EARLY ON® SOCIAL EMOTIONAL TOOLS PILOT
FINAL REPORT

Background

In April 2006, the State Interagency Coordinating Council (SICC)[1] approved the formation of an Ad Hoc Committee to review *Early On* assessment tools that were being recommended for use in eligibility determination, for their sensitivity to social and emotional development.

A Social Emotional stakeholder group was formed in July 2006 that consisted of individuals from Departments of Community Health, Education, Human Services, *Early On* Training and Technical Assistance (EOTTA), community mental health, local public health *Early On* Coordinators, and parents. This group posed a series of questions chosen to investigate whether the tool would:

- Meet IDEA requirements
- Measure child social/emotional outcomes
- Indicate standard score pre and post outcome measures
- Be easy to administer by professionals with a range of qualifications

The initial result of the Social Emotional stakeholder group was that:

- None of the tools were sensitive enough to assess social and emotional development in a way that can lead to early detection; or
- The tools required a high level of staff competence, education and training or a mental health clinician to interpret. (exception: HELP which cannot be used in initial eligibility determination)

The Ad Hoc Committee decided to look at tools created and used in the early childhood field to specifically assess social and emotional development. One additional question was added:

- Does the tool yield a % delay or standard deviation of delay score?
- Additional tools[2] that were reviewed included the 1) Devereux Early Childhood Assessment for Infants and Toddlers (DECA-I/T), 2) Functional Emotional Assessment Scale (FEAS) and the 3) Attachment, Interaction, Mastery and Support (AIMS)

After extensive review it was determined that the DECA-I/T addressed all questions related to social emotional sensitivity.

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[1] The SICC is now the Michigan Interagency Coordinating Council (MICC)

[2] These tools were culled from a list of 14 assessment tools that had been reviewed by a Department of Community Health early childhood assessment workgroup of infant mental health clinicians, supervisors and the executive director of the Michigan Association of Infant Mental Health.

Although it is not an assessment tool, the AIMS was recommended as a supplemental tool to provide guidance and direction for the Parent/Child observation component for *Early On* eligibility.

The Ad Hoc committee made a recommendation to the SICC to:

- Investigate whether or not the DECA-I/T and the AIMS were a good fit for the *Early On* evaluation process; and;
- Explore the DECA-I/T and AIMS ability to assist staff in identifying children with social and emotional concerns.

At the April 2007 meeting of the SICC the *Early On* Social-Emotional Pilot was approved.

Pilot Process

It was determined that six pilot sites would be established. Applications were distributed to all *Early On* Coordinators throughout the state. Participation in the pilot was encouraged with the benefits listed as:

1. Free training on the DECA I/T and the AIMS.
2. Better identification of children with social-emotional delays and disabilities in the *Early On* service area.
3. Help with meeting CAPTA goals and responsibilities.
4. Use of the new tools could aid in the measuring and federal reporting of social emotional delays for Child Outcomes, which is now a required component of Part C.
5. Opportunity to provide views and opinions on the instruments, their practical use, and the coordination of services.

Eleven applications were received and six sites were chosen. Sites were chosen from a variety of areas from around the state including rural, small, medium, metro, and urban regions. The six sites chosen include: 1) Hillsdale, 2) Oakland, 3) St. Joseph, 4) Lapeer, 5) Iosco[3], and 6) Washtenaw.

During the pilot, the DECA-I/T and the AIMS were to be used in conjunction with the Infant-Toddler Developmental Assessment (IDA) during the initial evaluation phase of determination for *Early On* eligibility to see if it helped to pick up on social and emotional concerns. (The IDA is the most commonly used general developmental assessment tool used as part of the *Early On* evaluation.) All *Early On* evaluators and their supervisors were required to attend training in the use of the DECA-I/T

[3] Iosco subsequently dropped out of the pilot.

and the AIMS on July 24 and July 25, 2007 at the EOTTA Center. A total of thirty-two (32) participants attended the two-day training provided by Mary Mackrain, Child Care Expulsion Prevention Training Coordinator, MDCH and Sr. Barbara Cline, Training Coordinator, EOTTA. Pilot sites were provided with all the necessary tools including a complete DECA-I/T kit, which included DECA-I/T Record Forms, set of Parent/Teacher Profile Master's, and the User's Guide. The website of the AIMS, which is available for download, was provided to the sites to print as needed. The pilot began on August 1, 2007 and continued until January 31, 2008 for a total of six months.

