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**CROSS-SITE EVALUATION OF  
PROJECT LAUNCH:  
INTERIM FINDINGS**

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**OPRE Report # 2014-46**

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Barbara Goodson  
Margaret K. Gwaltney  
Deborah Klein Walker

Project Officer: Laura Hoard

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Abt Associates Inc.  
55 Wheeler Street  
Cambridge, MA 02138



## OVERVIEW

Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health) is a federal grant program administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). Grantees provide funding to a pilot community for five years, pursuing dual goals of improving systems and services. As of September, 2011, 24 grantees were funded, all of them representing areas with a high need for services.

The goals of Project LAUNCH are to:

- Increase access to screening, assessment, and referral to appropriate services for young children and their families
- Expand use of culturally-relevant, evidence-based prevention and wellness promotion practices (EBPs) in a range of settings
- Increase integration of behavioral health into primary care settings
- Improve coordination and collaboration across local, state, tribal and federal agencies serving young children and their families
- Increase workforce knowledge of children’s social and emotional development and preparation to deliver high quality care

To achieve these goals, Project LAUNCH grantees use five strategies: screening and assessment in a range of child-serving settings; home visiting; family strengthening and parent skills training; integrating behavioral health into primary care settings; and mental health consultation in early care and education. Grantees are required to form Young Child Wellness Councils at both the state and community/tribal levels in order to ensure that key leaders are engaged in developing a strategy and plan for improving outcomes for young children and their families. The report uses data from several sources: (1) 64 key informant interviews with staff and state and community, (2) a review and analysis of services and systems data provided by grantees in the Web portal, and (3) abstraction and analysis of data from grantee end-of-year reports.

These interim findings provide a cumulative picture of the program, but reflect grantees at very different implementation stages of their grant program. Highlights include:

- The majority of the staff in LAUNCH-supported enhanced home visiting, early childhood education, and integrated medical settings reported some or substantial change in their knowledge of children’s socio-emotional development and appropriate referrals, and in their use of mental health consultation and systematic screening and assessment. Nearly 24,583 providers were trained across child service disciplines to effectively promote healthy social and emotional development.
- Across three cohorts and the multi-year implementation period, nearly 14,012 families received parenting training and support through evidence-based prevention programs as a result of their participation in LAUNCH.
- 5,778 community organizations collaborated to enact policies, financial mechanisms, and reforms that improved the integration and efficiency of the child-serving system. Community successes included increased use of data in decision making, a greater focus on trauma-informed care, expanded referral systems, and, in a few communities, policy changes related to reimbursement and access to care.

**Cross-Site Evaluation of Project LAUNCH: Interim Findings**

**Table of Contents**

**OVERVIEW ..... i**

**1. Introduction..... 1**

    1.1 Overview of Project LAUNCH ..... 1

        1.1.1 Program Goal and LAUNCH Promotion and Prevention Strategies..... 1

        1.1.2 LAUNCH Grantees ..... 2

    1.2 Project LAUNCH Cross-Site Evaluation ..... 2

    1.3 Organization of Report ..... 3

**2. Services for Children and Families ..... 6**

    2.1 Developmental Screening and Assessments..... 7

        2.1.1 Screening and Assessment in LAUNCH-Supported Home Visiting Programs .. 7

        2.1.2 Screening and Assessment in LAUNCH-Supported Family Support Programs . 8

        2.1.3 Screening and Assessment in Early Childhood Programs as Part of LAUNCH  
Mental Health Consultation..... 10

        2.1.4 Screening/Assessment in Elementary Schools as Part of LAUNCH Mental  
Health Consultation ..... 11

        2.1.5 Screening/Assessment in Primary Care Settings Participating in LAUNCH  
Integration of Behavioral Health ..... 11

    2.2 Home Visiting ..... 12

        2.2.1 LAUNCH-Supported Home Visiting Programs: Types of Programs and Types  
of LAUNCH Support ..... 13

        2.2.2 LAUNCH Supports for Existing Home Visiting Programs ..... 14

        2.2.3 Families Served in LAUNCH-Supported Home Visiting Programs..... 16

        2.2.4 Workforce Enhancement for Staff in LAUNCH-Supported Home Visiting  
Programs ..... 17

        2.2.5 Innovative Strategies in LAUNCH-Supported Home Visiting Programs..... 18

        2.2.6 Self-Reported Outcomes for Providers in LAUNCH-Supported Home Visiting  
Programs ..... 19

    2.3 Family Support Programs ..... 21

        2.3.1 LAUNCH-Supported Family Support Programs: Types of Programs and Types  
of LAUNCH Support..... 21

        2.3.2 LAUNCH Enhancements of Existing Family Support Programs ..... 22

        2.3.3 Families Served in LAUNCH-Supported Family Support Programs..... 23

        2.3.4 Workforce Enhancement for Staff in LAUNCH-Supported Family Support  
Programs..... 24

        2.3.5 Self-Reported Outcomes for Providers in LAUNCH-Supported Family Support  
Programs..... 25

    2.4 Mental Health Consultation..... 26

        2.4.1 Mental Health Consultation in Multiple Settings ..... 27

        2.4.2 Mental Health Consultation in Early Childhood Education and Care Settings . 27

        2.4.3 Workforce Enhancement for Staff in Early Childhood Education and Care  
Programs as Part of LAUNCH Mental Health Consultation..... 31

- 2.4.4 Self-Reported Outcomes for Early Childhood Education Providers in Programs Receiving LAUNCH Mental Health Consultation ..... 32
- 2.4.5 Mental Health Consultation in Elementary Schools..... 32
- 2.4.6 Workforce Enhancement for Staff in Elementary Schools as Part of LAUNCH Mental Health Consultation..... 34
- 2.4.7 Self-Reported Outcomes for Staff in Elementary Schools Receiving LAUNCH-Supported Mental Health Consultation ..... 34
- 2.4.8 Mental Health Consultation in Home Visiting Programs ..... 35
- 2.4.9 Outcomes for Home Visitors Receiving Mental Health Consultation..... 36
- 2.4.10 Mental Health Consultation in Other Settings..... 37
- 2.5 Integration of Behavioral Health in Primary Care..... 37
  - 2.5.1 Efforts to Integrate Behavioral Health in Primary Care Offices..... 37
  - 2.5.2 Workforce Enhancement for Staff in Primary Care Settings Participating in LAUNCH Integration of Behavioral Health..... 39
  - 2.5.3 Self-Reported Outcomes for Staff in Primary Care Offices Participating in LAUNCH Integration of Behavioral Health..... 39
- 3. Infrastructure Development and Systems Change ..... 41**
  - 3.1 Systems Theory As It Applies to Project LAUNCH..... 41
  - 3.2 State and Community Young Child Wellness Councils..... 43
    - 3.2.1 Organizational Composition of State and Community YCWCs ..... 44
    - 3.2.2 Grantees Self-Reported Top Three Key YCWC Initiatives ..... 48
    - 3.2.3 Successes and Challenges Associated with State and Community YCWCs ..... 48
    - 3.2.4 State- and Community-Level Challenges ..... 50
  - 3.3 LAUNCH-supported System Enhancements ..... 51
    - 3.3.1 State Successes ..... 52
    - 3.3.2 Community Successes ..... 53
  - 3.4 Other/Additional Training (not directly related to service strands)..... 55
  - 3.5 Public Awareness Activities..... 57
  - 3.6 Sustainability Activities..... 58
- 4. Next Steps for the Cross-Site Evaluation..... 61**
- References ..... 63**
- Appendix A: Project LAUNCH Grantees ..... 64**
- Appendix B: Cross-Site Evaluation Logic Model..... 65**
- Appendix C: LAUNCH-Supported Home Visiting Models..... 66**
- Appendix D: LAUNCH-Supported Family Support Models ..... 76**
- Appendix E: Description of the Designs for the LAUNCH Special Studies..... 87**

