Child Guidance

FY 2011 Annual Report

Oklahoma State Department of Health

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Dear Reader,

This year's *Child Guidance Annual Report* represents data from the first complete fiscal year following a program reorganization. July 1, 2010 the Child Guidance program was reorganized into 16 regional county locations, the number of staff was decreased from 80 to 57, impacting the total Child Guidance Budget by approximately $2 million dollars. The reorganization was necessitated by staff attrition, shrinking budgets and the needs of state and local partners. The reorganized Child Guidance Program is grounded in evidence based practices, maximizes federal revenue and fee collection, is collaborative with other state and local agencies and demonstrates outcomes toward improving the health of our children.

Advancement toward our goals has been encouraging. As with all projects there is always room for improvement, but I am impressed with the progress that has been made this year. I sincerely wish to thank our Child Guidance staff across the state who have worked so hard to achieve this progress. Support from senior leadership, especially our deputy and assistant deputy commissioners, Steve Ronck and Toni Frioux, has been invaluable. To all our agency partners, local and state, thanks for making Child Guidance, where families find solutions!

Beth M. Martin, M.A., C.C.C.

Chief, Child Guidance Service

Oklahoma State Department of Health

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Reorganization: The Plan

July 1, 2010 the Child Guidance Program underwent a reorganization with support from the Oklahoma State Department of Health (OSDH) senior leadership and input from key agency stakeholders and program staff. Factors influencing the need for a restructure of the program included staff attrition, budget restraints, discrepancies in mission and activities and lack of program evaluation.

The process in developing restructuring recommendations involved conducting an internal Needs Assessment that included:

- Input from other key agency stakeholders
- Review of current activities, outcomes, levels of productivity, staff qualifications, locations of service delivery, and current fee collections
- Identification of potential clinic locations and,
- Examination of current and future income producing activities to sustain the program

Four recommendations were agreed upon and OSDH began implementing the following action steps in July 2010:

Recommendation #1:

Restructure the location of existing Child Guidance sites to reduce the number of counties receiving services. This resulted in a reduction of the number of staff, from approximately 80 to approximately 50 – 55.

Based on review of multiple sources, it was determined to target more populated economic hubs to serve as Regional Child Guidance Centers. The proposed counties included: **Carter, Oklahoma, Rogers, Bryant, Canadian, Garfield, Comanche, Pottawatomie, Cleveland, Muskogee, Kay, Leflore, Pittsburg, Payne, Woodward and Tulsa.** Each of these sites would be staffed with a full cadre of Child Guidance clinicians to provide the most effective intervention approach. This would include a behavioral health clinician, child development specialist, and speech-language pathologist.

Recommendation #2:

The Family Planning fee schedule percent to pay, which lowers the income level on the private pay scale was adopted.

According to the current Board of Health rules, established in May, 2006, the Commissioner of Health approves the percent to pay on the Child Guidance fee schedule. It was recommended that the Family Planning percent to pay schedule be adopted, which begins at 100% and slides to 250% of FPL. This replaced the Child Guidance schedule that began at 185% and slides to 350% of FPL.

Recommendation #3: Medicaid was maximized as well as fee collection. This was done by establishing standards of 50% billable hours per week of direct services provided by clinicians.

In order to increase funding for Child Guidance program activities, primary expectations for service delivery were maximized to include:

- Each clinician providing at least 50% billable hours
- All individual services were provided at the headquarter location, with travel only to provide on-site consultation to child care, schools or primary care facilities, resulting in a cost saving for travel to satellite counties
- Services were focused on providing screening, assessment, intervention and skills based training. This allowed staff to focus on Child Guidance program income producing and measurable activities which decreased or eliminated activities that were not measurable or did not produce income.

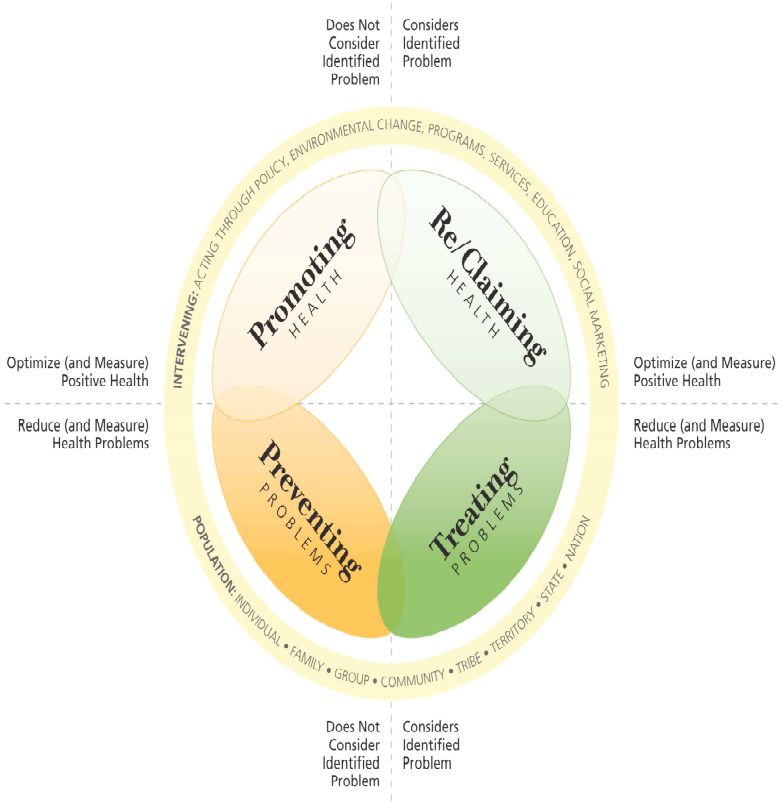
Recommendation #4: A specific set of services to be provided by Child Guidance staff was determined and evaluative measures were designed and implemented to begin the process of collecting baseline evaluation data. Tools developed included measuring participant satisfaction with services which included a review of the clients perceived results of the service, review of the overall services received, interaction with Child Guidance staff, and overall satisfaction. Pre-post test measures of perceived parenting stress, developmental skill levels, and attachment were developed and completed by the client. To support specific evidence-based skills based parenting models, measures were also developed and utilized. To measure productivity, it was determined that it would be necessary to have the supports within the PHOCIS system and other electronic data systems to collect and measure this information.