Participant Responsibilities: Data Collection

The Individual pilot sites were responsible for collecting and submitting data on a monthly basis. Monthly, pilot sites submitted data reports which included the following information:

- Total number of children evaluated with both IDA and DECA-I/T.
- Total number of children eligible for *Early On* based on the IDA only.
- Total number of children eligible for *Early On* based on the DECA-I/T only.
- Total number of children eligible for *Early On* based on both IDA and DECA-I/T.
- Total number of children re-evaluated:
    - Number of children continuing to qualify for *Early On* based on IDA only.
    - Number of children continuing to qualify for *Early On* based on DECA-I/T only.
    - Number of children continuing to qualify for *Early On* based on both.

In addition, service areas were asked to report on referrals made to families to help identify local resources, as well as identify needed community supports. Some of these services included:

- Child care or playgroups
- Parent received information promoting social/emotional development
- Parent received training on social-emotional development
- Home visitation programs
- Family and/or caregiver supports
- Mental health referral/intake
- Coordinated individual plan of service
- Infant mental health (IMH) or home-based services
- Wraparound services
- Crisis intervention
- Clinical mental health services from local community mental health service programs (CMHSPs)
- Clinical mental health services from private providers

- Clinical mental health services from Medicaid Health Plans
- Other

Participant Responsibilities: Conference Calls

Conference calls were held every two months, for all participants, to provide guidance and support throughout the process. The conference calls included input and discussion from supervisors and staff from all areas. Each conference call gave the pilot sites the opportunity to report on:

- DECA-I/T issues and discussion
- AIMS issues and discussion
- CMHSP connections and infant mental health referrals
- Community resource successes and barriers
- Monthly data reports

Site Visits

Upon completion of the data collection for the pilot on January 31, 2008, follow up visits were made to individual sites to collect additional information. Information collected from the pilot sites including feedback regarding the processes, procedures, implementation, and coordination issues with the use of the new tools. Information collected included Process, Usability, Family/Community Resource and Referral Questions.

Summary of Results

Across the five pilot sites where data was collected, 445 children were referred and evaluated for *Early On* services from August 1, 2007 - January 31, 2008. The IDA and the DECA-I/T were administered for all 445 children as part of the evaluation process for eligibility.

As can be seen in Table 1 below, of the 445 children evaluated, a total of 311 were found eligible for *Early On* services. Of those 311 children, 137 were found to be eligible for services based on IDA scores alone. One hundred and thirty five children were found eligible for services based on the combined results of the IDA and DECA-I/T scores. Thirty nine children were found eligible for services based on DECA-I/T scores alone, meaning the tool helped to pick up on a sample of children with social and emotional concerns that may have otherwise been found ineligible for services based on IDA scores.

Table 1. Total Number of Children Evaluated and Eligible for *Early On* Services.

A. Total number of children eligible for *Early On* service	311
B. Total number of children eligible based on IDA scores only	137
C. Total number of children eligible based on DECA-I/T scores only	39
D. Total number of children eligible based on IDA and DECA-I/T scores combined	135

The DECA-I/T assessment can elicit three scoring results, Strength, Typical or Area of Need. T-scores of 60 or above fall into the strength range, T-scores of 41-59 fall into the typical range and T-scores 40 or below are in the area of need range. The area of need range is one standard deviation from the norm in the direction of concern. Data on scoring results were available from two pilot sites for children that were found eligible for services with DECA-I/T scores alone. Within these two sites, 20 children were found eligible for services based on DECA-I/T scores. In Table 2 below, the scoring results for those 20 children can be seen. Sixteen of the children had DECA-I/T scores in the area of need range and four had typical scores. Many times typical scores can fall close to the borderline of area of need and warrant prevention services.

