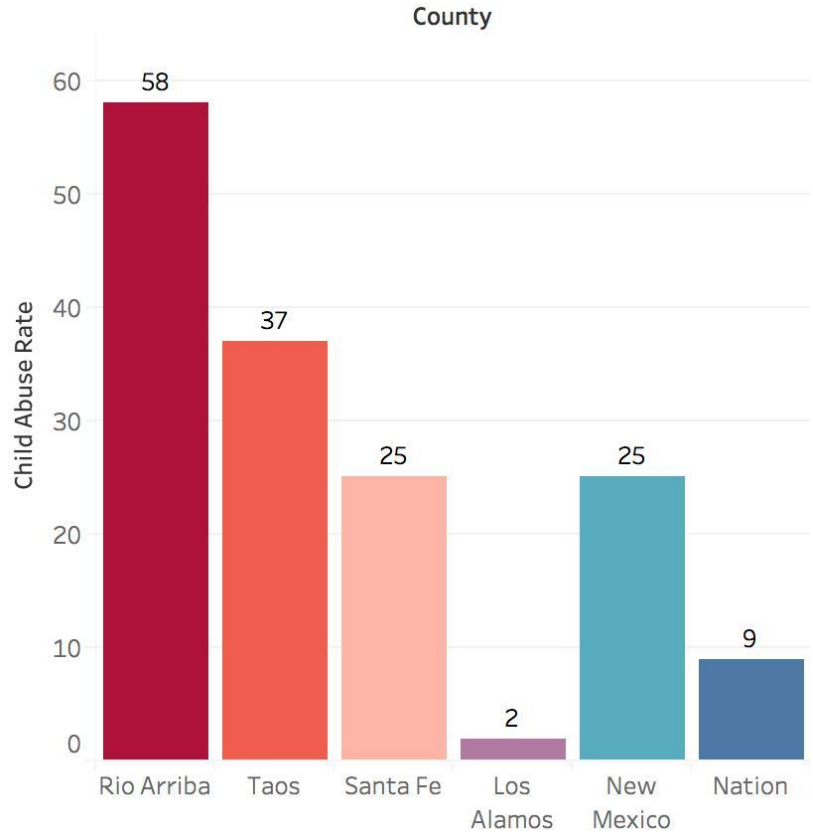
Appendix B: Additional Figures

Figure 1.B. Deaths by Related Behavioral Health Cause, 2011-2015



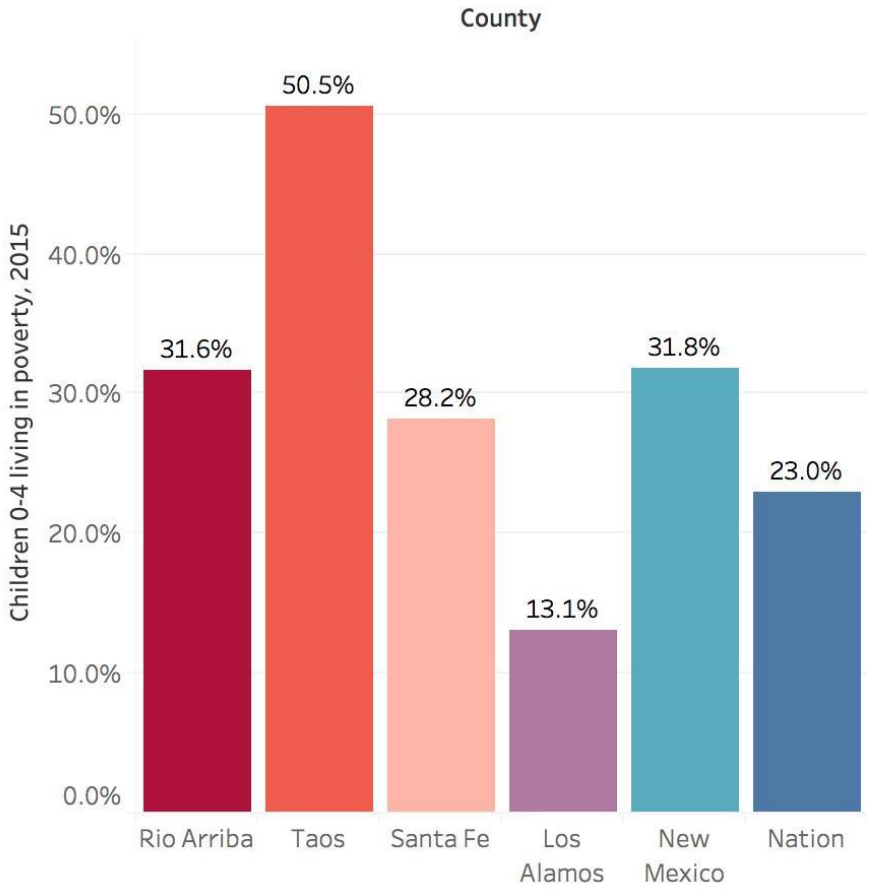
Alcohol Related, Drug Overdose, and Suicide related deaths for each County in comparison to New Mexico and national rates.
Source: New Mexico's Indicator-Based Information System (NM-IBIS)

Figure 2.B. Child Abuse Rate: Number of substantiated child victims per 1,000 children (SFY 2017)



Child Abuse Rate for each County in comparison to New Mexico and national rate.
Source: The Annie E. Casey Foundation, KIDS COUNT Data Center

Figure 3.B. Children 0-4 Living in Poverty, 2015



Children ages 0-4 living in poverty during the year 2015. Color shows details about County in comparison to New Mexico and the national rate.

Source: The Annie E. Casey Foundation, KIDS COUNT Data Center