Theoretical Foundations and Supporting Research

Child Guidance leadership also conducted a review of current literature on best practice recommendations in early childhood mental health for states, policy makers and practitioners. *A Public Health Approach to Mental Health*, a joint effort between SAMHSA and the National Technical Assistance Center for Children's Mental Health at Georgetown University Center for Child and Human Development developed a *Model for Intervening for Children's Mental Health*. This model addressed a continuum of services from Promotion to Re-Claiming Mental Health. The Child Guidance program strongly identified with the concepts and recommendations in the axis *Preventing Problems*. This particular axis consisted of the following services: mental health consultation; student support services; early identification, assessment, referral, and follow-up; short term

counseling and support groups; skills building classes; ongoing crisis support; and mentoring.

Figure 1



Based on this model, the Child Guidance program better defined the focus of its services into a program that was dedicated to best practice recommendations. The Child Guidance staff received continued training and currently provides mental health consultation, early identification, assessment, referral and follow-up, skills building classes, short term counseling and support groups. Specific program interventions currently being used that provide skills based parent training and outcomes include:

- Parent-Child Interaction Therapy (PCIT)
- The Incredible Years Program
- The Hanen Program

Another pivotal research study that guided the restructure of Child Guidance included a full review of the *Adverse Childhood Experience (ACE) Study.* [1] This study, completed in 1998, linked the importance of risk and protective factors in early childhood to numerous health outcomes in adults. Although the Child Guidance Program does not provide services to adolescents and adults, the result of effective early intervention with young children was irrevocably tied to health outcomes in adulthood. While much has been written in recent years on this ground breaking research, the most compelling statistic from this study for Child Guidance is the fact that only one-third of persons who participated in the original ACE study reported no adverse childhood experiences. That means that potentially two-thirds of all children have experiences in at least one category of adverse experience. Effective early intervention programs like Child Guidance provide the necessary supports to assist families and children to help avoid poor health outcomes.

[1] (Felitte & Anda)

Reorganization: UPDATE

Recommendation #1: The goal was to restructure the location of services from statewide to 16 regional County Health Department sites. This began in the spring of 2010 and was complete by July 1, 2010. Child Guidance staff was reduced from 80 to 57. Each regional location was comprised of professionals from the disciplines of Child Development, Behavioral Health and Speech/Language Pathology. This also included contracts for services in Oklahoma and Tulsa Counties. Beginning July 1, 2010, central office staff implemented recruiting efforts to fill 24 vacant OSDH positions and 8 contract positions in the identified counties. Initially, Woodward County was identified as a site for Child Guidance services, but recruiting efforts were not successful and those positions were relocated to Custer County later in the fiscal year.

Figure 2

Recommendation #2: The Family Planning fee schedule was adopted, it begins at 100% of the Federal Poverty Level (FPL) and slides to 250% of the FPL. This replaced the previous Child Guidance sliding scale which began at 185% of the FPL and went to 350% of the FPL. These changes were put into place July 1, 2010. The purpose of compressing the fee schedule aligned Child Guidance's fee schedule with the rest of the agency and increased the amount that private pay (non-Medicaid) clients paid for services.

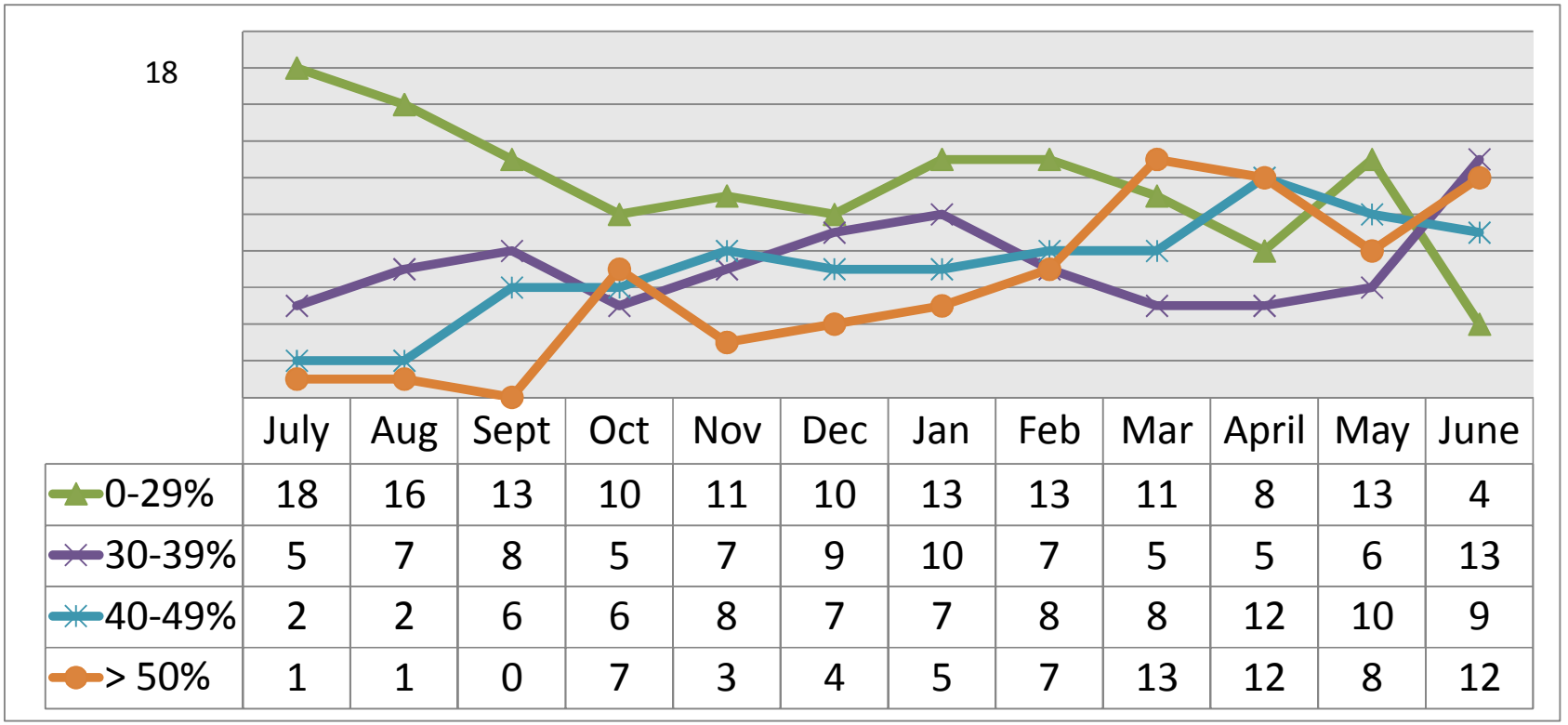
Recommendation #3: In order to maximize fee collection both private pay, contract and Medicaid; Child Guidance services became clinic-based. These services focused on screening, assessment/evaluation and treatment. Table 1 shows a comparison of billing and collections for SFY 2010 and 2011. It should be noted that in SFY 2010 Child Guidance had approximately 86 clinicians providing services and for the majority of SFY 2011 there were approximately 50 clinicians providing services.