Table 2. DECA-I/T Scoring Ranges for Children Found Eligible for *Early On* Services (in two pilot sites)

A. Total children eligible based on the DECA-I/T alone	20
B. Total number of children in the strength range	0
C. Total number of children in the typical range	4
D. Total number of children in the area of need range	16

Discussion Questions for *Early On* Social Emotional Pilot Site Visits
Summary of Process, Usability and Family/Community Resource and Referral Questions:

1. **How did the use of the DECA-I/T enhance the *Early On* evaluation process?**
   All sites used the DECA I/T to assist with social emotional development. All sites felt that the tool was useful in looking at social emotional health. The tool validated the referrals the *Early On* staff were making to local CMHSPs, Infant Mental Health, and Early Head Start. The DECA- I/T was useful because it gave a standard score so that everyone was using the same language when making a referral. Most sites agreed that the tool was useful with the CAPTA population referrals from Department of Human Services (DHS) in identifying social emotional concerns for this group of children. Participants in the pilot agreed that the DECA-I/T enhanced the ability to be descriptive in the social and emotional domain and conversations with parents were much more open.

2. **Does the use of these specific tools enhance the determination of *Early On* eligibility under the Social Emotional domain?**
   Overall, the pilot sites felt that the use of the DECA-I/T enhanced the Early On evaluation. They felt it was helpful to have the parent's perspective rather than the few items on the IDA addressing parent input. The DECA-I/T scores correlated with what the parents were telling the service coordinator. The information from the DECA-I/T was useful to be able to share with parents. The tool supported communication with families. As results were shared, parents could elaborate on their thoughts and answers with *Early On* staff. Using the DECA-I/T gave the worker the family's input. It provided an additional tool to enhance the evaluation process.

3. **How useful was adding the DECA-I/T to the IDA? If it was useful, how did it help?**
   Adding the DECA-I/T to the IDA was useful overall according to the most sites. One site communicated, "It really did help (DECA-I/T) and validated the IDA. It helped to have the parent perspective. It was simple to add to the assessment process; 5 minutes to have the parents fill it out and 3 minutes to score it back at the office. After the IDA, they had mom fill out the DECA-I/T. If the child was having a difficult time, they would wait and have them fill it out at the next visit."

4. **Was the amount of time it took for parents to complete the assessment appropriate?**
   When asked if the amount of time it took for parents to complete the assessment was appropriate, pilot site staff generally responded that most parents filled it out in 5-10 minutes.

5. **Was the DECA-I/T easy to score and interpret for the practitioner?**
   All the pilot sites agreed that the DECA-I/T was easy to score and the results were easy to share with parents. They felt that the results were accurate and they seemed to validate parent's feelings and or concerns about their children. It gave a new perspective in some areas and made it easier to connect with parents. It was felt that using the scores from the DECA-I/T could be helpful to most sites when reporting outcome scores for the Child Outcomes reporting. "With the DECA-I/T, it makes it more concrete to have the score and see where it falls in the area of need." One home visitor reported that they had two exit assessments and both children improved on the DECA-I/T and the assessment protocol made it easier to show the improvement.

6. **Did parents have questions about items on the DECA-I/T that were hard to understand? Did you have parents you could not use it with because of a language barrier? (e.g. Spanish speaking)**
   The pilot sites were asked if parents had questions about items on the DECA-I/T that were hard to understand. For most parents, the items were easy to interpret and easy to complete Some sites indicated that they read the DECA-I/T questions to families with low literacy. One site indicated some concern about large words being used in the questions, i.e., frustration, preference, surroundings, and affection. Some families did not understand some questions or felt some questions were similar and the parents wondered why they were asked again.
   For some pilot communities, language was a barrier for some of their families who had home languages other than English. Currently, the DECA-I/T is only available in English however it will be available in Spanish on July 1, 2008. One area indicated a need for an Indian and Chinese translation and all felt the Spanish translation DECA-I/T would be helpful.