# 1. Introduction

## 1.1 Overview of Project LAUNCH

### 1.1.1 Program Goal and LAUNCH Promotion and Prevention Strategies

Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health) is a federal grant program administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). The goal of this national program is to promote the social, emotional, behavioral, and physical health and cognitive development of young children from birth to eight years of age. Grantees select a pilot community within the state to participate in Project LAUNCH.

To achieve these goals, Project LAUNCH grantees implement five research-based prevention and promotion strategies.

1. **Screening and assessment in a range of child-serving settings.** Screening for social and emotional well-being in young children can help to identify indicators of developmental delays or behavioral concerns that signal a more extensive assessment is warranted.
2. **Home visiting.** Home visitors work directly with families and caregivers in their homes to provide support and guidance on health care, education, and child development. Training is provided for home visitors on program models as well as social and emotional development to improve the effectiveness of home visiting programs at supporting families.
3. **Family strengthening and parent skills training.** Evidence-based tools and approaches can be used to help families create healthy environments that support children’s development.
4. **Integration of behavioral health into primary care settings.** Integration models seek to bring mental health expertise into the primary care practice both through having mental health consultants on site and through training primary care staff to be able to recognize, assess, and provide appropriate referrals to help their patients who have mental health needs.
5. **Mental health consultation in early care and education.** Mental health professionals work collaboratively with early childhood education programs and staff and families to improve their ability to prevent, identify, treat, and reduce the effects of mental health problems among children from birth through age eight and to implement classroom and center-based practices that promote healthy social and emotional development (National Center for Mental Health Promotion and Youth Violence Prevention, 2012).

In September 2012, SAMHSA had funded 24 grantees in three cohorts: 2008, 2009, and 2010.<sup>1</sup> The grantees in Cohorts 1 and 2 include 16 states, the District of Columbia, and a Native American tribe; grantees in Cohort 3 are 6 local communities (see Appendix A). Each Project LAUNCH grantee implements evidence-based programs and services within each of the five strategies and, if outcomes are positive, works to sustain the programs after grant funding ends.

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<sup>1</sup> The 6 grants in Cohort 1 and 12 grants in Cohort 2 were awarded to the Title V Maternal and Child Health agency at the state level. The six grants in Cohort 3 were awarded to local communities.

Grantees are required to form Young Child Wellness Councils (YCWCs) at both the state (Cohorts 1 and 2) and community/tribal levels (all cohorts) to engage key leaders in developing a strategy and plan for improving outcomes for young children and their families. Grantees could establish new YCWCs or integrate the functions of the YCWCs into existing advisory groups or councils that focus on young child wellness. At a minimum, YCWCs are expected to have representatives from health, mental health, child welfare, Medicaid, substance abuse prevention, early childhood and state education, and Title V administering agencies (if applicable), as well as representation from families in the target population (SAMHSA, 2008; 2009; 2010).

Within the first year of the grant, YCWCs conducted an environmental scan—a needs assessment of state (Cohorts 1 and 2) and community assets (all cohorts), service gaps, and systems barriers. Using this environmental scan, grantees then developed a strategic plan to guide their implementation of prevention and promotion strategies. The strategic plan identified the evidence-based programs to be implemented within communities across the five core LAUNCH strategies, as well as systems development activities at the state, tribal, and community levels.

### 1.1.2 LAUNCH Grantees

SAMHSA awarded grant in Cohorts 1 and 2 to the state agency responsible for the Title V Maternal and Child Health program. Grants in Cohort 3 were awarded to community agencies or organizations. Each grantee then identified a target community in which to implement evidence-based programs and services for young children and their families.

While geographically diverse and varied in their target populations, all LAUNCH communities were selected because of their high need for services—e.g., children and families had significant risk factors, services were not sufficient to meet all needs, and the communities had significant health and economic disparities (Gwaltney, Goodson, and Walker, 2013). For example, families living below the poverty level were 40 percent higher in LAUNCH communities than the country overall (14.4 vs. 9.9 percent in 2009), and 18.5 percent of all births in LAUNCH communities were to women receiving late or no prenatal care compared to 7.0 percent in the U.S. On average, 25.4 percent of individuals in LAUNCH communities spoke a language other than English at home, compared to 19.6 percent of U.S. residents. The proportion speaking a language other than English ranges from 1.0 to 74.9 percent across all Project LAUNCH communities.

## 1.2 Project LAUNCH Cross-Site Evaluation

The cross-site evaluation of Project LAUNCH is intended to describe program implementation, including changes in systems and services, and outcomes for children and families in the LAUNCH communities. In addition, estimates from grantee-specific local evaluations and population studies will provide an overall picture of the effectiveness of Project LAUNCH at improving developmental outcomes for young children (Goodson, Walker, and Gwaltney, 2012). A program logic model (Appendix B) and the following evaluation questions provide the framework for the evaluation:

- What are the system-level changes at the state level?
- What are the system-level changes at the community/local level?
- How have child and family services in the community been enhanced?

- What is the effect on the health and well-being of young children in the Project LAUNCH communities?

A report written in the first year describes the cross-site evaluation design (Goodson, Walker, and Gwaltney, 2012) and a second report provides cross-site evaluation findings after grantees' first grant year (Gwaltney, Goodson, and Walker, 2013). This third report, which focuses mainly on program implementation, draws upon data from several sources: (1) 64 key informant interviews with staff and state and community partners (e.g., the state project director, LAUNCH coordinator, and chairs of the state and community YCWCs) within all grant programs, (2) a review and analysis of services and systems data provided by grantees in the Web portal over five reporting periods for Cohort 1, three reporting periods for Cohort 2, and one reporting period for Cohort 3, and (3) abstraction and analysis of data from grantee end-of-year reports submitted in December 1009, 2010 and 2011.<sup>2</sup>

The cross-site evaluation team used an interview guide to focus the inquiry and discussion during key informant interviews. Information on services and systems activities were reported by grantees in the Web portal by completing surveys on different types of LAUNCH-supported activities: direct services (home visiting and family support programs); mental health consultation (MHC) in early care and education; MHC in primary care; MHC in other settings; other developmental assessments (i.e., that is not part of other services); other provider training (i.e., that is not part of another service); family referrals; state systems activities; community systems activities; and tribal systems activities. End-of-year reports summarize findings of grantees' own evaluations and describe activities implemented within each program strategy, as well as lessons learned.

