



Foundations for Success

*Improving early childhood mental health
to support successful families and communities in Ramsey County*

Ages & Stages Questionnaires®: Social-Emotional results January 2007

Foundations for Success is a five-year initiative designed to develop and implement a county-wide system for early childhood mental health services in Ramsey County. Funded by the John S. and James L. Knight Foundation and coordinated by the Community Action Partnership of Ramsey and Washington Counties, the initiative promotes culturally competent and family friendly services. Services are developed and implemented by a collaboration of more than 100 community agencies, representing local foundations, government, parents, school districts, health, mental health, early childhood professionals, and the University of Minnesota.

The initiative is evaluated by Wilder Research. One component of the evaluation is an analysis of the results of the Ages & Stages Questionnaires®: Social-Emotional (ASQ:SE), which is being used to screen children across the county for emotional or behavioral concerns. This report summarizes the results of 5,301 screening assessments completed between January 2005 and December 2006.

Completed screenings were submitted by nine agencies: Saint Paul Public Schools (30%), Community Action Partnership of Washington and Ramsey Counties Head Start (25%), North St. Paul-Maplewood-Oakdale Schools (15%), White Bear Lake Schools (13%), Mounds View Schools (10%), Roseville Area Schools (7%), Ramsey County Early Childhood Information and Referral (<1%), Lifetrack Resources (<1%), and the Amherst H. Wilder Foundation (<1%).

The ASQ:SE has eight versions, each designed for children of a specific age. For example, the 24-month

version of the ASQ:SE should be completed for children between the ages of 21 and 26 months. Most of the screening forms submitted were the 48-month (46%) or the 60-month versions (43%).

Most forms (95%) were completed in English. Four percent were completed in Spanish and 1 percent was completed in either Hmong or Somali.

Most forms (85%) were completed by mothers; others were completed by fathers, grandparents, foster parents, and guardians. Most people (93%) did not require assistance to complete the forms; others required some assistance, such as help reading the form or language translation.

Variation in screening results

Twelve percent of the children had elevated scores.

A total of 647 children had scores that fell above the clinical cut-off, suggesting a need for additional assessment and possible referral to services.

Some children were disproportionately likely to receive elevated scores (i.e., scores above the clinical cut-off) including:

- Children screened at Head Start (26% elevated, compared to 10% or less for other agencies).
- Younger children (28% elevated for the 36-month forms and 52% of all younger age versions combined, compared to 10% for the 48-month and 60-month screenings).
- Children from non-Caucasian racial/ethnic backgrounds (20% elevated for children from all other racial/ethnic groups combined, compared to 5% of Caucasian children).

- Children with a non-English screening (58% elevated in Hmong, 31% in Spanish, and 22% in Somali, compared to 11% in English).
- Children whose mother did not have a college degree (20% elevated, compared to 4% of those whose mother had at least a two-year degree).
- Children with family incomes of \$24,000 or less (25% elevated, compared to 6% those with family incomes of more than \$24,000).
- Children with disabilities, such as speech problems (42% elevated, compared to 13% of those without a disability).

Administration/completion concerns

Incorrect versions of the screening forms were sometimes used. Some screenings (14%) were at least one age level older or younger than appropriate based on the child’s actual age. Four percent of the screened children were either older than 66 months, making them too old for the 60 month version, or younger than 3 months, making them too young for the six month version. The prevalence of errors remained consistent when only screenings submitted over the previous six months were examined.

Computation errors are relatively common. Of 56 randomly selected screenings submitted within the last six months, 25 percent had a computation error (i.e., the score on the summary page did not match the actual score based on the items endorsed). While this suggests that computation errors are still occurring, the results are more positive than those obtained six months ago, when 40 percent of the randomly selected forms had a computation error.

Screenings are often not conducted in the primary language of families. Across the previous six months, only one in five families who spoke Somali or Hmong at home completed a screening in their primary language. Spanish forms were used more often, with three of every four families who spoke Spanish at home completing a Spanish version of the screening form.

Some forms are completed incorrectly. A review of completed screenings indicates several other completion errors. First, respondents very rarely checked the column indicating that behaviors were seen as a problem, even when children were rated as frequently exhibiting potentially problematic behaviors. The failure to check this column may reduce scores, leading to an under-identification of at-risk children. Second, the instructions for scoring assessments are often not followed, with missing items simply omitted from the score, again leading to potential under-identification.

Conclusions and recommendations

First, the results of this analysis suggest that the administration challenges highlighted in previous reports continue to be issues. Screening partners are encouraged to continue to address these challenges, by: (1) checking forms prior to administration to ensure that the form accurately reflects the child’s age; (2) adhering to administration procedures to ensure that forms are completed accurately and yield valid scores; and (3) ensuring that forms are completed in the language that is most comfortable for respondents.

Second, as more screenings are completed in Hmong and Somali, it will be important to review the findings and discuss the implications for standardizing the screenings. More children receive scores above the clinical cut-off when the Hmong and Somali versions are used. Initiative partners should discuss whether this reflects validity concerns in the instrument, or higher levels of risk in these populations.

Third, partners should continue to consider the types of follow-up support or services that may be required to meet the needs of children with elevated scores. Options for support services should be reviewed to ensure that they are appropriate for the children most likely to receive elevated scores.

For more information

For more information about Foundations for Success, contact Catherine Wright at Community Action Head Start, 651-603-5813 or cwright@caprw.org.

For more information about this report, contact Cheryl Holm-Hansen at Wilder Research, 651-647-4624 or cah1@wilder.org.

Author: Cheryl Holm-Hansen

JANUARY 2007