Table 1

	Medicaid Billed	PAR Billed	Total	Medicaid Collected	PAR Collected	Total
FY2010	$897,173.04	$325,167.66	$1,222,340.70	$606,566.48	$278,956.58	$885,523.06
FY2011	$578,209.88	$310,658.60	$888,868.48	$667,690.77*	$264,342.23	$932,033.00

* Includes Medicaid collects and MAC collections

Table 2



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
0-29%	18	16	13	10	11	10	13	13	11	8	13	4
30-39%	5	7	8	5	7	9	10	7	5	5	6	13
40-49%	2	2	6	6	8	7	7	8	8	12	10	9
> 50%	1	1	0	7	3	4	5	7	13	12	8	12

The second part of Recommendation #2 involved increasing staff productivity levels. A goal of 50% billable hours per week was set. Steady progress has been documented toward meeting this goal (Table 2). In July 2010, 11% of the staff achieved 40% productivity or better. By the end of the fiscal year, 55% of the staff achieved 40% productivity or better and 32% of the staff were consistently achieving the 50% mark. As the Child Guidance productivity numbers improved, income generated by the program has increased, which will enable more self-sufficiency and less dependence on other revenue sources. While it is not feasible for this program to be totally self-sufficient, it is possible to generate revenue through individual billing and contracts to offset approximately 50% of the costs.

It is noted that factors that played a role in the success of revenue collections included strong clerical support and clinician start up time. Due to recent budget constraints many of the local county health departments have

experienced clerical shortages. In order for the restructured Child Guidance Program to be effective, clerical support was crucial. The less time that a clinician spent scheduling appointments, entering billing information in to PHOCIS, completing PHOCIS modules, etc., the more time they had to spend with clients. The counties that have demonstrated the most success in increasing revenues have been the ones with dedicated clerical support. Another factor that affected productivity and billing was the amount of time it took to train and orient a new clinician to the program or an existing clinician to orient to a new location. The foundation of the program has been based on referrals and community connections. If a clinician was new to an area, it could take six months to a year to connect with community partners and develop a referral base to support services. Of the 16 locations, 9 had either 2 or more clinicians that were new to the location and had to be recruited, trained, and establish themselves and their services within the community and/or a Child Guidance clinic location had not been in that area for several years making it difficult to generate referrals until community collaboration could be established.

Recommendation #4: Focusing on quality of relationships, parental ability, and capacity of communities served as the determined evaluative indicators for the Child Guidance Program. These indicators then resulted in the development and implementation of evaluation measures to result in baseline outcomes. Beginning July 1, 2010 every client who received services through the Child Guidance Program was asked to complete pre/post surveys and a client satisfaction survey. Broad measures of client satisfaction, parenting competence and school readiness were collected for the first time. Assessment protocols were also developed for the evidence-based program, *Incredible Years.*

Child Guidance Client Demographics

Demographics for the Child Guidance Program are reported for *Individual Services* and *Population Based Services*. Individual Services are represented as **total client services** and as **new client services.**

Individual Services

Total Client Services

During State Fiscal Year 2011, Child Guidance staff provided services to 5,359 individual clients. These clients received 24,700 services during 17,555 encounter visits.

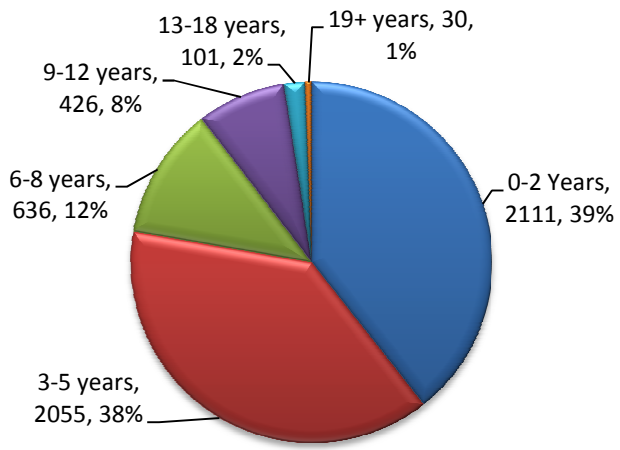
Table 3 provides information about clients receiving services in Child Guidance clinics. Almost 60% of clients seen were males. 94% of Child Guidance clients spoke English as their primary language. A little over 5% of clients reported speaking Spanish which remains consistent from previous years. Providing services to children in foster care is a priority for the Child Guidance program and almost 5% of the clients seen were in foster care.

Table 3

Child Guidance Clients FY 2011		
	#	%
Gender		
Female	2,201	41.1%
Male	3,158	58.9%
	5,359	
Primary Language		
English	5,037	94.0%
Spanish	292	5.4%
American Sign Language	3	0.1%
Other	27	0.5%
	5,359	
Disability		
Vision Impaired	0	0.0%
Hearing Impaired	7	0.1%
Other	58	1.1%
None	3,968	74.0%
Unknown	1326	24.7%
	5359	
Foster Child		
Yes	250	4.7%
No	5,109	95.3%
	5359	

Figure 3

Number of Clients by Age Group

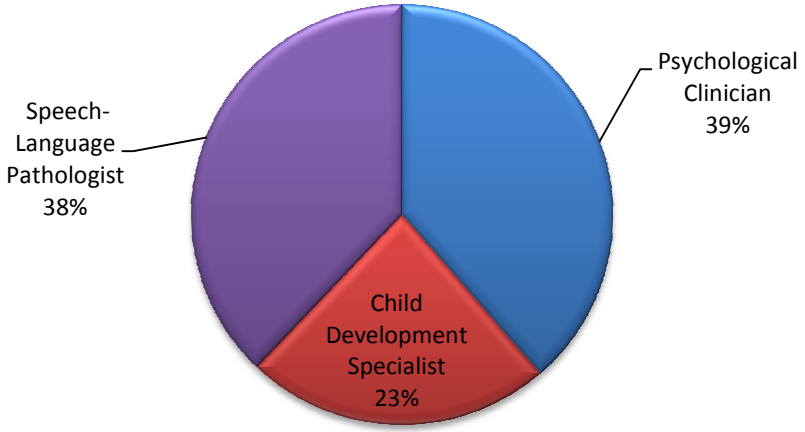


By statute, Child Guidance services are available to Oklahoma children from birth to 13 years of age and their families. However, occasionally services are provided on an emergency basis to clients outside this age range. Figure 3 shows the number of clients separated by age group. 89% of the total population seen for Child Guidance services were children birth to age eight years. This represents the population identified by agency partners and stakeholders as most in need of services, both assessment and intervention. Child Guidance has been identified by these same partners as being most qualified to provide such services.