7. **Did you get the type of scores necessary for your program- percent delay, standard deviation delay?**
   The sites were asked if they were able to get the type of scores necessary for your program, percent delay, standard deviation delay. The sites did not use the DECA-I/T to get a percent delay because currently any delay meets the current *Early On* eligibility criteria. It was indicated by the sites, however, that you can get a percent delay or standard deviation delay from the DECA-I/T.

8. **What information can be provided to parents to assist them in promoting their child's social-emotional development?**

   Sites reported on information that can be provided to parents to assist them in promoting their child's social-emotional development. Some of these resources include Ages and Stages Questionnaire (ASQ), Help at Home, role modeling, Great Parents/Great Start Play groups, Love and Logic, providing Social/Emotional Wheels to parents and reviewing the wheels with the parents, referral to Early Head Start, Center for Disease Control (CDC) Learn the Signs Milestones, videos, Parenting Counts, Parents as Teachers materials, Emotional Coaching (Tolaris), Healthy Beginnings library, monthly parent get-togethers, Born Learning, play groups with Head Start which focus on meal time and eating issues, infant mental health programs, and parenting workshops.

9. **Does the use of the DECA-I/T assist with referrals to local CMHSPs?**

   All sites agreed that accessing infant mental health through local community mental health services programs is necessary and useful for infants and toddlers with social and emotional needs. In those communities where the local CMHSP was a partner in the pilot, the DECA-I/T assisted with that access.

10. **Was the amount of training on the DECA-I/T adequate for staff to be able to use and interpret the tool efficiently?**

    All staff from the five sites seemed satisfied with the amount of training. Some people thought it could have been shortened. Everyone felt that the conference calls were supportive. One area commented that they went back to their service area and trained several others on the DECA-I/T.

11. **Did the DECA-I/T assist with facilitating and obtaining services for the child and family?**

    One site replied that two families were referred to the local CMHSP and one followed through and one family did not. They also added that it did not assist with specific educational services. Another site replied "Yes, absolutely. *Early On* will continue to use the DECA-I/T for all kids in foster care (CAPTA referrals) and for all kids that show a social and emotional concern." This site indicated they will continue to collect data and CMHSP will continue to use it for at least a year to track the children. A third site said it helped in accessing services. A fourth site said, "Yes, it did with Special Education and some were qualified for *Early On*." A fifth site said that the tool did not help access services, however, this site reported using the DECA-I/T with only ten children.

Questions and Comments to be addressed with the DECA-I/T and the AIMS :

1. **How useful was adding the AIMS to the IDA? If it was useful, how did it help?**
   The use of the AIMS had mixed reviews. Some felt it would help a new worker in the field, but it was not that helpful to experienced staff. Two service areas stated that they did not use the AIMS at all. On the other hand, two sites stated, "It made the observation much richer. It gave credence that the observations had been made. The AIMS makes it very clear, the items are very clear, concrete and measurable which helps with audits." The majority of sites felt that adding the AIMS to the IDA was overwhelming. This resulted in two sites not using the AIMS throughout the pilot.

2. **Are there any other comments or observations that you would like to share about using the DECA-I/T or AIMS?**

   Some of the responses to particular questions or observations listed below were addressed during training and some came up during the pilot phase and would be addressed by technical assistance and additional training.