This cross-site evaluation report highlights key findings on implementation of each Project LAUNCH service strategy—developmental assessment, home visiting, family support, mental health consultation in early care and education, and integration of behavioral health in primary care—and for systems change initiatives implemented by grantees at the state, tribal, and community levels. Data analyses included qualitative and quantitative methods. Descriptive statistics were generated to document the activities and features of LAUNCH-supported activities, participation in services, developmental assessments and referrals, and topics and recipients of provider training. In addition, qualitative analyses of data collected from interviews and culled from grantee reports provide information on 1) program context at the state, community, and tribal levels; 2) service models; 3) categories of systems initiatives; and 4) program accomplishments and challenges. Inductive analysis was used to derive themes from the qualitative data.

### 1.3 Organization of Report

The report is organized in four chapters. In this first chapter, we provide an overview of the Project LAUNCH program and the cross-site evaluation. Chapter 2 discusses the services implemented by Project LAUNCH grantees as of September 2011. The next chapter (Chapter 3) summarizes system and infrastructure development activities and accomplishments across cohorts, and Chapter 4 summarizes next steps for the cross-site evaluation.

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<sup>2</sup> For this report, we have reviewed grantees' end-of-year programmatic reports and evaluation reports. The cross-site evaluation has used end-of-year programmatic reports only to supplement other data about state-level systems change.

The report presents findings for the Project LAUNCH program since initial funding in September 2008 through September 2011. An important caveat when reading this report is that Project LAUNCH grantees were at different developmental stages in September 2011 (Exhibit 1.1). Grantees in the first cohort were at the end of their third year; grantees in the second cohort were ending their second year; and grantees in the third cohort had finished their first year. Earlier cohorts had implemented their programs for longer periods of time and therefore had opportunities to provide services to more children and families and to work longer on building infrastructure and service systems. These interim findings are therefore a cumulative picture of the program, but reflecting grantees at very different stages of their grant program. Program implementation, service delivery, and services and systems outcomes of the Project LAUNCH initiative will be better understood once all grantees have completed their full five-year grant program.

The cross-site evaluation extends from September 2008 through June 2013. All LAUNCH grantees—6 grantees funded in 2008 (Cohort 1), 12 in 2009 (Cohort 2), and 6 in 2010 (Cohort 3)—are included in the cross-site evaluation. In 2012, each grantee was continuing to provide services within its target community<sup>3</sup> and working on infrastructure and systems development at the state and community levels.<sup>4</sup> The cross-site evaluation's final report, to be submitted in June 2014, will offer a more complete analysis of program implementation and outcomes.

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<sup>3</sup> One grantee in Cohort 2 selected a new target community in September 2011, two years into its grant period. Because this grantee was just starting and community-level data were not yet available, services and local systems data for this grant program are not included in this report. State data are also unavailable for this grantee.

<sup>4</sup> Data from the tribal grantee is included in our analysis of community-level systems data.

Exhibit 1.1 Grantee Developmental Stage, by Cohort, and Data Sources Used for Report <sup>5</sup>			
Cohort (Year funded)	Implementation Year 1	Implementation Year 2	Implementation Year 3
Cohort 1 (2008)	Web portal: 5 reporting periods (Fall 2009, Spring 2010, Fall 2010, Spring 2011, Fall 2011) Telephone interviews: Fall 2008, 2010 Site visit: Fall 2009 End-of-year program report: December 2010, December 2011 (for information on systems change activities only) End-of-year evaluation report: December 2010, December 2011		
Cohort 2 (2009)	Web portal: 3 reporting periods (Fall 2010, Spring 2011, Fall 2011) Telephone interviews: Fall 2010 Site visit: Fall 2011 End-of-year program report: December 2010, December 2011 (for information on systems change activities only) End-of-year evaluation report: December 2010, December 2011		
Cohort 3 (2010)	Web portal: 1 reporting period (Fall 2011) Telephone interviews: Fall 2011 End-of-year program report: December 2011 (for information on systems change activities only) End-of-year evaluation report: December 2011		

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<sup>5</sup> Data from 2009 reports were not included because there they did not consistently include infrastructure and system change activities.

## 2. Services for Children and Families

Project LAUNCH grantees were expected to implement five types of promotion and prevention strategies, covering core areas considered critical to young children's social-emotional health and later success in school: developmental screening and assessment, home visiting, family strengthening and parent training, mental health consultation in early care and education settings, and integration of behavioral health in primary care. Most of the Project LAUNCH grantees described the existing child service system in their communities as being fragmented, lacking coordination and collaboration among providers. Additionally, grantees reported on a variety of service gaps: insufficient slots in programs that families needed, lack of access to services for part of the community with language or cultural barriers, and service providers with insufficient knowledge of how to identify and provide appropriate services to children with mental and behavioral health problems. Further, in the area of mental health consultation, many communities lacked programs and sometimes even reported a shortage of clinical staff to deliver mental health consultation in early care and education or mental health services in primary care settings.

As described in the cross-site evaluation report on the findings from the first year of implementation (Gwaltney, Goodson, and Walker, 2013), at the end of the first year, grantees had established comprehensive strategic plans that addressed all programmatic elements of Project LAUNCH, including evidence-based programs grantees would implement in all five prevention and promotion strategies, systems and infrastructure building activities, and a plan for sustaining LAUNCH-funded services and infrastructure improvements. By the end of the first year of implementation, all grantees had begun implementing at least part of their plans for delivering services to children and families.

This chapter discusses the services supported by all Project LAUNCH grantees as of September 2011 (note: one grantee in Cohort 2 had selected a new LAUNCH community in September 2011 and therefore is not included in this analysis). As noted previously, grantees in the three cohorts were at different developmental stages depending on the year they were funded. Thus, the chapter is a cumulative picture across grantees at this time period.

The current report discusses outcomes for Project LAUNCH providers. Outcomes for families and children will be presented in the final Cross-Site Evaluation Report, to be written in Summer 2014. This final report will include findings on outcomes for individual home visiting and family support programs as well as population-level outcomes. The data on child and family outcomes will come from the end-of-year local evaluations and will include 5-year findings from Cohort 1 grantees, 4-year findings from Cohort 2 grantees, and 3-year findings from Cohort 3 grantees. In addition, the final report will present estimates of effects on child outcomes derived from five population "special studies" funded by SAMHSA through the cross-site evaluation contract. Two Cohort 1 grantees and three Cohort 2 grantees are conducting population studies of outcomes for LAUNCH children, but the final results of these studies will not be completed until late 2014 or early 2015 and therefore will not be included in the final Cross-Site Evaluation Report.

## 2.1 Developmental Screening and Assessments

### *Summary of Key Findings for Developmental Screening and Assessments*

Project LAUNCH supported screening and assessment of children and parents in all types of direct services programs: home visiting, family support, mental health consultation in early care and education, and integration of behavioral health in primary care. Of all home visiting programs supported by LAUNCH, just under half screened children for socio-emotional development; a third screened children for cognitive development. Forty percent (40%) of home visiting programs introduced parent depression screening. The total number of programs supporting screening increased over time. Additionally, in Cohorts 1 and 2, the number of children screened per program increased from one year to the next. The number of parents screened per program increased over time within Cohort 1, but decreased slightly for programs implemented in Cohort 2. Across all cohorts, just under 3,000 children and nearly 2,000 parents were screened in home visiting programs.