Behavioral Health services make up 39% of the all encounters with Speech/Language Pathology services providing 38% of encounters and Child Development at 23%.

Figure 4

Number of Encounters by Discipline



After each encounter with a client, Child Guidance staff code each service provided for entry into the OSDH Public Health Oklahoma Client Information System (PHOCIS). Figures 4,5 and 6 show the services provided by Child Development Specialists, Behavioral Health and Speech/Language Pathologists respectively. The majority of individual client services provided by Child Development Specialists are developmental screenings or assessments, while Behavioral Health Clinicians provide the majority of intervention services. Speech/Language Pathologists provided almost half of their services in screening, approximately 40% in intervention and the rest are made up of consultation and assessment.

Figure 4

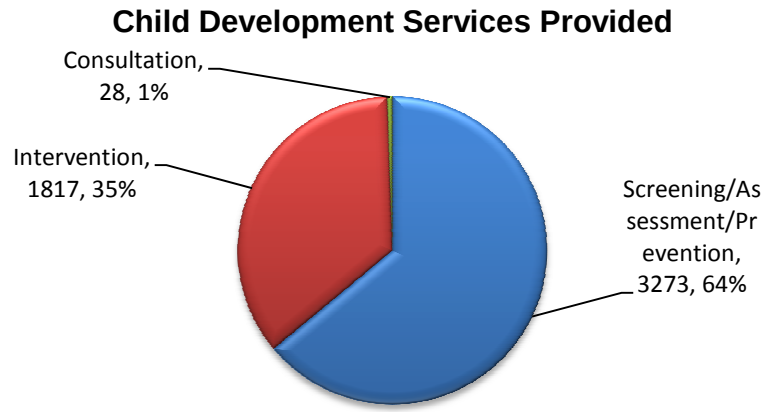


Figure 5

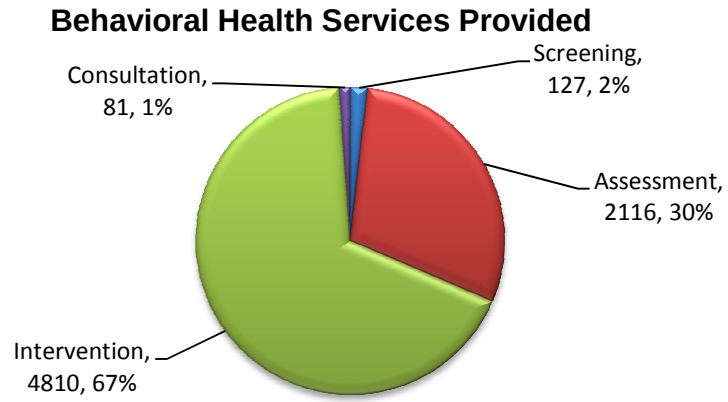


Figure 6

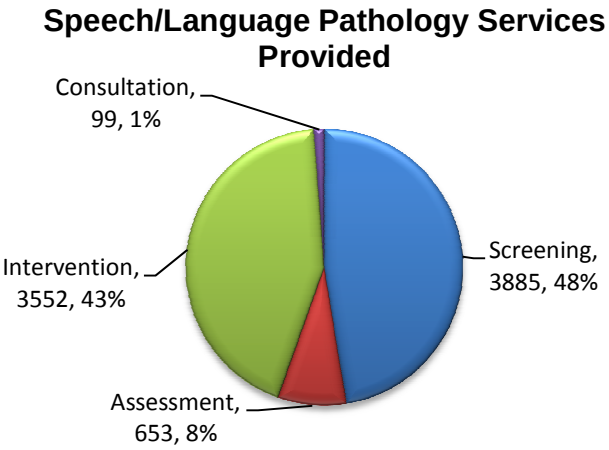


Figure 7

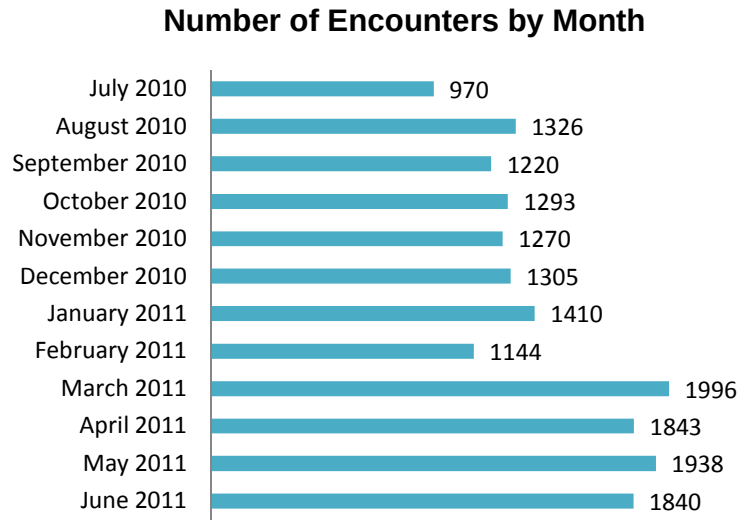
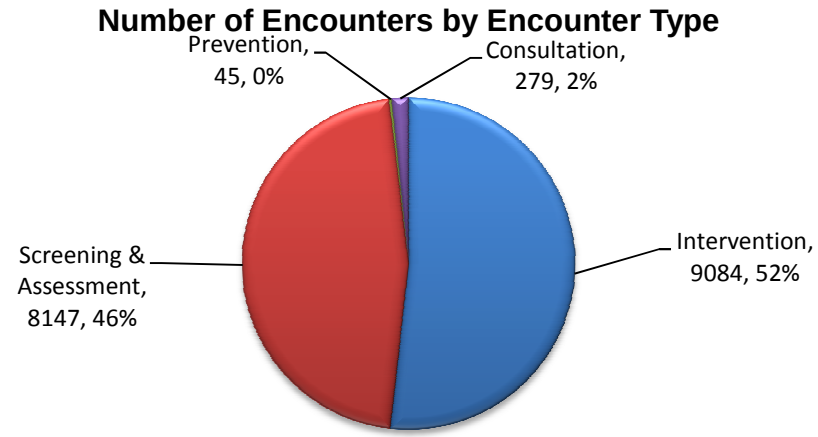


Figure 8



In SFY 2011 Child Guidance services were provided in regional clinic locations, fourteen OSDH county sites and through contracts with Oklahoma City County Health Department and Tulsa City County Health Department. Figure 7 shows a steady increase in services as the year progresses. This trend correlates with information collected regarding staff productivity and billing.