   - All the sites had concerns with the age ranges believing that the ages need to be broken down further such as 0-3 months, 3-6 months, etc
   - The amount of time for parents to fill out the questionnaire was 5-10 minutes with the exception of when there were language barriers, foster parents involved, and families involved with Children's Protective Services who seemed to be more defensive.
   - One site reported that getting the consent to participate in the pilot form signed and explaining the assessment tools that were a part of a pilot study took a lot of time. They stated concern that the DECA-I/T is not an approved tool for measuring the Child Outcome "Children have positive social relationships".
   - One site suggested that there be a breakdown in the 0-18 months with the DECA-I/T since it is such a large age span or an alternative would be to have a N/A response. It was reported that two parents saw their child differently when both of the child's parents completed the questionnaire.
   - One site felt that the DECA-I/T may have lost value when using a Spanish translator or when the evaluation tool was read out loud, the content may have changed for the listener.
   - It was stated that it would be helpful to have the DECA-I/T Strategies Guide that is yet to be published.

Summary of Additional Comments

"It was the most worthwhile pilot ever". The *Early On* service area and the local community mental health services program (CMHSP) are committed to continuing to use the DECA-I/T.

"The DECA-I/T enhanced the ability to be descriptive in the social emotional area. The DECA-I/T provides areas of typical behavior and strengths that highlight the positive and not just point out the things that are deficits". "We will continue to use the DECA-I/T".

We made the decision to continue to use the DECA-I/T. For a child that does not appear to have any social and emotional areas of concern and clearly has another issue, then the DECA-I/T should be administered annually. For a child with social-emotional concerns, they plan to administer the DECA-I/T on a quarterly basis.

"There was one child where the results from the DECA-I/T alone made the child eligible for services from the local (CMHSP)."

Conclusion

The objective of this pilot was to:

- Investigate whether or not the DECA-I/T and the AIMS were a good fit for the *Early On* evaluations process; and;
- Explore the DECA-I/T and AIMS ability to assist staff in identifying children with social and emotional concerns.

Overall, the DECA-I/T was identified as a usable tool across the pilot sites. It was easy to complete and score, easy to understand and the results were able to be shared readily with families. The tool is sensitive to change and can show improvement and provides standard deviation scores. The AIMS was used intermittently in programs. Overall, pilot sites felt it was a good tool for observation yet wasn't always necessary for the more "seasoned" staff.

The DECA-I/T assisted the pilot sites to identify 39 additional infants and toddlers for *Early On* services that otherwise would not have qualified based on IDA scores alone. Using this tool did assist in identifying children with social-emotional risk including children referred from DHS. In addition, in those sites where CMH was a partner, the DECA-I/T facilitated access to CMH for services.

It was unclear whether or not the AIMS assisted in identifying children with social-emotional risk as it was not used consistently across the pilot sites and outcomes from the AIMS were not reported in the monthly data reports as it is an observational tool that does not elicit standard scores. It may be a tool

that is used to help drive observation of social emotional health for newer staff. Based on these results, the following recommendations are being made.

RECOMMENDATIONS TO THE MICC:

1. It is recommended that the DECA -I/T be utilized along with the IDA (or other assessment tool) when evaluating infants and toddlers for *Early On* eligibility and enrollment.

2. It is recommended that the *Early On* Coordinators receive training on the DECA-I/T statewide and have access to technical assistance regarding the DECA-I/T and social emotional health.

ATTACHMENT A

Social Emotional Tools
Protocol of Questions

1. Does the tool measure the infant-toddler's positive social relationships?
2. Does the tool measure attachment to the significant caregiver in their lives?
3. Does the tool measure the infant –toddler's ability to initiate and/or maintain social interactions?
4. Does the tool measure the infant-toddler's behavior that allows the to participate in a variety of settings and situations? (childcare, playground, etc.)
5. Does the tool measure the infant-toddler's having trust in others?
6. Does the tool measure the infant-toddler's ability to regulate their emotions?
7. Does the tool measure the infant-toddler building and maintaining relationships with children and adults?
8. Does the tool measure the infant-toddler's ability to understand and follow rules?
9. Does the tool measure the infant-toddler's ability to solve social problems?
10. Is the tool straightforward enough to be administered, scored, and interpreted by staff with diverse educational backgrounds?
11. Can the tool be used to show change (pre-post) in the social-emotional are?
12. Is the tool applicable for infants and toddlers from birth to 3 years of age?