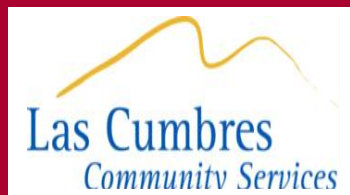# 2016-2017 Evaluation Plan for
Las Cumbres Community Services

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PREPARED BY

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Table of Contents

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/or developmental challenges in the northern New Mexican counties of Los Alamos, Rio Arriba, Santa Fe, and Taos. In the past 45 years, Las Cumbres has reached families in rural communities through various services and programs. Las Cumbres specializes in serving families dealing with trauma, poverty, substance abuse, incarceration, domestic abuse, custody concerns, and parental and infant mental health issues. Health care providers, educators, and the Child Protective Services Division of New Mexico, Youth and Families Department (CYFD), and others refer families to LCCS.

Multiple programs focus on early childhood development and the well-being of children age zero to six years old in LCCS's Child and Family Services Department. The two programs that are the focus of this evaluation specialize in mental health of infants prenatal to age six. The Santa Fe Community Infant Program (CIP), serving Santa Fe County, and its sister program, the Northern New Mexico Early Childhood Behavioral Health (BH), serving Rio Arriba and Los Alamos counties provide counseling, emotional support, and parenting and developmental guidance for families. These programs have the same goal, to promote safe and healthy relationships between children and their caregivers. Most children in these programs are survivors of trauma, and as a result, are socially and emotionally vulnerable. Traumatic events are likely to cause a delay in the child's development, thus, addressing the effects of trauma early builds a foundation for healthy behaviors and relationship development (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998; Cohen, 2016; Shonkoff & Fischer, 2013).

This current evaluation fits within the goal of a multi-year evaluation to assess the effectiveness of LCCS's data collection methods that track client progress and program outcomes. The main objective of this evaluation is to learn if the CIP and BH programs are collecting comprehensive data to produce feedback on the effectiveness of LCCS's programs and to measure client benchmarks and outcomes. LCCS is currently using Electronic Medical Record (EMR)-Bear to collect data. The evaluation seeks to understand the extent that the EMR-Bear can be utilized as a common data collection tool for assessing outcome indicators.

The parties involved in this evaluation process are Las Cumbres Community Services and the New Mexico Evaluation Lab at UNM. The Evaluation Lab students are Jared Clay and Ranjavola Andriamanana, under the mentorship of Amanda Bissell. The representatives for LCCS are Robyn Covelli-Hunt, the Director of Development and Communications, and Megan Délano, Chief Operations Officer. Robyn also serves as the Evaluation Coordinator.

Thus far, the team has been working on a program logic model and reviewing the data collection parameters as well as the reporting system of the EMR software. The evaluation team is taking a preliminary look at reports and indicators that EMR-Bear currently generates. This process will enable the team to clarify what data is available to analyze the efficiency of the EMR-Bear system.

2. Context

Children in Rio Arriba and Santa Fe counties, and in New Mexico, compared to the United States overall, experience varying degrees of trauma and life stressors. Characteristics of community challenges provide context that highlight traumatic events, such as child poverty, neglect, abuse, and behavioral causes of death. The context helps to demonstrate adverse conditions children face in these locations, which can lead to poor health outcomes in adulthood (Felitti et al., 1988). The reverse can also occur, for adult behaviors can also lead to adverse experiences for the child. New Mexico's Indicator-Based Information Systems (NM-IBIS) provides various data on New Mexico and New Mexico counties for a comparison of local conditions that are associated with stress and trauma. In addition, the U.S. Department of Health and Human Services, Health's Children's Bureau, provides data for child maltreatment comparisons between the state and the nation.[1]

The first context is the percentage of children under age five who live in poverty, from 2010 to 2014, comparing Rio Arriba County, Santa Fe County, New Mexico, and the United States. As shown in *Figure 1*, both counties and the state are well above the national average of 24 percent. Thirty-one percent of children live in poverty in Rio Arriba County and in the state of New Mexico overall. Twenty-eight percent of children in Santa Fe County live in poverty. (See figure 1.)

A second feature that provides community context is the rate of children who have experienced neglect or abuse in 2014, see *Figure 2*. Compared to the national rate, both counties and the state have higher rates of child neglect or abuse. Children neglected or abused in Rio Arriba County is 18.9 per 1,000 children, double the national rate of 9.4 per 1,000 children. Santa Fe County it is 11.9 per 1,000 children, yet New Mexico it is 16.7 per 1,000 children who have experienced neglect or abuse. (See figure 2).

[1] NM-IBIS is a data and information resource provided by the New Mexico Department of Health in order to promote wellness and improve health outcomes for the people of New Mexico. See http://ibis.health.state.nm.us. The U.S. Department of Health & Human Services Administration for Children and Families promote economic and social well-being of families, children, individuals and communities. Their Children's Bureau supports programs, research and monitoring systems to help prevent child neglect and abuse. See https://www.acf.hhs.gov/cb/focus-areas/child-abuse-neglect for more information.