Figure 8 represents the types of encounter services that were provided by Child Guidance staff. Services were approximately half intervention and half screening and assessment; with a small portion of time spent in consultation and prevention. This figure confirms the change in direction of increasing the amount of billable services and decreasing the amount of non-billable services.

Top 10 Child Guidance Diagnosis Codes

Table 4

	Coding Frequency	Percent
315.3 **Language Disorder**	3601	20.6%
315.9 **Unspecified delay in development**	3535	20.2%
V61.20 **Counseling for parent-child problem, unspecified**	815	4.7%
315.39 **Other speech disorder; Developmental articulation disorder; Dyslalia; Phonological disorder**	810	4.6%
V71 **Observation for other specified suspected condition (speech WNL)**	747	4.3%
314.00 **Attention deficit disorder w/o hyperactivity**	732	4.2%
312.9 **Unspecified disturbance of conduct**	700	4.0%
389.1 **Sensorineural Hearing Loss Unspecified**	694	4.0%
V72.11 **Encounter for hearing exam following failed hearing screening**	675	3.9%
309.4 **Adjustment reaction with mixed disturbance of emotions and conduct**	572	3.3%

Language Disorder was the most commonly diagnosed condition by Child Guidance clinicians followed closely by Developmental Delay. A little over 4% of the clients seen were diagnosed with Attention Deficit Disorder without Hyperactivity. Hearing screening made up another 8%.

New Clients Seen in SFY 2011

Table 5

Child's Current Health Status			
	Excellent	1034	28.1%
	Very good	1133	30.7%
	Good	1205	32.7%
	Fair	134	3.6%
	Poor	22	0.6%
	Unknown	158	4.3%
		3686	
Child's Weight at Birth			
	Very Low Birth Wt.	74	2.0%
	Low Birth Wt.	383	10.4%
	Average Birth Wt.	2594	70.4%
	Above Average Birth Wt.	207	5.6%
	Unknown	428	11.6%
		3686	

There were a total of 3,686 ***new*** clients receiving Child Guidance services during SFY 2011, approximately 90% of whom self-reported to be in good to excellent health. A little over 12% self-reported as having low or very low birth weight.

Table 6

Child is on IEP or IFSP	#	%
Yes	312	8.5
No	2976	80.7
Unknown	398	10.8
	3686	
Size of child's household		
2 persons	286	7.8
3-4 persons	1971	53.5
5-6 persons	990	26.9
7-8 persons	212	5.8
9-10 persons	27	0.7
11 or more	9	0.2
Unknown	191	5.2
	3686	
Household receives Public Assistance		
Yes	2968	80.5
No	703	19.1
Unknown	15	0.4
	3686	
Person(s) responsible for Child's Care		
Married parents	1599	43.5
Single mother	917	25.0
Non-married parents living together	422	11.5
Unknown	218	6.0
Foster parent(s) / Guardian(s)	161	4.4
Divorced parents, joint responsibilities	158	4.3
Grandparent(s)	138	3.7
Single father	58	1.6

The majority of children seen for Child Guidance services, 80%, also receive some kind of public assistance. This may include Sooner Care, WIC services, Temporary Aid For Needy Families (TANF), Food Stamps, housing assistance, Social Security, unemployment payment, free or reduced school meals or job training assistance. Approximately 44% of clients seen this year lived with two married parents and the same proportion identified biological mother as the primary caregiver (these are not necessarily the same families). Foster parents made up 4.4% of parents seeking services from the Child Guidance program.