A quarter of the LAUNCH-supported family support programs conducted child screening; fewer programs conducted parent screening. The difference in the percentage of family support programs supporting screening compared with home visiting programs could be a result of differences in these two types of programs. Home visiting programs typically include longer-term, direct work with children and parents, while family support programs more often involve working only with parents and often for a limited time period (e.g., a set number of sessions). Screening was less appropriate in the context of shorter-term programs, because these programs have less intensive relationships with families. Of all family support programs supported by LAUNCH, screening was most likely to be part of navigation and family coordination programs, where assessment and referral were primary objectives of the program. The majority of family support programs that screened children screened them on their socio-emotional development. Among programs that conducted parent screening, the most common type of screening involved assessment of family needs and risks as part of an intake interview. Across all cohorts, approximately 3,500 children and 2,600 parents were screened in family support programs.

The majority (77%) of LAUNCH-supported mental health consultation programs in early childhood settings conducted child screening. Screenings were conducted either by the mental health consultant on children referred for mental health or behavior concerns and or by the early childhood staff on all children. Ninety percent of grantees that conducted child assessments used a measure of children's socio-emotional functioning. In total, 1,287 children were screened or assessed in early childhood programs receiving mental health consultation programs.

Child screening was conducted as part of mental health consultation in just two of the nine mental health consultation programs supported by LAUNCH in elementary schools. In both programs, the assessment was conducted by a mental health consultant when a child was referred for problem behavior in the classroom. Across these two programs, 164 children were assessed, and 9 were referred for additional evaluation or services.

Child assessments were a key component of all LAUNCH-supported programs focused on integrating behavioral health in primary care. Each program screened children on their socio-emotional development as well as their cognitive and physical development. Parent screening also was part of the programs. All programs screened for parent depression and other family needs. Across the implementation period, 3,745 children and 2,609 parents were screened as part of the programs to integrate behavioral health into primary care.

Across all direct services and all cohorts, a total of 11,560 children and 7,186 parents were screened with the support of Project LAUNCH.

#### 2.1.1 Screening and Assessment in LAUNCH-Supported Home Visiting Programs

The purpose of developmental screening and assessment of young children is to identify those who may be at risk for developmental delay, diagnose the presence and extent of developmental problems, identify children's specific abilities and skills, and determine appropriate intervention strategies, if

needed. Traditionally, screening has occurred in pediatric settings, but may also occur in early childhood education and intervention settings, such as home visiting programs (National Research Council, 2008). A key objective of Project LAUNCH is to expand the settings in which screening and assessment take place, thereby increasing the number of children who are screened, as well as introducing and increasing screening of maternal depression. This objective is starting to be met by Project LAUNCH, with just under half of LAUNCH-supported home visiting programs screening children and parents during the period from 2009 to 2012 (Exhibit 2.1.1). Most of the home visiting programs that conducted child screening assessed children's socio-emotional development alone or in conjunction with screening for aspects of cognitive development. In all but two of these programs, LAUNCH introduced the use of new screening measures, especially the ASQ and ASQ-SE. The most common parent screening was for maternal depression, but programs also screened for other family risks, such as parent stress or parental abuse of alcohol or drugs.

Exhibit 2.1.1 Number and Proportion of LAUNCH-Supported Home Visiting Programs Screening Children and Parents by Cohort and Year of Implementation							
	Cohort 1 (6 grantees)			Cohort 2 (11 grantees)		Cohort 3 (6 grantees)	All Cohorts (23 grantees)
	Year 1 (4 home visiting programs)	Year 2 (6 home visiting programs)	Year 3 (6 home visiting programs)	Year 1 (13 home visiting programs)	Year 2 (15 home visiting programs)	Year 1 (4 home visiting programs)	All Years (25 home visiting programs)
Child socioemotional development	1 (25%)	4 (67%)	5 (83%)	5 (38%)	5 (38%)	1 (25%)	11 (44%)
Child cognitive development	4 (100%)	4 (67%)	4 (67%)	5 (38%)	6 (40%)	0	9 (36%)
Parent depression	2 (40%)	3 (50%)	3 (50%)	6 (40%)	6 (40%)	1 (25%)	10 (40%)

Across all cohorts, LAUNCH-supported home visiting programs screened nearly 3,000 children and 1,900 parents (Exhibit 2.1.2). Over time, the total number of screenings and the average number of children being screened per home visiting program increased. In Cohort 1, the average number of children screened in a program grew from 21 in the first year of implementation to 86 in the third year of implementation (Exhibit 2.1.2). Comparable increases occurred with the number of parents screened. In Cohort 2, the average number of children screened increased from the first to the second year of implementation, but the average number of parents screened did not.

It is notable that the number of children screened in home visiting programs in grantees' first year of implementation is fairly low, but increased substantially in the second year (Cohorts 1 and 2). This possibly reflects the fact that programs did not start their implementation until the middle of the first year, after which attention was placed on training staff to conduct screening and development of tracking systems for developmental screening, assessment, and referral.

### 2.1.2 Screening and Assessment in LAUNCH-Supported Family Support Programs

Project LAUNCH grantees introduced systematic screening into family support programs, both new programs initiated by and existing programs supported by LAUNCH. Across all cohorts, around a quarter of the LAUNCH-supported family support programs conducted child screening and fewer programs conducted parent screening (Exhibit 2.1.3). The fact that screening was part of fewer family support programs, compared with home visiting programs, could be the result of differences in

how these two types of programs were implemented. Home visiting programs typically include longer-term, direct work with children and parents, while family support programs more often involve only working with parents and often for a short and limited time period (e.g., a set number of sessions). Programs reported that screening did not seem as appropriate in the context of the shorter-term, less intensive relationships with families in family support programs. Among the different types of family support programs, compared with the parent training and consultation programs, screening was more likely to be part of navigation and family coordination programs, where assessment and referral were primary objectives of the program.