Figure 1: Children under Age 5 Living in Poverty, 2010-2014
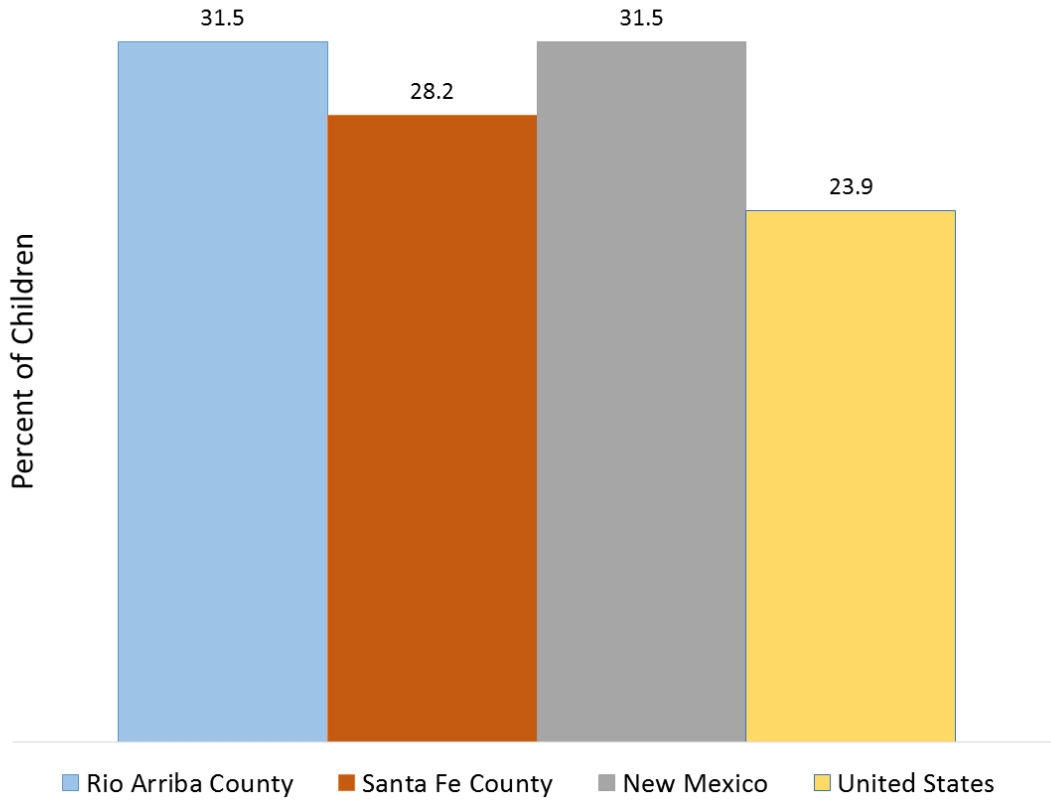
Source: New Mexico's Indicator-Based Information System (NM-IBIS), http://ibis.health.
state.nm.us

Figure 2: Rate of Child Neglect or Abuse, 2014
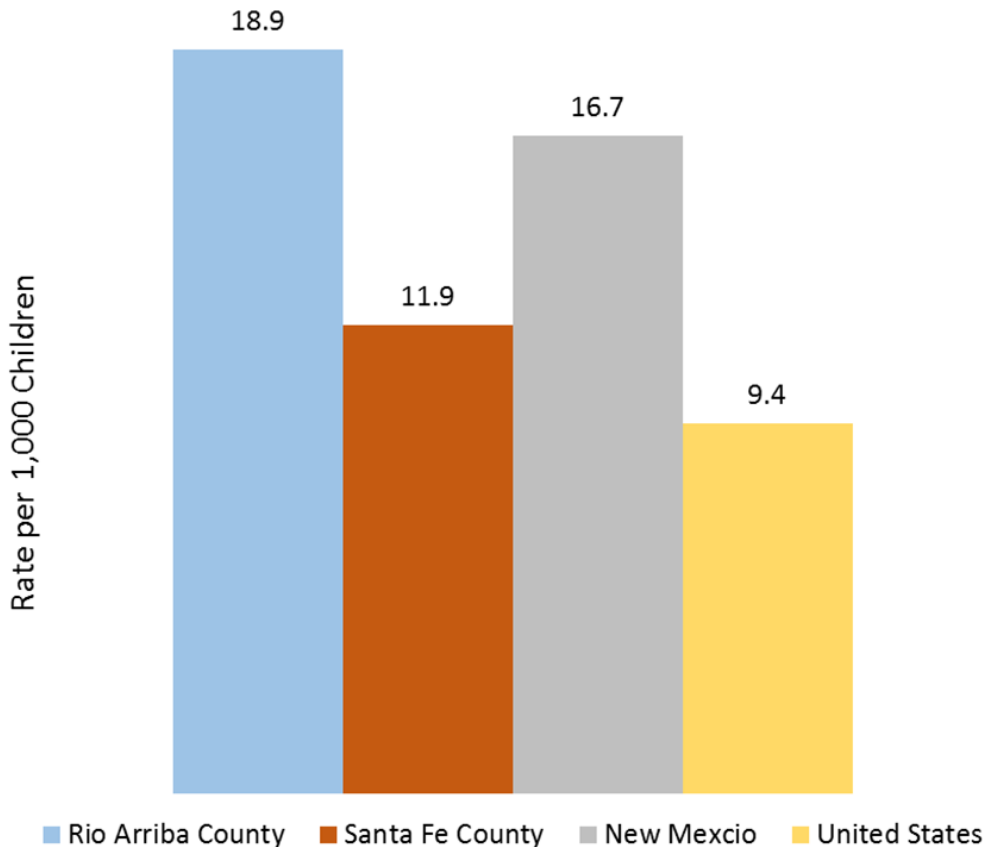
While *Figure 2* shows the rates of child neglect and abuse are higher at the local
and state level relative to the national level in 2014, however, there is variation
between the percent of child victims and type of maltreatment—neglect,
psychological maltreatment, physical abuse, and sexual abuse. (See *Figure A-1* in
Appendix A for further comparison between New Mexico and the United States on
the various types of maltreatment rates). The percent of child neglect is higher in
New Mexico (82.4) compared to the United States overall (75), yet the state has a
lower percent of physical abuse (13.4) compared to the national percent (17).

The first-time child victim rate of maltreatment, however, has increased from 8.1
per 1,000 children in 2011 to 11.3 per 1,000 in 2014. (See *Figure A-2* in Appendix A
for yearly first-time child victim rates for New Mexico and the United States).