Figure 9

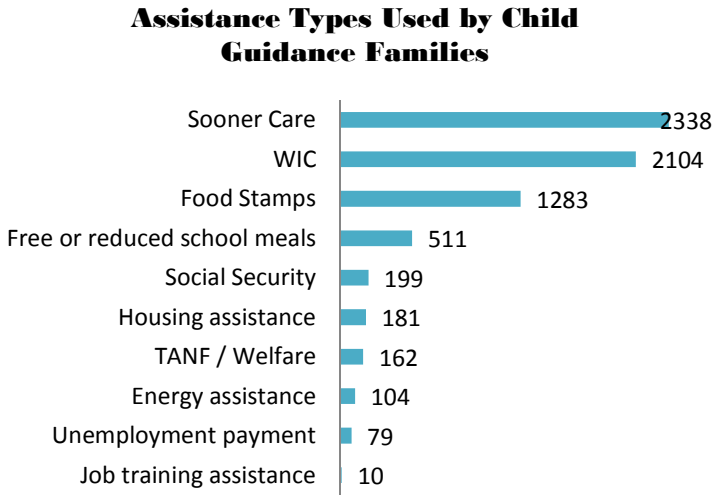


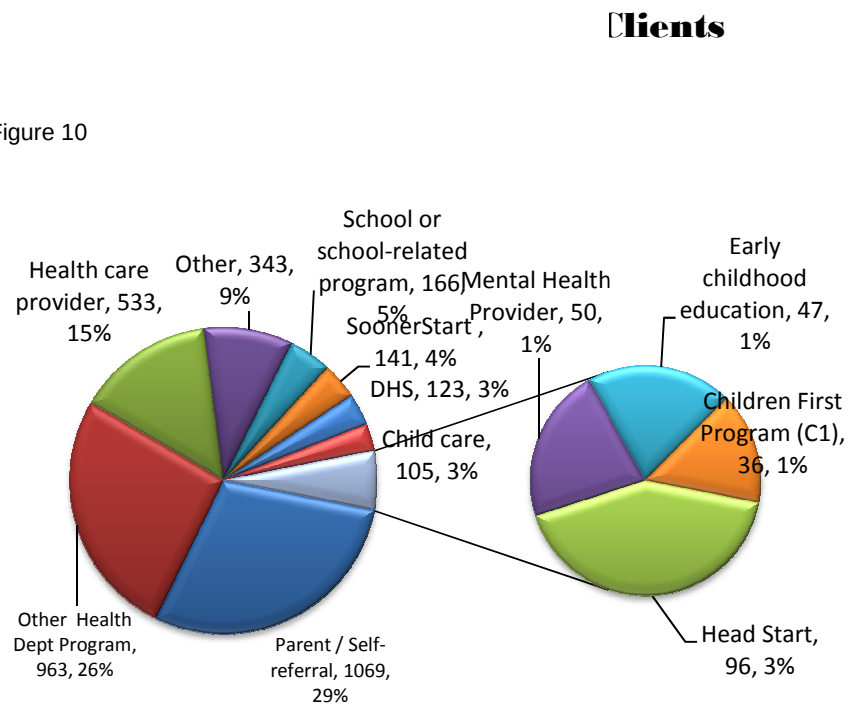
Table 7

Of the children served by the Child Guidance program, where biological mother is the primary caregiver, 28% of mothers reported having a high school education and 57.3% had at least some college. Research has shown that a mother's educational level can have a profound effect on a child's cognitive and behavioral development. In a study by Carneiro et al, a one year increase in mother's education (past high school) has "…strong effects on child behavioral problems. There is an interesting pattern in these results: the effects on math and reading decline with the age of the child, while the effect on behavior is increasing."[2] The earlier a child's behavioral problems are addressed the better the likelihood of long term success.

Biological Mother is Primary Caregiver			
Yes		1605	43.5
No		2081	56.5
If Yes, Mother's Highest Educational Level			
	Grades 0-8	42	2.6%
	Grades 9-11	193	12.0%
	High School	451	28.1%
	Some college	560	34.9%
	College Graduate	220	13.7%
	Post-college degree	54	3.4%
	Unknown	85	5.3%
Highest Educational Level in Household			
	Grades 0-8	60	1.6%
	Grades 9-11	225	6.1%
	High School	922	25.0%
	Some college	1138	30.9%
	College Graduate	676	18.3%
	Post-college degree	204	5.5%
	Unknown	461	12.5%

[2] (Carneiro, Meghir, & Parey, 2007)

Figure 10



Child Guidance clients are referred for services through a variety of circumstances. The majority of new clients were either self referred or referred by another health department program. Figure 10 shows the referral sources for new clients in FY 2011.

Historically the SoonerStart Early Intervention Program (EI) has been a strong partner with Child Guidance in serving very young children. This year, another dimension was added to that partnership. Budget constraints and the need for services affected both programs, so a working agreement was developed with the approval of the Oklahoma State Department of Education (OSDE) and OSDH. In the event EI staffing levels and/or contract funds are inadequate to meet service needs, SoonerStart will make a referral to Child Guidance for infants and toddlers receiving services on an IFSP or determined eligible to receive services and who are Medicaid-eligible.

In the event an EI service provider cannot be identified as indicated above, infants and toddlers who are Medicaid-eligible shall be referred to Child Guidance in areas where available when speech, child development, or behavioral health services are determined to be the most appropriate. IFSP services offered to families provided by Child Guidance will be provided at the County Health Department.

This agreement has been beneficial to both programs. Child Guidance staff have provided clinic-based direct service hours and SoonerStart has been able to serve families that may not have received adequate services.

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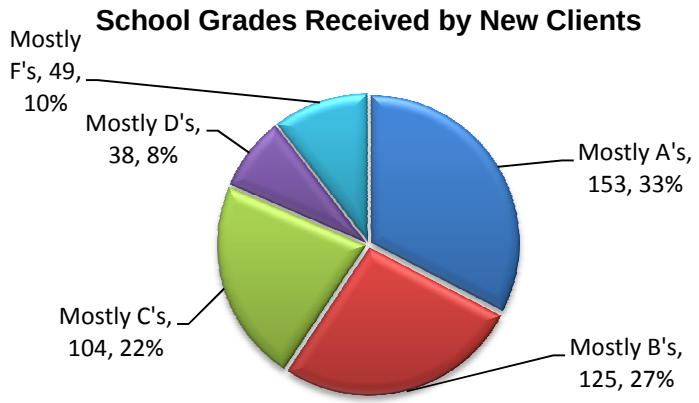
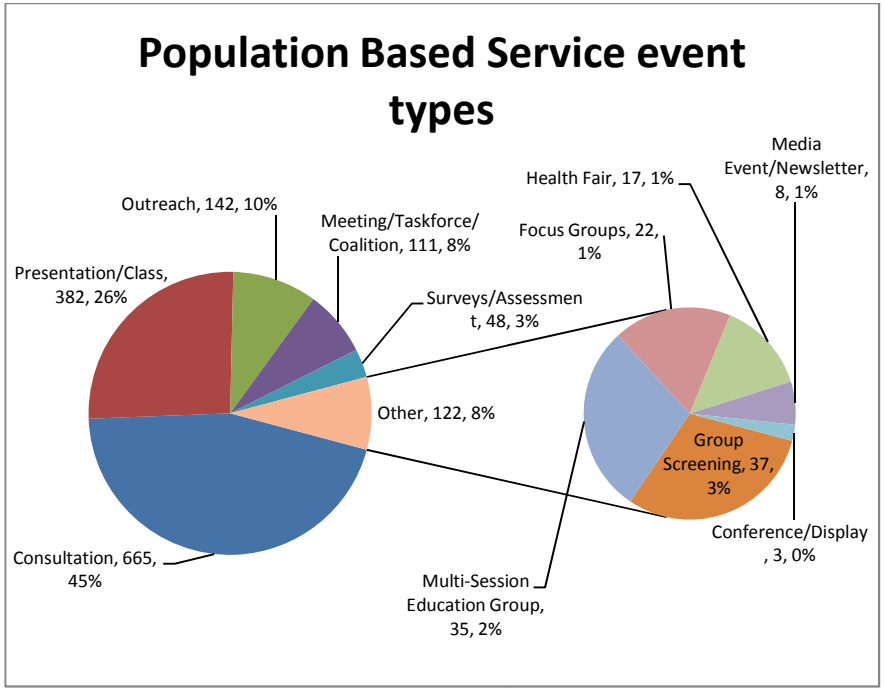
Figure 11



Data on school grades were collected on 469 new clients. Figure 11 shows the grades new clients were receiving upon intake. 77% of new clients seen through the Child Guidance Program were not school age and therefore this measure of school success was not applicable. Of the school age clients seen, 18% were having significant problems with school achievement.

d Services

Child Guidance staff provided a total of 1,470 Population Based Events were provided by Child Guidance staff during FY 2011. Population Based Services are those in which more than one person is in attendance to receive the services, and generally take place in a location other than the county health department.