Exhibit 2.1.2 Number of Children and Parents Screened in LAUNCH-Supported Home Visiting Programs by Cohort and Year of Implementation							
	Cohort 1 (6 grantees)			Cohort 2 (11 grantees)		Cohort 3 (6 grantees)	All Cohorts (23 grantees)
	Year 1 (4 LAUNCH home visiting programs)	Year 2 (6 LAUNCH home visiting programs)	Year 3 (6 LAUNCH home visiting programs)	Year 1 (13 LAUNCH home visiting programs)	Year 2 (15 LAUNCH home visiting programs)	Year 1 (4 LAUNCH home visiting programs)	All Years (25 LAUNCH home visiting programs)
Total # children screened	85	254	519	733	1,367	3	2961
Average # children screened/program	21.3	42.3	86.5	56.4	91.1	0.8	118.4
Total # parents screened	150	249	395	582	555	2	1933
Average # parents screened/program	37.5	41.5	65.8	44.8	37.0	0.5	77.3

Exhibit 2.1.3 Number and Proportion of LAUNCH-Supported Family Support Programs Screening Children and Parents by Cohort and Year of Implementation							
	Cohort 1 (6 grantees)			Cohort 2 (11 grantees)		Cohort 3 (6 grantees)	All Cohorts (23 grantees)
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 1	All Years
Child socioemotional development	2 (18%)	4 (36%)	5 (45%)	3 (16%)	6 (32%)	2 (13%)	13 (25%)
Child cognitive development	2 (18%)	3 (27%)	5 (45%)	2 (11%)	3 (16%)	2 (13%)	11 (21%)
Parent depression	1 (9%)	2 (18%)	2 (18%)	2 (11%)	3 (16%)	0	5 (10%)
Parent substance use/abuse	0	0	1 (9%)	0	1 (5%)	0	2 (4%)
Other family risks/needs	3 (27%)	1 (9%)	2 (18%)	5 (26%)	7 (37%)	0	10 (19%)

Among the programs that conducted child screenings, the majority screened children on their socio-emotional development. Among the programs that conducted parent screening, the most common

type of screening involved assessment of family needs and risks as part of an intake interview. Across all cohorts, approximately 3,500 children and 2,600 parents were screened as part of family support programs, and like home visiting programs, the average number screened per program increased significantly from the first to second year (Exhibit 2.1.4).

Exhibit 2.1.4 Number of Children and Parents Screened in LAUNCH-Supported Family Support Programs by Cohort and Year of Implementation							
	Cohort 1 (6 grantees)			Cohort 2 (11 grantees)		Cohort 3 (6 grantees)	All Cohorts (23 grantees)
	Year 1 (11 LAUNCH FS programs)	Year 2 (17 LAUNCH FS programs)	Year 3 (19 LAUNCH FS programs)	Year 1 (19 LAUNCH FS programs)	Year 2 (28 LAUNCH FS programs)	Year 1 (5 LAUNCH FS programs)	All Years (52 LAUNCH FS programs)
Total # children screened	27	92	396	821	2182	49	3567
Average # children screened/program	2.5	5.4	20.8	43.2	77.9	9.8	68.6
Total # parents screened	141	36	328	649	1490	0	2644
Average # parents screened/program	12.8	2.1	17.3	34.2	53.2	0	50.8

**2.1.3 Screening and Assessment in Early Childhood Programs as Part of LAUNCH Mental Health Consultation**

Child screening was conducted in 10 of the 13 mental health consultation programs in early childhood (77%). Screenings included those conducted by the mental health consultant on children referred for mental health or behavior concerns and assessments conducted by the early childhood staff on all children. Nine of the ten grantees that conducted child assessments included a measure of children’s socio-emotional functioning. Five grantees used the Devereux Early Childhood Assessment (DECA), two used the ASQ-SE, one used the Social Skills Improvement System, and one used the Modified Checklist for Autism in Toddlers (M-CHAT). Altogether, 1,287 children were screened or assessed in early childhood programs receiving mental health consultation programs (Exhibit 2.1.5).

Over time, the number of programs receiving mental health consultation increased, as did the average number of children assessed in each program. The reasons for this relatively slow start and significant increase from the first year to the next are similar to those noted previously for home visiting and family support programs. The higher percentage of programs implementing child screening may be due to the presence of mental health consultants who were responsible for the screening and assessment and early childhood staff who had some level of previous training on conducting developmental screening, although not necessarily screening on social-emotional development.

Exhibit 2.1.5 Number of Children and Parents Screened in Early Childhood Education and Care Programs Receiving LAUNCH-Supported Mental Health Consultation by Cohort and Year of Implementation							
	Cohort 1 (6 grantees)			Cohort 2 (11 grantees)		Cohort 3 (6 grantees)	All Cohorts (23 grantees)
	Year 1 (2 LAUNCH MHC programs with screening)	Year 2 (3 LAUNCH MHC programs with screening)	Year 3 (4 LAUNCH MHC programs with screening)	Year 1 (2 LAUNCH MHC programs with screening)	Year 2 (6 LAUNCH MHC programs with screening)	Year 1 (0 LAUNCH MHC programs with screening)	All Years (10 LAUNCH MHC programs with screening)
Total # children screened	80	385	421	19	382	0	1287
Average # children screened/program	40.0	128.3	105.3	9.5	63.7	0	128.7

#### 2.1.4 Screening/Assessment in Elementary Schools as Part of LAUNCH Mental Health Consultation

Child screening was conducted as part of the mental health consultation in two of the 9 programs in schools (22%). In both of these programs, the assessment was for children referred to the mental health consultant as demonstrating problem behavior in the classroom. One grantee reported that 160 children were assessed over two years, with 5 of these children referred for additional evaluation or services. The second grantee reported that four children were assessed, and all four were referred.

#### 2.1.5 Screening/Assessment in Primary Care Settings Participating in LAUNCH Integration of Behavioral Health

In all of the 11 LAUNCH programs (48 percent of the total) focused on integrating behavioral health into primary care, child assessments were a key component. Children were screened on their socio-emotional development, as well as their cognitive and physical development. Parent screening also was part of these programs. Each of the programs screened for parent depression and other family needs. Across the implementation period, 3,745 children and 2,609 parents were screened in the programs to integrate behavioral health into primary care (Exhibit 2.1.6).

In summary, Project LAUNCH grantees have successfully addressed the goal of Project LAUNCH to increase the use of validated screening instruments, with an emphasis on social-emotional functioning, in order to ensure that developmental issues are identified and addressed early. Grantees have successfully implemented screening and assessment in many of the programs and services they are supporting and have maintained or, in most cases, expanded the number of programs conducting screening across settings, as well as the average number of children screened, in each subsequent year of program implementation. A possible explanation for less screening activity in the first year of the programs in all three cohorts is that grantees began implementing their programs half way through their first grant year and, early on, spent time working with programs to introduce new, validated developmental screening and assessment tools, including those for social-emotional development (e.g., the ASQ-SE). Moreover, successfully introducing a new practice like developmental screening first requires staff training on use of screening tools, how to use and interpret results, and how to communicate results to family members and other professionals. It also requires development of management systems for maintaining and tracking results. Furthermore, screening is demanding of

staff time and resources, and some programs or settings have been reluctant to put these new practices in place. For these reasons, full implementation does not occur immediately.