The third feature that provides the context of community adversity, is the rate of deaths between 2010 and 20014 due to three types of behavioral health risks, see *Figure 3*. The rate of alcohol-related-deaths and drug overdose are markedly higher in Rio Arriba County. The rate of alcohol-deaths per 100,000 of the population is 126.3 in Rio Arriba County, which is nearly double the deaths of Santa Fe County (52.9) and the state overall (54). The state and county are well above the national rate of 29.4 per 100,000. From 2010 to 2014, the drug overdose death per 100,000 in Rio Arriba County is 78.4, Santa Fe is 29.4, New Mexico is 24.3, and nationally it is 13.8. State and local suicide deaths are well above the national average. The number of suicide deaths per 100,000 in Rio Arriba County is 23.7, Santa Fe it is 20.7, New Mexico overall it is 20.5, and the number per 100,000 for at the national level is 12.5. (See figure 3).

Figure 3: Deaths by Related Behavioral Health Cause, 2010-2014
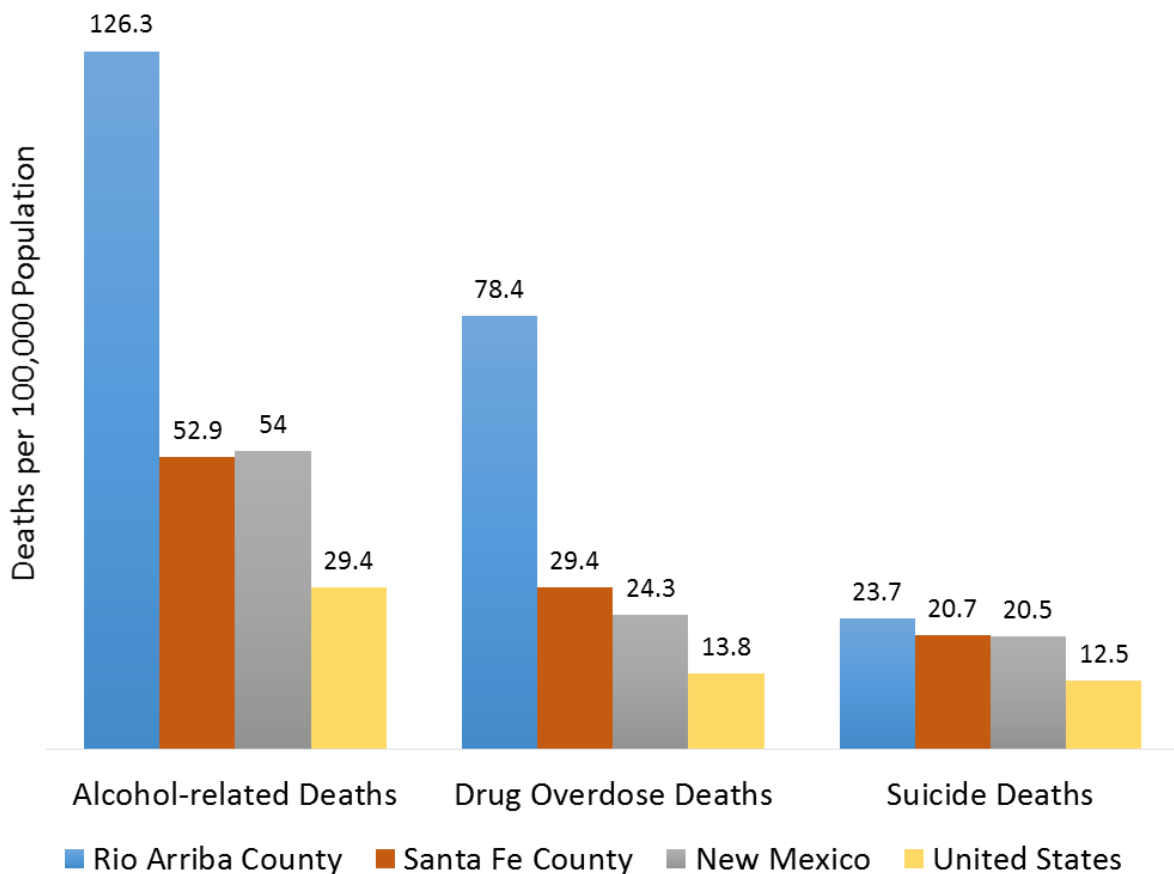
Source: New Mexico's Indicator-Based Information System (NM-IBIS), http://ibis.health. state.nm.us; Note: age-adjusted

The number and causes of death, the number of neglected and abused children, and the percent of children under 5 living in poverty demonstrate Rio Arriba County, Santa Fe County, and New Mexico have higher instances of adverse experiences relative to what occurs nationally. Thus, the need for LCCS CIP and BH programs are more than substantiated by the trauma and experiences that many New Mexican families, especially those in the service area, experience.

3. Logic Model

The CIP and BH programs' overall goal is to help families experience healthy and happy lives through overcoming the barriers of acute and systemic trauma. The logic model of the CIP and BH programs highlight LCCS's process for improving the safety, confidence, and relationships of the clients they serve (see Appendix B for the Logic Model). To achieve increased emotional and social health LCCS provides several evidenced-based services in the CIP and BH programs.

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 as a way to build capabilities for a positive parent-child relationship and improve the child's environment, see Appendix C. Trauma and stressful events in early childhood produces a biological response and has an adverse effect on brain development, which are associated with unhealthy behaviors later in life (Felitti et al., 1998; Shonkoff & Fischer, 2013; Cohen, 2016). Felitti et al. shows that there is an association between adverse childhood experiences (ACEs) and unhealthy behaviors affecting physical and mental health in adulthood (1998).