Child Guidance Program Indicators and Outcomes

Recommendation number four under the Child Guidance reorganization was to implement program evaluation measures. The purpose of program evaluation was to determine indicators and gather baseline data that began the process of measuring the effectiveness of Child Guidance programs using outcome evaluation methods. Further, to verify the extent of fidelity to evidence-based programs, process evaluation measures were developed and implemented to gather evaluation information. These measures were specifically created to support *The Incredible Years* program.

Outcome Evaluation

As part of the outcome evaluation satisfaction surveys and pre and post test surveys were utilized. Clients receiving a screening, assessment, or evaluation only received a short satisfaction survey to complete. Clients receiving treatment or intervention services received the pre and post surveys and the long satisfaction survey to complete.

The Child Guidance pre and post surveys are administered to measure change in the client and to compare data with other data sources. The long satisfaction survey is administered to assess the when the client receives intervention or treatment services.

The Child Guidance Program Outcomes were developed in line with the goals of the program:

- To improve the quality of family relationships, including parental, parent-child and sibling; and relationships of family members to their external community and its institutions

    1. Parents using Child Guidance services will report a decrease in inappropriate social emotional behaviors (i.e. difficulty with emotion, concentration, behavior, and/or being able to get along with other people).
    2. Clients using Child Guidance services will have a decrease in expulsion from care/school settings (i.e. child care, mother's day out, Head Start, preschool, Pre-K, or school) due to their behavior.

- To increase parent's abilities to provide appropriate guidance and learning opportunities for children

    1. Parents using Child Guidance services will report an increase in their ability to help their child learn.
    2. Parents and children using Child Guidance services will report an increase in protective

factors for child abuse and neglect (supportive caregiver child relationship, coping strategies, readiness for change, knowledge of parenting, knowledge of child development)

3. Parents and children using Child Guidance services will report a decrease in risk factors for child abuse and neglect. (impaired caregiver/child relationship, family conflict, use of harsh discipline, parents unaware of developmental norms, negative attitude toward child's behavior)

- To improve the capacities of communities to provide support and resources for families to successfully rear their children
  1. Child Guidance Program will staff 14 OSDH counties and two contracts (Oklahoma and Tulsa Counties) with teams of professionals made up of Behavioral Health Specialists, Child Development Specialists and Speech/Language Pathologists.
  2. Child Guidance Program staff will increase the number of Mental Health Consultations provided to Child Care Facilities.
  3. Child Guidance Service/DHS Child Care Warmline will increase the number of calls responded to by Warmline staff.

Table 8

Indicator 1: Quality of Relationships	Target	Result
***Outcome 1*:** Percent of families receiving Child Guidance services who report a decrease in inappropriate social emotional behaviors.	*	48.2%
***Outcome 2*:** Percent of clients receiving Child Guidance services who report an expulsion from school/care due to behavior.	*	7%
Indicator 2: Parental Ability		
***Outcome 1*:** Percent of parents receiving Child Guidance services who report an increase in their ability to help their child learn	*	30%
Outcome 2: Percent of parents receiving Child Guidance services who report an increase in protective factors for child abuse and neglect.	*	30%
***Outcome 3*:** Percent of parents receiving Child Guidance services who report a decrease in risk factors for child abuse and neglect.	*	25%
Indicator 2: Capacity of Communities		
***Outcome 1*:** Number of counties with full Child Guidance Teams in FY2011	16	13
***Outcome 2*:** Number of requests for Mental Health Consultations provided in FY2011	149	158
***Outcome3*:** Number of calls to the Warmline for FY 2011	1,849	1,969

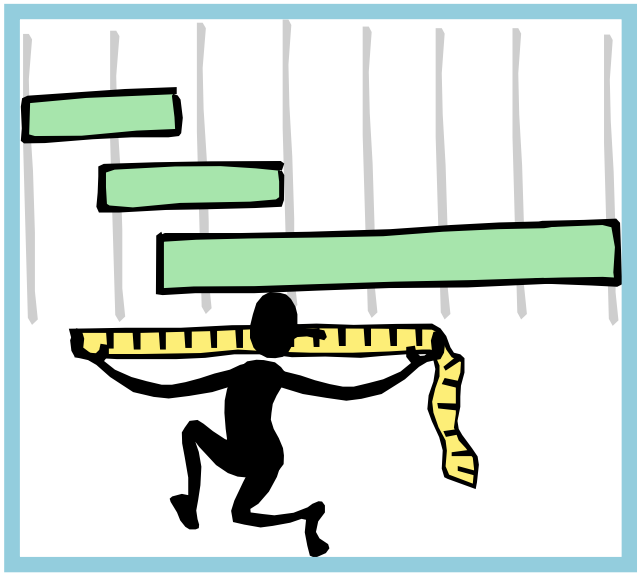
*As this represents the first year of data collection for the program, no baseline targets were set for FY2011. This data will now be used to set baselines for FY2012.

Academic preparedness is not the only marker for school readiness. It may not even be the most important marker. "Children who are emotionally well adjusted have a significantly greater chance of early school success, while children who experience serious emotional difficulty face grave risks of early school difficulty." [3] Of the families who responded to Child Guidance surveys in SFY 2011, almost half 48.2% reported seeing a decrease in inappropriate social emotional behaviors in their children.

In order for a child to learn, they must be present in a learning environment. Children who are expelled from care/school settings due to their behavior are not afforded the same learning opportunities as other classmates. While a relatively small number of Child Guidance clients reported experiencing care/school expulsion while receiving Child Guidance services, 7%; the Child Guidance Program provides specific services in this area. As part of the network of Early Childhood Mental Health Consultants, Child Guidance Behavioral Health Specialists and Child Development Specialists provide mental health consultation across the state to child care facilities who accept subsidy from the Department of Human Services (DHS). In SFY 2011, 24 Child Guidance clinicians made 754 visits to 104 different child care facilities in Oklahoma.

It has been said that parents are their children's first and best teachers, 30% of respondents who received Child Guidance services in SFY 2011 reported an increase in their ability to help their child learn.

30% of families who received Child Guidance services reported an increase of protective factors such as supportive caregiver child relationship, coping strategies, readiness for change, knowledge of parenting and knowledge of child development. 25% reported a decrease in risk factors such as impaired caregiver/child relationship, family conflict, use of harsh discipline, parents unaware of developmental norms and negative attitude toward child's behavior.