Exhibit 2.1.6 Number of Children and Parents Screened in Primary Care Settings Participating in LAUNCH Integration of Behavioral Health by Cohort and Year of Implementation							
	Cohort 1 (6 grantees)			Cohort 2 (11 grantees)		Cohort 3 (6 grantees)	All Cohorts (23 grantees)
	Year 1 (2 LAUNCH IBH programs with screening)	Year 2 (3 LAUNCH IBH programs with screening)	Year 3 (4 LAUNCH IBH programs with screening)	Year 1 (5 LAUNCH IBH programs with screening)	Year 2 (5 LAUNCH IBH programs with screening)	Year 1 (2 LAUNCH IBH programs with screening)	All Years (11 LAUNCH IBH programs with screening)
Total # children screened	80	273	268	496	3215	424	3,745
Average # children screened/program	40.0	91.0	67.0	99.2	643.0	212.0	340.5
Total # parents screened	105	254	305	283	1642	0	2,609
Average # parents screened/program	52.0	84.7	76.3	56.6	328.4	0	237.2

## 2.2 Home Visiting

### *Summary of Key Findings for Home Visiting*

Most of the LAUNCH grantees are supporting at least one home visiting program in their communities—all of the Cohort 1 grantees, 90 percent of the Cohort 2 grantees, and 67 percent of the Cohort 3 grantees. Nearly three-quarters of the home visiting programs receiving LAUNCH support are existing programs that are being extended and/or enhanced with LAUNCH funding. Consistent with SAMHSA recommendations, the majority (64 percent) of the home visiting programs being supported are using evidence-based models. Across the three cohorts and multi-year implementation period, the LAUNCH-supported home visiting programs have served approximately 3,100 families.

LAUNCH support for home visiting programs includes workforce enhancement through various types of training: training to improve fidelity of implementation, training to increase provider knowledge about socio-emotional development and assessment and referrals for mental and behavioral health problems, and how to engage and educate parents. Across the three cohorts and multi-year implementation period, 584 home visitors participated in at least one LAUNCH-supported training.

The majority of home visitors in all three cohorts of programs reported growth in their knowledge of children's socio-emotional development (86%) and of options for follow-up services for children with mental or behavioral health issues (80%) as a result of their involvement in Project LAUNCH. In addition, home visitors reported changes in practices involving the use of mental health consultation (74%) and of screening/assessments of children (69%).

Some of the LAUNCH grantees have introduced an innovative strategy for home visiting through the use of mental health consultation for the home visiting programs and staff. This strategy addresses the perceived need to enhance the skills of the home visitors in helping families facing serious mental health or early

parenting concerns. The mental health consultants provide staff with training and education around parent and child mental health and also help support staff in dealing with their own increasing levels of stress and “secondary trauma” as a result of working with families with multiple and serious risks. In some sites, the mental health consultants also work directly with families who are identified by their home visitors as being at high risk; for these families, the consultants provide short-term, direct consultation to augment the services already being offered by the home visitors.

Two other notable approaches are represented in the home visiting approaches being implemented by LAUNCH grantees. First, more grantees in later cohorts are supporting home visiting models that focus on clinical issues such as attachment and bonding, as opposed to general child development and cognitive-language development or school readiness. Second, as states have received funding through the HRSA/ACF home visiting initiative (Maternal, Infant, and Early Childhood Home Visiting, or MIECHV, program), there is increasing coordination between LAUNCH grantees and the MIECHV home visiting programs in their communities.

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### 2.2.1 LAUNCH-Supported Home Visiting Programs: Types of Programs and Types of LAUNCH Support

Prior to Project LAUNCH, all of the target communities had one or more home visiting programs in place, and the majority of the 23 LAUNCH grantees (75 percent) reported that there was an *evidence-based* home visiting program model being implemented in their communities. However, all grantees reported that existing home visiting programs could not fully meet the needs within the community, either because of insufficient slots or because programs had eligibility criteria that cut off services at designated child ages or length of participation, even for families with continuing needs.

The majority of LAUNCH grantees (18 out of 23, or 78 percent) provided support for at least one home visiting program (Exhibit 2.2.1). (Four of the grantees supported two home visiting programs, and one grantee supported implementation of the same home visiting model in three different organizations, for a total of 25 home visiting programs receiving funding from Project LAUNCH) The majority of the home visiting programs receiving LAUNCH support were programs that were already in place when LAUNCH began (75%), which LAUNCH enhanced in various ways. When LAUNCH grantees initiated a new home visiting program in their communities, it was reflected in the funding. LAUNCH funds accounted for nearly all of the funding for new home visiting programs (average of 92 percent of funding), compared with less than half of the funding for programs that LAUNCH expanded or enhanced (average of 40 percent of funding).

Exhibit 2.2.1 Number of New and Existing Home Visiting (HV) Programs Supported by LAUNCH Grantees by Cohort and Year of Implementation			
Cohort/type of home visiting program (# grantees in cohort)	# (%) Grantees Supporting Home Visiting Programs and # of Home Visiting Programs		
	Year 1	Year 2	Year 3
<b>Cohort 1 (n = 6 grantees)</b>	4 grantees (67%) 4 programs	6 grantees (100%) 6 programs	6 grantees (100%) 6 programs
New	0 (0%)	2 (33%)	2 (22%)
Enhanced	4 (100%)	4 (67%)	4 (67%)
<b>Cohort 2 (11 grantees)</b>	8 grantees (72%) 13 programs	10 grantees (91%)/ 15 programs	NA
New	3 (23%)	3 (20%)	NA
Enhanced	10 (77%)	12 (80%)	NA
<b>Cohort 3 (6 grantees)</b>	3 grantees (50%) 4 programs	NA	NA
New	1 (25%)	NA	NA
Enhanced	3 (75%)	NA	NA
<b>All cohorts (23 grantees)</b>	15 grantees (65%) 21 programs	16 grantees (94%) 21 programs	6 grantees (100%) 5 programs
New	4 (24%)	5 (24%)	2 (33%)
Enhanced	17 (76%)	16 (76%)	4 (56%)

The home visiting programs supported by LAUNCH grantees represented a variety of models (Exhibit 2.2.2). The majority of the LAUNCH-supported home visiting programs (14 out of 25, or 56 percent) were models identified by one or more rating systems as having “substantial” evidence on effectiveness; two other home visiting programs were using models identified as having “emerging” evidence.<sup>6</sup> The grantees that supported models that were not evidence-based fall into two groups. Two grantees elected to work with the newborn home visiting programs administered by the state department of public health. These programs do not use a specific curriculum model and therefore are not identified as evidence-based. Three other programs developed home visiting models that focused more intensively on case management versus parenting, because grantees felt that what their families needed was appropriate referrals and access to services in the community. This focus on evidence-based models is consistent with SAMHSA guidance that recommends that grantees support this type of model whenever possible. (Appendix A provides supporting information on the home visiting models shown in Exhibit 2.2.2, including citations for the home visiting models [Exhibit A.1] and information on the evidence base for each model [Exhibit A.2], and the rating criteria for evaluating the quality of the evidence base [Exhibit A.3]).

### 2.2.2 LAUNCH Supports for Existing Home Visiting Programs

In 11 of the 18 (61 percent) existing home visiting programs, LAUNCH grantees provided funding for expansion of the program slots to allow more families to be served. In five of these programs, LAUNCH focused the expansion in parts of the community where families were identified by the

<sup>6</sup> Evidence-based programs are defined as interventions that have shown impacts in multiple studies using rigorous and well-designed research. For example, SAMHSA’s National Registry of Evidence-Based Programs and Practices uses a system for rating the quality of the research on an intervention. Promising practices, as defined by RAND Promising Practices Network, refers to programs that have shown an impact but the evaluation design of the design displays some weaknesses such as a poorly matched comparison group.

grant as being underserved in the past by home visiting programs, for example, families from Spanish-speaking families who have not been able to participate in English language programs, families with children who have “aged out” of services but who still need additional supports, or rural families who have not been able to access services that operate in more populous communities.