Traumatic stressors in childhood can lead to neurological processes that result in poor health. Therefore, strategies to address early childhood trauma and stress can mitigate behavioral issues later in life. LCCS theory of change is based on the notion that early intervention and treatment of children 0 to 6 can lead to better mental, emotional, and social health. Yet, one of the best ways to address stress and trauma for children is to have a comprehensive strategy involving parental skill building that helps improve child-parent relationships and provides a better home environment (Cohen, 2016). LCCS operates programs, such as child-parent psychotherapy, that is shown to decrease depression and post-traumatic stress disorders for children and their parents who experience traumatic stress (Ippen, Harris, Van Horn, & Lieberman, 2011). The literature findings affirm the logic model for addressing adverse, traumatic, and stressful experiences for children and aiding parental capacities. (See Appendix C for a more detailed literature).

Las Cumbres is a well-established organization that invests resources in the form of committed and educated staff, funding, and capital in order to provide service

activities to aid infants, toddlers, and their parents and families. One of the initial engagement activities of the CIP and BH programs is an intake process, during which clients are assessed and connected to the appropriate in-house services or external referral agencies or other community resources to best address the client's needs. At intake, LCCS collects demographic information, a client's problem/psychosocial history, builds a list of symptoms and prepares an initial treatment plan for clients in the CIP and BH programs. Treatment activities may include art therapy, play therapy, child-parent psychotherapy, Dialectical Behavioral Therapy (DBT), and Circle of Security Parenting. These activities are conducted at home or on-site, and include individual therapy, parent-child dyad therapy, and parenting support groups. Throughout treatment services, data are collected through multiple screens and surveys, including a pre/post client satisfaction survey, validated assessment measures, and client progress tracked by clinicians in an electronic medical record.

The outputs of the programs include a treatment plan that focuses on evidence-based practices and measures for assessing goals and treatment completion. There are two types of output measures, count and index measures. Count measures include the numbers of visits, clients served, discharges, scheduling times, and the number of clients on a waitlist. Index measures include, but are not limited to, indicators of depression, anxiety, social/emotional development, and adverse childhood experiences. Unlike outcome measures, output measures count what was produced through a program's activities, they do not measure the impact or value of a program's services.

Increased safety, parental confidence, and improved parent/child relationship are among the three primary outcomes the CIP and BH programs seek to achieve. Safety outcomes include increased protection 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 comfortability in sharing parent/child moments (Ippen et al., 2011; Cohen, 2016).

The expected impact is an improvement of children and parent's emotional and social health. These impacts include an improvement in environmental conditions and safety, connections to community resources, an increase in a parent's understanding of their child and the ability to address the child's needs, and increased confidence as a parent or caregiver. Another expected impact is growth in the ability to nurture a secure and healthy parent/child relationship.

The logic model will guide the focus of the evaluation, investigating what data is being captured in EMR-Bear (activities), how well EMR-Bear is being used by LCCS clinicians and staff (activities), that leads to generating reports (outputs), to assess whether LCCS services meet the goals and expectations of the programs they provide (outcomes).

4. Evaluation Plan

This is the second 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 the findings from the previous year, the scope of work includes two evaluation projects:

> 1) Generate reports of EMR-Bear data, understand what is and is not captured by EMR-Bear, and create a template of measures based on data captured in EMR-Bear.
> 2) Develop instruments to evaluate how well staff and clinicians utilize EMR-Bear.

1) The first project is based on the following question: What reports, tracking, and information are captured in EMR-Bear for process indicators that measure program outcomes?

LCCS would like to measure how the CIP and BH programs are performing. This will include an overview of current process indicators (see Appendix D), and a review of client outcome measures. The following activities will support this project:

- Running blank reports from EMR-Bear to:
  - Generate a list of what data/reporting measures are available
  - Match data fields with process indicator list
  - Describe the process on how to pull periodic reports
- Working with the Evaluation Coordinator to pull at least two decoded reports of client level data (SMART objectives and treatment goals).
- Drafting a flow diagram of the "gold standard" of how/when data should be collected for each client throughout their interaction with the organization; and sketch a visual diagram of how the data collection instruments are related to one another.
- Pull at reports of data that match process indicator list; observe real-time data entry, if feasible.

- Drafting a report on findings to include:
    - o An inventory of reports and data fields
    - o An assessment of what fields are consistently being captured and which are not
    - o What information and questions was generated by the sets of pulled reports
    - o Recommendations on how to improve the data collection process and on which process indicators are best captured/measured by EMR-Bear
    - o Revise current indicator list.

2) The second project is based on the following question: How well is the EMR-Bear system utilized by the CIP and BH programs to track client outcomes and goals?

This is an initial stage of the second project, since LCCS staff and EMR-Bear developers are currently working to develop EMR-Bear data entry fields. None-the-less, understanding how clinicians are using EMR-Bear, and why the software is not used consistently by clinicians and across programs, is pivotal to this evaluation project. EMR-Bear populated menus generate the majority of quantitative data available for evaluation. However, clinicians do not regularly use these populated menus. This information will lead to better training and use of the software, generating consistent client data, and SMART outcomes and goals. Activities to support this initial stage of the second project include:

- Tracking EMR-Bear training outcomes for clinicians to become competent users of EMR-Bear through a pre and post survey to be developed by the Evaluation Lab Team. The following training outcomes will be used:
    - o TO BE DETERMINED/RESEARCHED
- Tracking clinician use of EMR-Bear populated menus and documenting the successes and challenges of using the software through surveys developed by the Eval Team and through data checks from pulled reports.
    - o Observe real-time data entry in EMR-Bear.

5. Timeline

The evaluation activities will continue from October 2016 through March 2017, with report presentations and revisions April to May 2017.