[3] (Raver)

Parental Satisfaction

Parental Satisfaction with Child Guidance Treatment Services

A client satisfaction survey was given to those receiving Child Guidance treatment services, defined as three or more visits. Clients were asked to rate their satisfaction on several items in the categories of *Results*, *Staff*, *Services* and *Overall Satisfaction*. Responses were rated on a scale of 0 to 4 with "0" representing "no opinion" and "4" representing "strong agreement". The results of this survey indicated that clients were, in general, satisfied with the services they received. The percentages reported below indicate the percent of "4's" that item received:

- 80% of clients showed especially strong agreement that the services provided were helpful to their children and families
- 61% of clients strongly agreed that the location of service was convenient
- 66% strongly agreed that available times were convenient
- 53% reported being involved in treatment plan development for their child.
- 82% of those surveyed liked the Child Guidance staff that worked with them
- 81% reported that staff listened to them and treated them with respect
- 75% reported that staff spoke with them in a way they understood
- 73% reported that they were satisfied with the services they received
- 77% reported that they would use Child Guidance services again
- 75% reported that they would recommend Child Guidance to a friend

Parental Satisfaction with Child Guidance Screening and Assessment Services

Families who accessed Child Guidance services for screening and/or assessment services, defined as one to three visits, were provided a shorter version of the Satisfaction Survey. The same rating scale was used. The percentages reported below indicate the percent of "4's" that item received:

- 76% reported the services were of good quality
- 75% reported that the clinician helped them understand the next steps to take with their child
- 73% reported that they would follow up with suggestions they received
- 79% reported that they were treated with respect

Incredible Years

The Incredible Years Parent Program is a 12 to 16 week evidence-based program for parents of children birth to 8 years of age. The focus of the program is strengthening positive and nurturing parenting skills, as well as reducing challenging behaviors in children and increasing their social and self-control skills.

Results

Parents were asked to complete the Social Competence Scale for Parents (P-COMP) and the Parent Practices Interview (PPI) both before the first class and after the last class. These were used to measure the effects of treatment.

For the P-COMP, one subscale (Emotional Regulation Skills) and the total scale had a statistically significant difference in pre and post means, showing that after the Incredible Years Parent classes, parent's believed their child had better emotional regulation skills. For the PPI, two of the subscales had a statistically significant difference in pre and post means, showing that after the Incredible Years Parent classes, parents were not as harsh or inconsistent with their discipline and they reported a decrease in the use of physical punishment. Although there was not a statistically significant difference in means for the other subscales, this could be related to the high pre-class scores.

Satisfaction questionnaires were administered at the end of the Incredible Years Parent Program. Responses were coded on a 7-point Likert Scale, with 1 being the lowest and 7 being the highest score. The table below shows the mean scores for parent type and an overall score.

Table 9

	#	Program	Difficulty of Teaching Format	Useful-ness of Teaching Format	Difficulty of Specific Parenting Technique	Usefulness of Specific Parenting Techniques
Mom	16	6.18	5.98	6.41	5.83	6.47
Dad	6	5.97	5.70	6.07	5.69	5.91
Grand-parent	1	6.36	7.00	7.00	6.00	7.00
Other (Mom's Boy-friend)	1	6.91	7.00	7.00	7.00	7.00
Other (Step-dad)	1	6.64	6.20	6.80	6.00	6.33
	#	The Overall Program	Difficulty of Teaching Format	Useful-ness of Teaching Format	Difficulty of Specific Parenting Technique	Usefulness of Specific Parenting Techniques
Total	25	6.19	6.00	6.39	5.85	6.37

Child Care Warmline

1-888-574-5437

The Warmline for Oklahoma Child Care Providers offers free telephone consultation to child care providers on numerous topics of concern. Consultants can also refer providers to appropriate services and resources within their communities.

A Consultant Can Help:

- Clarify a problem
- Provide information, included printed materials, if available
- Help generate ideas and solutions
- Offer guidance on developmentally appropriate practices
- Provide referrals to meet individual needs and requests
- Direct providers to relevant resources to assist with a concern
- Provide follow-up when needed

Consultants answer the Warmline Monday through Friday from 8 a.m. until 5 p.m. Messages left after hours will be answered as soon as a consultant is available. Questions can also be emailed.

Staff working the Child Care Warmline logged 1,016 contacts during SFY 2011. Of the contacts received, 575 were inbound telephone calls and 441 were internet hits to the automated topical library. The most popular topics on the automated system were: Biting in the Toddler Years, Respiratory Syncytial Virus (RSV) and Temper Tantrums: Teaching Your Child Coping Skills. Table 10, below shows the breakdown of telephone calls by reason.

Table 10

Reason for Call	Number
Health Information	136
Behavioral Information	130
Referral for MHC	89
Warmline Promotion	77
Program Planning	50
Other	33
General Information	22
Referral for Child	21
Parent Involvement	13
Staff Issue	3

Early Childhood Mental Health Consultation

Recent studies have confirmed that more young children are exhibiting challenging behaviors, and families with children in child care are experiencing more stress. Child care centers and family homes that have an OKDHS subsidy contract may receive on-site professional consultation on a regular basis upon request through the *Child Care Warmline, 1-888-574-5437*.

The Child Care Warmline and Consultation service is provided in partnership with the Oklahoma Department of Human Services and the Oklahoma Department of Mental Health and Substance Abuse Services.

Agency Summary

39 Clinicians from 6 agencies conducted visits during SFY 2011

Oklahoma State Department of Health

- 24 clinicians conducted visits
- 754 visits made
- total visit hours – 1,229.35
- average hours/visit – 1.63
- 126 total referrals
- 104 unique child care centers served
- average hours/referral – 9.76

Referral Summary

175 requests made for Early Childhood Mental Health Consultation

- 142 unique centers made these requests
- 4 centers declined services after request was made
- 3 centers did not receive services for some other reason

97 referrals in 77 unique centers were completed during SFY 2011

- 71 were requested and completed during SFY 2011
- 26 were requested during SFY 2010 and completed in FY 2010

Averages per referral

- 6.36 visits per referral
- 11.11 visit hours per referral

Visit Summary

- 1114 total visits were made during FY 2011
- 1,945.86 total visit hours conducted during FY 2011
- average hours per visit – 1.75 hours
- Services were provided to assist Child Care Facilities in 17 counties