Exhibit 2.2.2 Home Visiting Models and Approaches Supported by LAUNCH Grantees <sup>a,b</sup>		
Home Visiting Models	# Programs	Evidence Base <sup>c</sup>
Parents as Teachers (PAT)	8 <sup>d</sup>	Substantial
Healthy Families	2	Substantial
Nurse Family Partnership (NFP)	2	Substantial
Early Head Start	1	Substantial
Video Feedback Parent Child Dyadic Intervention (VIPP)	1	Substantial
First Born	1	Emerging
Child First	1	Emerging
Approaches/Frameworks Used in Home Visiting		
Touchpoints	2	Evidence reported by developer but no studies cited
Promoting Maternal Mental Health during Pregnancy	1	Limited/None
Positive Behavior Intervention System	1	Limited/None
Center on the Social and Emotional Foundations for Early Learning (CSEFEL)	1	Limited/None

<sup>a</sup> Including both newly-initiated and existing home visiting programs supported by LAUNCH grantees

<sup>b</sup> Does not include 4 grantees supporting expanding public health home visiting models with no other enhancements

<sup>c</sup> See Appendix A, Exhibit A.4 for sources, description of evidence rating criteria

<sup>d</sup> In addition, two grantees implemented components of the Parents As Teachers curriculum as a supplement to an existing home visiting program model (Healthy Families and Help Me Grow)

In addition to expanding programs, LAUNCH grantees enhanced program quality in five ways:

1. Supporting training of staff on the program model to promote fidelity of implementation,
2. Supporting training of staff on topics related to child mental and behavioral health,
3. Adding a new component to an existing model that enhanced the focus on children mental and behavioral health,
4. Increasing the cultural competency of the program by translating materials into other languages and adapting materials to be more appropriate to the families served (e.g., changing pictures, examples in parent materials) or hiring bilingual staff to work with special language groups, and
5. Providing support to the staff in the form of mental health consultation and/or reflective supervision.

Exhibit 2.2.3 shows the frequency of the types of enhancements that LAUNCH grantees introduced into home visiting programs. Most grantees introduced more than one type of enhancement to the home visiting programs they were supporting. In just over a quarter of the programs, LAUNCH funded training for staff on the program model, hired bilingual staff and/or translated program materials into Spanish for programs being extended to Hispanic families in the communities, or added a component to a home visiting model to extend the content.

In a third of the home visiting programs that were enhanced with LAUNCH funding, LAUNCH grantees provided professional supervision and support to the home visitors through reflective supervision alone or as part of broader mental health consultation. This mental health consultation is an innovative practice that has developed out of the recognition by LAUNCH grantees of the

increased need for home visitors to be capable of recognizing, interpreting and supporting the individual socio-emotional needs of children and families in their care when there are mental health concerns, and to support families in creating home environments that are positive climates for children’s learning and growth. In LAUNCH, mental health consultation involves multiple types of

Exhibit 2.2.3 Enhancements of Existing Home Visiting Programs by LAUNCH Grantees (n = 18 programs)	
Type of Enhancement	# (%) of enhanced home visiting programs
Improved fidelity of implementation of model (improved fidelity)	5 (28%)
Adding a new component to the program	5 (28%)
Professional support for home visitors	6 (33%)
• Reflective supervision	6 (33%)
• Mental health consultation	6 (33%)
Increased cultural competence of program	4 (27%)
• Translation of materials into other languages	4 (27%)
• Hiring bilingual staff/translators	4 (27%)
Other quality enhancements	1 (7%)
• Additional staff (same 3 of participants) to decrease staff workload	1 (7%)

<sup>a</sup> For example, adding PAT curriculum to ongoing home visiting program, adding Promoting First Relationships to public health home visiting program

support for home visitors, including consultation about the individual needs of children and families, broader professional development on mental health-related topics, and group and one-on-one reflective supervision.<sup>7</sup> Within LAUNCH, mental health consultation with home visiting programs is being considered by additional grantees, both new and previously-funded grantees, as they learn from the grantees already introducing this approach.

Mental health consultation has been designed to help home visitors work more effectively with the highest-risk families and to support the home visitors in dealing with their own job-related stress and secondary trauma. The mental health consultants play a variety of roles with the home visiting programs, including providing reflective supervision, building staff capacity to deal with mental health issues in families, such as maternal depression and/or attachment or bonding problems between mothers and their infants, and working alongside the staff with individual parents or families who are identified as needing some immediate short-term clinical intervention. To date, these supports to staff are being implemented with home visiting programs that do not have a strong clinical focus, including Early Head Start, Parents As Teachers (PAT) and Nurse Family Partnership (NFP). These clinical supports represent a unique contribution of LAUNCH and a potentially significant innovation in the home visiting field. This form of enhancement is discussed more fully below.

**2.2.3 Families Served in LAUNCH-Supported Home Visiting Programs**

In the first year of implementation, for the three cohorts combined, approximately 1,000 families were served by LAUNCH-supported home visiting programs (Exhibit 2.2.4). In Cohorts 1 and 2, as the number of LAUNCH-supported home visiting programs increased, so did the number of families

<sup>7</sup> Reflective supervision is a support to staff that is often mentioned in studies of the implementation of home visiting. This approach provides home visitors with ongoing and regular opportunities for reflection to sort out and cope with strong feelings brought on by complex work with families. Reflective supervision also allows the home visitor to experience the same high quality, supportive relationship that she is expected to provide for infants, toddlers and families.

served in each of the subsequent implementation years. Across the first three years of Project LAUNCH, approximately 3,164 families were served.

Exhibit 2.2.4 Number of Families Served by LAUNCH-Supported Home Visiting (HV) Programs by Cohort and Year of Implementation				
Cohort (# of funded grantees)	# Families Served (# Grantees Implementing Home Visiting Programs, # Programs)			
	Year 1	Year 2	Year 3	All Years
Cohort 1 (6 grantees)	23 families 5 grantees, 4 programs	290 families 5 grantees, 5 programs	247families 5 grantees, 6 programs	768 families 5 grantees, 5 programs
Cohort 2 (11 grantees)	818families 8 grantees, 13 programs <sup>a</sup>	1556 families 10 grantees, 15 programs	NA	2374 families 10 grantees, 15 programs
Cohort 3 (6 grantees)	22 families 3 grantees, 4 programs	NA	NA	22 families 3 grantees, 4 programs
All cohorts <sup>b</sup>	1071 families 15 grantees, 21 programs	1846 families 15 grantees, 20 programs	247 families 5 grantees, 5 programs	3164 families 18 grantees, 24 programs

<sup>a</sup> One of the 13 Cohort 2 HV programs trained staff but did not serve families in the year

<sup>b</sup> Total number of grantees varies by year of implementation: 23 in Year 1 (all 3 cohorts), 17 in Year 2 (cohorts 1 & 2), and 6 in Year 3 (cohort 1 only).