October

- Submit draft evaluation plan to LCCS for feedback and suggestions
- Finalize Logic Model

November

- Finalize Evaluation Plan
- Run preliminary reports of EMR-Bear

December

- Meet and discuss missing data and information in EMR-Bear
- Run reports from EMR-Bear, determine how and where they are available (Client level data and Process Indicators)

January

- Continue to run reports from EMR-Bear (Client level data and Process Indicators)
- Construct matrix of process indicators available in current reports.
- Develop survey for clinicians focused on their training of EMR-Bear
- Draft a flow diagram of the "gold standard" of how/when data should be collected for each client throughout their interaction with the organization.
- Sketch a visual diagram of how the data collection instruments are related to one another.
- Revise list of process indicators.

February

- Revisions of survey for clinicians on their experience of using EMR-Bear
- Revise matrix, flow diagram, and flow chart.
- Observe real-time data entry.
- Begin drafting final evaluation report.

March

- Draft evaluation report to organization to include report on data and measures and results from surveys given to clinicians
- Organization receives report March 31st.

April

- Meeting with LCCS to present and discuss evaluation report
- Evaluation report revisions
- Evaluation Poster Presentation

May

- Final evaluation report with organization comments finalized, May 11

References

Cohen, S. (2016). Applying the Science of Child Development in Child Welfare
    Systems. *Center on the Developing Child at Harvard University,*
    http://www.developingchild.harvard.edu

Felitti V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss,
    M., & Marks, J. (1998). Relationship of childhood abuse and household
    dysfunction on many of the leading causes of death in adults. The Adverse
    Childhood Experiences (ACE) Study. *American Journal of Preventive
    Medicine, 14*(4), 245-258.

Francis, D. (2016, December 7). Poverty and Mistreatment of Children go Hand in
    Hand. *The National Bureau of Economic Research.* Retrieved from
    http://www.nber.org/digest/jan00/w7343.html

Ippen, C., Harris, W., Van Horn, P., & Lieberman, A. (2011). Traumatic and
    stressful events in early childhood: Can treatment help those at highest risk?.
    Child Abuse & Neglect, 35, 504-513.

Shonkoff, J., & Fisher, P. (2013). Rethinking evidence-based practice and two-
    generation programs to create the future of early childhood policy.
    Development and Psychopathology, 25, 1635-1653.

Appendix A

Figure A-1: Type of Maltreatment Victims, 2014
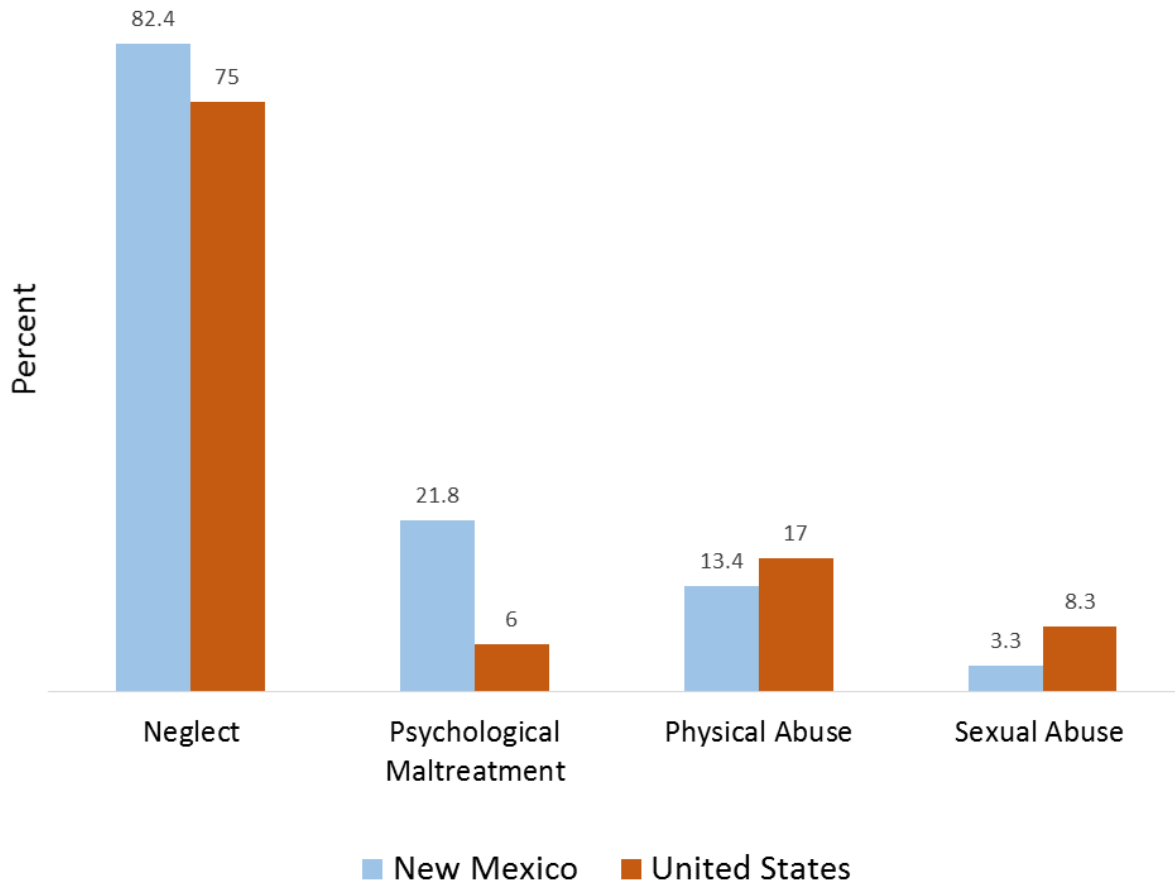
Relative to four types of maltreatment, there is variation between doing better and worse in New Mexico compared to the United States. In 2014, the types of maltreatment of reported child victims show varying contexts of neglect and abuse. The percent of child victims in 2014 for neglect was higher in New Mexico (82.4%) compared to the United States (75%). The percent of psychological maltreatment of children in New Mexico is 21.8%, well above the national percentage, which is 6%. New Mexico has lower percentages of physical abuse (13.4%) relative to the national percentage (17%), and New Mexico has lower rates of child sexual abuse (3.3%) compared to the United States overall(8.3%). This variation may speak to the extreme poverty seen in the state, which is more often associated with neglect than physical abuse (Francis, 2016).

