



## Foundations for Success

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

# Ages & Stages Questionnaire®: Social Emotional results September 2008

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 Questionnaire®: 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 12,184 screening assessments completed between January 2005 and June 2008.

Completed screenings were submitted by nine agencies: Community Action Partnership of Washington and Ramsey Counties Head Start (36%), Saint Paul Public Schools (23%), North St. Paul-Maplewood-Oakdale Schools (16%), White Bear Lake Schools (9%), Mounds View Schools (9%), Roseville Area Schools (5%), Ramsey County Early Childhood Information and Referral (1%), Amherst H. Wilder Foundation (<1%), and Lifetrack Resources (<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%) and the 60-month (44%).

Almost all forms (94%) were completed in English. Four percent were completed in Spanish and about 1 percent each were completed in Hmong or Somali.

Most forms (84%) 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.

### *Variation in screening results*

**Twelve percent of the children had elevated scores.** A total of 1,449 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 including:**

- Children screened at Head Start (19% elevated, compared to 10% or less for most other agencies). It should be noted that 85 percent of the children screened through Early Childhood Information and Referral also had elevated scores. This higher percentage of elevated scores can be attributed to the fact that children generally only receive referrals if there are already concerns about their social or emotional well-being. Head Start and the school districts, in contrast, routinely screen all young children.
- Younger children (27% elevated for the 36-month forms and 33% of all younger age versions combined, compared to 10% for the 48-month and 60-month screenings).
- Children from non-Caucasian racial/ethnic backgrounds (19% elevated for children from all other racial/ethnic groups combined, compared to 5% of Caucasian children).

- Children with a non-English screening (53% elevated in Hmong, 26% in Spanish, and 26% in Somali, compared to 11% in English).
- Children whose mother did not have a college degree (19% elevated, compared to 5% of those whose mother had at least a two-year degree).
- Children with family incomes of \$24,000 or less (23% elevated, compared to 6% those with family incomes of more than \$24,000).
- Children with disabilities, such as speech problems (39% elevated, compared to 12% of those without a disability).
- Children receiving special services (35% elevated, compared to 12% of children not receiving special services.)

### ***Administration/completion concerns***

**Incorrect versions of the screening forms were sometimes administered.** Fourteen percent of children had a screening that was at least one age level older or younger than appropriate based on their actual age. Three percent of the screened children fell outside of the eligible age range for the assessment (i.e., either older than 66 months or younger than 3 months).

**Computation errors are relatively common among paper assessments, which were hand scored.** Of 50 randomly selected screenings submitted between July and December 2007, 34 percent had a computation error (i.e., the score on the summary page did not match the actual score based on the items endorsed). Eight percent of screenings had rounding errors, possibly to due to missing items. Computation errors increased compared to screenings submitted between January and June 2007, when only 24 percent of 50 random assessments forms had an error. Screenings submitted in 2008 were not examined systematically for errors, though an anecdotal review suggests that these errors are still relatively prevalent.

**Screenings are often not conducted in the primary language of families.** To date, Somali forms were completed with only 15 percent of the families who reported speaking Somali in the home. Similarly, Hmong forms were completed with only 16 percent of the Hmong-speaking families. Spanish

forms were used more frequently (67% of the families with Spanish as the primary language).

### **Some forms continue to be completed incorrectly.**

A review of completed screenings indicates several other 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. Second, scoring instructions are often not followed, with missing items simply omitted from the score. Missing items should be filled in by attempting to contact parents for the information. A second option is to insert the average score of the answered items in place of missing items; however, this depends on the age range of the assessment and the number of missing items. Both errors may reduce scores, leading to an under-identification of at-risk children.

### ***Conclusions and recommendations***

The results of this analysis suggest that the administration challenges highlighted in previous reports continue. Screeners using the paper (rather than electronic) versions of the screening are encouraged to continue their efforts to address these challenges, by ensuring that the correct forms are administered, adhering to administration procedures, and ensuring that forms are completed in the most comfortable language 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**

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