Figure A-2: First-time Child Victims by Year
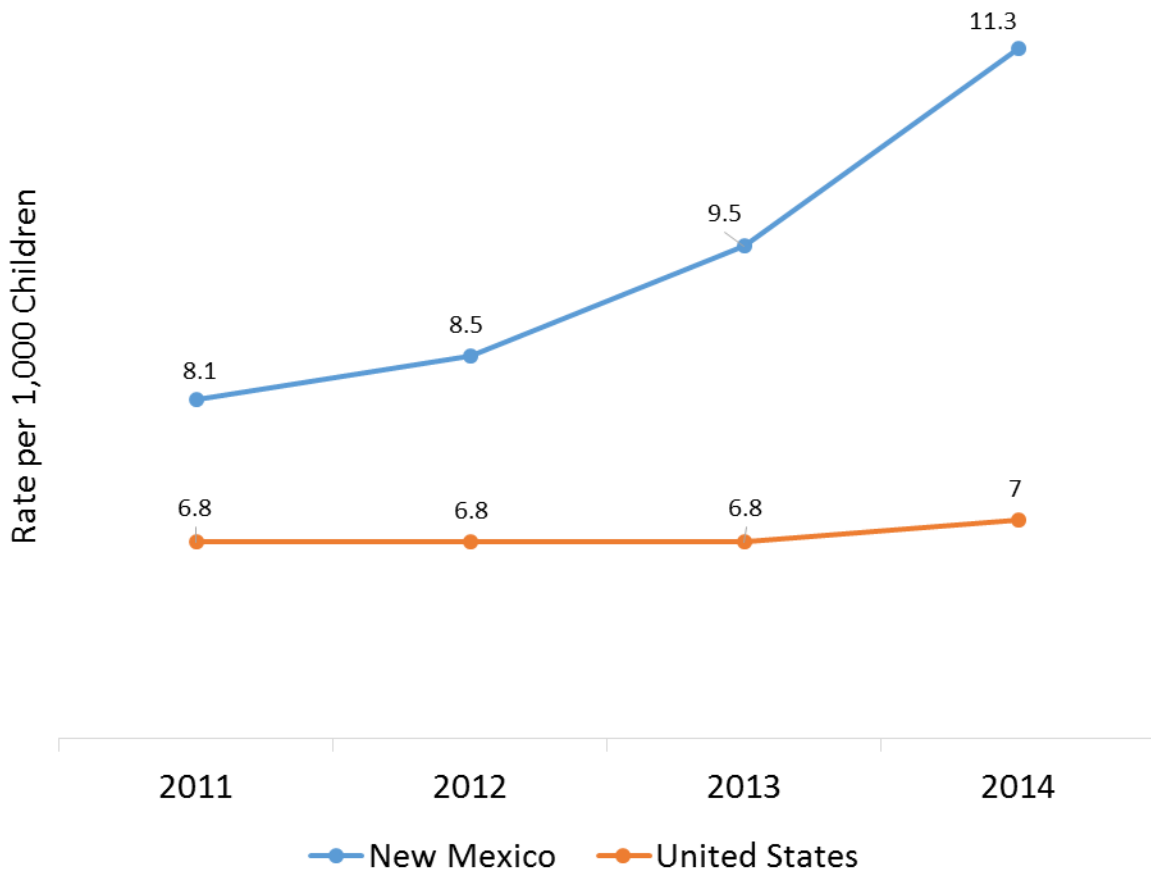
11.3

9.5

8.5

8.1

6.8   6.8   6.8   7

2011   2012   2013   2014

Rate per 1,000 Children

— New Mexico   — United States

The first-time child victim rate of maltreatment per 1,000 children is relatively stable nationally from 2011 with 6.8 per 1,000 children to 2014 with 7.0 in 2014 per 1,000 children. The first-time child victim rate for New Mexico, however, has steadily increased from 2011 to 2014, increasing from a rate of 8.1 per 1,000 children in 2011 to a rate of 11.3 in 2014.[2]

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[2] This is due, in part, to a greater awareness of child abuse and an increase in the number of incidents reported to the authorities.   See Terrell, S. (11 April 2014) Child abuse reports in state are on the rise. *Santa Fe New Mexican*. Retrieved from http://www.santafenewmexican.com/news/local_news/child-abuse-reports-in-state-are-on-the-rise/article_dbe83470-113e-5b23-8c64-fe90bdf4355b.html.

Appendix B

Program Logic Model: Las Cumbres Community Services (LCCS)
Santa Fe Community Infant Program (CIP) & Northern New Mexico Early Childhood Behavioral Health (BH)

Inputs *Resources*	Activities	Outputs *Indicators*	Outcomes	Long-term Impacts
Reputation • Las Cumbres Community Services in service for 47 years • Established network among the community • Addresses needs of the community • CIP in services for 17 years **Core Services** • Home Visits • On-site Visits • Group Visits **Human and Physical Capital** • Facilities • Staff with training and credentials **Funding** • Grants • Medicaid	**Intake & Assessment** • Demographics • Psychosocial history • Treatment plan preparation **Case Management** • Referral • Assessment of needs • Connect to appropriate resources **Core Services** • Home Visitations • On-site Visitations • Group Visitations **Data Collection** • Electronic medical record entry • Pre/Post Service Family Feedback Forms **Behavioral Health Treatment/ Evidence-Based Practices** • Art therapy • Child-centered play therapy • Child-parent psycho-therapy • Dialectical Behavior Therapy • Circle of Security™ Parenting	**Treatment Plan** • Number of goals met • Evidence-Based practices utilized for treatments • Treatment Plan Review (every 90 days) **Count Measures** • Visits • Clients Serviced • Discharges • Scheduling time and waitlist **Number of Validated Assessments to Periodicity** • Depression • Anxiety • Social/Emotional Development	**Safety** • Reduced environmental stressors • Increased protective factors • Housing, food, and transportation • Connection to community resources **Confidence** • Reduced parent depression and anxiety • Able to respond to own & child's emotional needs • Better able to manage behavior • Established support system • Increased understanding of child and ability to address child's needs **Relationships** • Nurturing secure and healthy relationships • Improved parent/child relationship • Addressed mismatch in temperament • Developed coping mechanisms • Increased comfortability/ sharing moments	**Decrease in Environmental Stressors** • More predictable, less chaotic living situation. • Families improved well-being for decreasing acute and systemic trauma. **Increasing Healthy Development** • Child is Kindergarten Ready / School Ready • Continued building of self-regulating behavioral skills..

Pre-Service Survey ⇢ Post- Service Survey | Client satisfaction survey

Assumptions: · Trauma has occurred -- Clients come and want to improve -- Evidence-based approaches work with LCCS's target population -- Therapy works to improve behavior and/or health -- Services are delivered with fidelity -- Conditions will change (e.g., no more domestic violence).

Target Population: The target population are children (ages 0-6), parents, grandparents, caregivers, and pregnant families who are residents of following Santa Fe County , Rio Arriba County, Los Alamos County, Taos County, the Eight Northern Indian Pueblos, and the Jicarilla Apache.

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Rev 11.08.16

Appendix C

This literature review section focuses on elements that develop LCCS's theory of change. The primary expectation of the CIP and BH programs is to develop and promote a healthy emotional and social well-being of children who experience trauma, as well as establish parental capabilities in establishing healthy relationships with their child. Scholars have studied how certain childhood experiences negatively influence the lives of children, which affect their social and emotional well-being from childhood all the way to adulthood. There is congruence between scholars and the purpose of LCCS's CIP and BH programs that links the importance of early treatment related to trauma and stressful events in order to ensure that every child gets a chance to develop behaviors for a healthy, successful life.

The science of child development in child welfare system.
Scholars at the Center on the Developing Child at Harvard University take a broad and basic approach to why investing in treating children with early childhood trauma is a concern for child welfare systems. Cohen (2016) argues that in order to improve child development, one must understand how the human brain develops, and how it influences the mental, emotional, and social development of children. This article raises the question of "how can we use insights from cutting-edge science to improve the well-being and long-term life prospects of the most vulnerable children in our society." Cohen (2016) recommends that child welfare policy and practice should recognize the needs of infants and toddlers for establishing healthy behaviors and learning since the brain develops the most in early childhood (p.15).

Cohen does a great job of explaining basic concepts, yet, highlights important terms such as neglect and self-regulation from a scientific viewpoint. These key terms are crucial to understanding the science behind the consequences of child development under the strain of constant stress and trauma. His explanation centers on the interruption of brain architecture due to traumatic early experiences that impede the foundation for healthy learning, behavioral development, and healthy growth. Experiences play a major role in children's development and negative ones tend to leave a lasting impact on brain development.

Another aspect Cohen emphasizes is the responsive and reciprocal interactions between children and their caregivers. However, building responsive relationships is difficult under external circumstances of trauma and environmental stressors (i.e., dangerous housing, insufficient food). These circumstances cause stress among adults, thus, children sense and experience the stress that adults are going through and then children develop stress because of the reciprocal interaction between child and caregiver. Consequently, the relationships between parents and children weaken and both can develop mental and physical health challenges (Cohen, 2016).

Cohen strongly advocates for early treatment and prevention. He advises policymakers to invest in programs that promote better mental and physical health outcomes among children and their caregivers. He offers three main solutions: 1) Reduce external sources of stresses (such as programs that relieve financial burden), 2) develop responsive relationships (promote positive interactions between children and their caregivers), and 3) strengthen core life skills (promote programs that help adults reach their goals) (Cohen, 2016). These are practical recommendations that not only benefit the children but their caregivers as well, and if the two parties receive appropriate care, a healthy and harmonious relationship is likely, which, as shown by research, is essential to the development of the child.

The ACE study
Many scholars who study early childhood development and the variation of development among children turn to the Adverse Childhood Experiences Study as a base for addressing early adverse experience in children before unhealthy behaviors develop. In their article, Felitti et al. (1998) find an association between childhood abuse and household dysfunction as a leading cause of unhealthy behaviors in adults that lead to early death. They conducted a study in which they seek to see if adults who are exposed to traumatic events early on in their lives are likely to have challenges as adults with their physical health and mental behavior. Adults who experience adverse childhood experiences tend to adopt behaviors, such as smoking, drinking, substance abuse, overeating, and others, that have long-term consequences that ultimately increase risks to their lives (Felitti et al., 1998; Cohen, 2016). Those adults who experience four or more categories of adverse experiences are four to twelve times more likely to develop unhealthy adult habits (Felitti et al., 1998; Cohen, 2016). These habits contribute to the development of diseases, such as heart and lung diseases. They recommend early treatment of people who were exposed to ACEs as early as possible to prevent these long-term consequences.

Traumatic and stressful events in early childhood and treatment
Ippen, Harris, Van Horn, and Lieberman (2011) have a similar focus as Felitti et al. (1998), as they focus on how to treat those that have experienced traumatic events as a young child. Their approach is different because they reanalyze data from a previous study on whether child-parent psychotherapy (CPP) is effective for the development of children with traumatic and stressful life events (Ippen et al., 2011). The study's sample size is small, comprised of 75 preschool children whose mothers are survivors of domestic violence. They randomly assign child-parent dyads to a control group, a comparison group (who received monthly case management, referrals to community, and a 6-month follow-up), and a treatment groups (who received the CPP services).

Ippen et al. (2011) find that high-risk children (with four or more traumatic and stressful life events) in the treatment group, improved their PTSD and depression symptoms, diagnosis, and overall behaviors with CPP compared to the control group (Ippen et al., 2011). The treatment (CPP) group showed significant reductions,

whereas the comparison group shows an increasing trend in total number of child behavior problems checklist. They do not focus their paper on the low-risk children (less than four traumatic and stressful life events), but, they did notice that even the low-risk child participants in CPP show decreasing symptoms of PTSD (Ippen et al., 2011). Additionally, mothers of the high-risk children also did better in decreasing PTSD and depression symptoms compared to the control group when they participated in CPP (Ippen et al., 2011). Another takeaway of the study is that there is some evidence of sustained improvements for participants six months after treatments. The overall contribution of this article to the literature is that child-parent psychotherapy helps to diminish stress and post-traumatic stress for children and caregivers. Ippen et al. emphasizes the impact of parental involvement in child's treatment is beneficial to develop healthy relationships and improve the long-term mental, emotional, and social well-being of children and parents (2011).

Early childhood policy using evidence-based practice
Shonkoff and Fischer (2013) stress the benefits of paying attention to the needs of the caregivers in order to improve the development of children. Like Ippen et al., they promote the involvement of the adults in the lives of children by strengthening the capabilities of the caregivers and addressing the material needs of their families. The authors acknowledge that this is a challenge because programs have primarily focused on the children, and to change this requires major reforms that some programs might not be willing to take. The article calls for a new approach that adopts fully integrated two-generation programs, and encourages the field of child development to take risks for developing new intervention strategies even if there is a probability that they will fail (Shonkoff & Fischer, 2013 p. 1636). The authors advocate for change with the belief that there are lessons and new information to gain from responsive risk taking, applying new interventions, and learning from failure. By taking risks, programs can develop new ways of thinking and develop new strategies to address early childhood adverse experiences, which can lead to advantageous innovations in treatments. The motivation behind reforms is that Shonkoff and Fischer currently see little progress to help vulnerable children and caregivers, therefore, they call on the community to move beyond quality improvements in programs and take a different approach by incorporating child wellness and adult capabilities (2013).

The works in this literature stress a similar point: early childhood events matter in the development of children and can have an impact on their lives even in adulthood. They recommend that earlier treatments are better for the brain's development and overall health. Thus, programs that help both children and their caregivers are beneficial to the overall health community members. The CIP and BH programs at LCCS are important in New Mexico because they promote healthy relationships between children survivors of traumatic events and their caregivers, and seek to help develop the mental, emotional, and social well-being of children.

Appendix D:

Las Cumbres Community Service Process Indicators

Community Infant Program (CIP)	This Month	Previous Month	Previous 12 Month period	
Dates:	**Jul-16**	**Jun-16**	**July 1, 2015-June 30, 2016**	**notes**
Clients Served				all active clients during time period
Families				
Adults				
Infants (0-23 months at start of service)				
Toddlers (24-35 months at start of service)				
Pre-Schoolers (3-4 years old at start of service)				
School age (5 and older)				
Discharges				
Number of families discharged				
Percent of families discharged (families discharged/families served)X100				
Type of discharge:				what are relevant categories / is this information available in EMR Bear?
Met therapy goals (?)				
Number of families				
Percent of discharged families				
Referred elsewhere (?)				
Number of families				
Percent of discharged families				
Client not attending, not responding to calls (?)				
Number of families				
Percent of discharged families				
Other discharge type				
Number of families				
Percent of discharged families				

Duration in program				
AVERAGE duration in program in weeks for all *active families* (date of last visit minus date of first visit divided by 7)				
MEDIAN duration in program in weeks for all *active families* (date of last visit minus date of first visit divided by 7). Half of families have durations at or longer than this number of weeks; half have shorter durations.				
AVERAGE duration in program in weeks for all *discharged families* (date of last visit minus date of first visit divided by 7)				
MEDIAN duration in program in weeks for all *discharged families* (date of last visit minus date of first visit divided by 7). Half of families have durations at or longer than this number of weeks; half have shorter durations.				
Percent of discharged families whose duration was 90 days or longer				
Number of service hours for discharged families				
AVERAGE number of service hours in program for all discharged families				
MEDIAN number of service hours for all discharged families (date of last visit minus date of first visit divided by 7). Half of families had contact hours at or greater than this number of weeks; half had fewer contact hours.				
Percent of discharged families who had 12 or more service hours.				
Program intensity by duration: service hours per month for discharged families				
All months of service				
First month of service				Useful?
Second and third months of service				
Fourth month and following				
Scheduling time and waitlist				

Average time between first contact and scheduled appointment. (Scheduled appointment minus date scheduled.)				
Time to first available appointment on last business day of the time period				
Number of families on waitlist on last business day of month				
No-shows				
Number of no-shows without 24-hour? notification				
Total service hours delivered by service type				
Art Therapy				
Child Centered Play Therapy				
Circle of Security				
Parent-Child Therapy				
Dialectical Behavior Therapy				
Source of referral for all active families				
CYFD				
School				
Health care provider				
Other service provider				
Self				
Current or former LCCS client				
Other				

Note: Dr. Melissa Binder and Michael Ayala, with input from LCCS staff, produced the process indicators list in the summer of 2016.