#### 2.2.4 Workforce Enhancement for Staff in LAUNCH-Supported Home Visiting Programs

Seventeen of the 23 LAUNCH grantees provided training to staff in one or more of the home visiting programs they were supporting. The training was intended to enhance staff understanding of children’s socio-emotional development, their knowledge of how to assess children’s mental and behavioral health, and options for referrals for children where there are concerns. Increasing the skills and knowledge of the home visiting program staff has the objective not only of improving the home visitors’ ability to work with parents and children around mental and behavioral health in informed and effective ways, but also to change the child service system in more permanent ways that could sustain the benefits of LAUNCH beyond the grant period.

The most common topic of staff training was children’s mental and behavioral health—identifying concerns at different ages and making appropriate referrals (Exhibit 2.2.5). In a majority of the home visiting programs, LAUNCH grantees provided training on understanding and assessing children’s mental and behavioral health to the majority of the home visiting programs. The second most common training topic was strategies for engaging and working with families (61 percent of home visiting programs).

LAUNCH grantees reported that the training was nearly always provided to all of the staff in a program. Across the three cohorts and all of the implementation years, LAUNCH-supported training was received by nearly 600 home visiting staff (Exhibit 2.2.6).

Exhibit 2.2.5 Topics of LAUNCH-Supported Training for Home Visiting Programs by Cohort Across Years of Implementation							
# Home Visiting Programs Addressing Topic (% Home Visiting Programs)							
Cohort # of grantees supporting home visiting/ # of home visiting programs supported	Milestones in Children's Development		Screening/Assessment of Children's Development		Options for Children with Mental/Behavioral Health Concerns		Working with Families
	Cognitive	Socio- Emotional	Cognitive	Socio- Emotional	Treatment	Referral	
Cohort 1 5 grantees, 5 programs	4 (66%)	5 (83%)	3 (50%)	4 (66%)	1 (17%)	3 (50%)	5 (83%)
Cohort 2 8 grantees, 15 programs	7 (47%)	10 (67%)	5 (33%)	9 (60%)	3 (20%)	4 (27%)	8 (53%)
Cohort 3 3 grantees, 4 programs	0	1 (25%)	1 (25%)	1 (25%)	1 (25%)	2 (50%)	1 (25%)
All cohorts (23 grantees)	11 (48%)	16 (70%)	9 (39%)	14 (61%)	5 (22%)	9 (39%)	14 (61%)

Exhibit 2.2.6 Number of Home Visitors Receiving LAUNCH-Supported Training by Cohort and Year of Implementation						
Cohort # of grantees supporting home visiting/ # of home visiting programs supported	Year 1		Year 2		Year 3	
	# HV programs with training/ % HV programs	# home visitors trained	# HV programs with training/ % HV programs	# home visitors trained	# HV programs with training/ % HV programs	# home visitors trained
Cohort 1 5 grantees, 5 programs	4 100%	32	5 83%	104	5 83%	100
Cohort 2 8 grantees, 15 programs	13 100%	81	14 93%	233	NA	NA
Cohort 3 3 grantees, 4 programs	4 100%	34	NA	NA	NA	NA
All cohorts (23 grantees)	21 100%	147	19	337	5 83%	100

### 2.2.5 Innovative Strategies in LAUNCH-Supported Home Visiting Programs

Over time, three notable changes are evident in the approach to home visiting implemented by the LAUNCH grantees. The first, referenced above, involves the provision of mental health consultation to the staff in home visiting programs. Among the five grantees who have introduced mental health

consultation into home visiting, none described this strategy as part of their original strategic plan. This strategy appears to have been started to address needs and stresses identified by home visitors. The mental health consultants have:

- Provided mental health support to home visitors (i.e., a safe place to discuss their own trauma),
- Provided mental health consultation about individual families (i.e., “reflective supervision”), and
- Worked directly with high-risk families alongside home visitors.

The Project LAUNCH grantees that introduced mental health consultation into home visiting were working with home visiting programs that were designed to address general parenting and child development issues. Other grantees adopted a different strategy for increasing the focus on mental health in home visiting. Five grantees implemented new home visiting program models into their communities that addressed clinical issues such as attachment and bonding, as opposed to general child development and cognitive-language development or school readiness. One of the six Cohort 1 models can be described as a clinically-oriented model (Video Intervention to Promote Positive Parenting), compared with one of the ten Cohort 2 models (Problem Behavioral Intervention and Supports) and 2 of the four (50 percent) Cohort 3 models can be described as more clinical in focus (Promoting Maternal Mental Health during Pregnancy, Child First).

Another development in home visiting is the increasing linkages between LAUNCH grantees and other programs and initiatives related to home visiting. One important connection is between LAUNCH and the federal HRSA/ACF home visiting initiative: the Maternal, Infant, and Early Childhood Home Visiting program (MIECHV). Under MIECHV, 15 of the LAUNCH states have received funding to support the implementation of evidence-based home visiting programs in designated communities. Two of the LAUNCH communities have been designated by their states as target communities for MIECHV home visiting programs (East Oakland and Milwaukee). For example, in Milwaukee, LAUNCH has undertaken to create a professional learning community across home visiting programs, with joint training and focus on the Infant Mental Health certification for home visitors.

#### 2.2.6 Self-Reported Outcomes for Providers in LAUNCH-Supported Home Visiting Programs

Outcomes for providers as a result of the workforce enhancement strategies are a key objective of Project LAUNCH. Grantees assessed provider outcomes using surveys that ask providers to report on changes in their knowledge, skills, and practices related to children’s mental and behavioral health issues as a result of their participation in LAUNCH-supported training or other supports. In the first two years of implementation, grantees all used retrospective pre-post surveys to collect data on provider changes. These surveys are administered at the end of each year. There is no baseline survey; instead, providers estimate the amount of change that has occurred since their involvement in LAUNCH. To date, none of the local evaluations is currently studying effects on Project LAUNCH providers using a comparison group design.

SAMHSA provided grantees with a short 4-item survey form (co-developed by Cohort 1 evaluators, SAMHSA, and Abt) to assess changes in providers. The survey is a retrospective pre-post survey that asks providers to indicate the extent of change they have experienced (no change, a little change, some change, or substantial change) in four areas: (1) knowledge of children’s socio-emotional development, (2) knowledge of referral options in their community for children identified as having

behavioral or mental health concerns, (3) use of mental health consultation for children with behavioral or mental health concerns; and (4) use of screening in their practices.

Exhibit 2.2.7 presents the responses on this survey for home visitors in Cohorts 1 and 2 only; none of the Cohort 3 home visiting programs measured provider outcomes in the first year of implementation. Although the sample sizes were small, response rates were above 80 percent for all time points except Cohort 1, Year 1.<sup>8</sup> The small sample sizes reflect the fact that home visiting programs tend to be small, with a relatively small number of staff. The majority of the home visitors in Cohort 1 reported “*some*” or “*substantial*” change in each of the four areas in each of the three years of implementation. Lower percentages of home visitors in the Cohort 2 programs reported changes as a result of their involvement in LAUNCH, compared with Cohort 1. The two areas involving increased knowledge (as opposed to practice) had higher proportions of home visitors reporting change, for both Cohorts 1 and 2.

Exhibit 2.2.7 Changes in Knowledge and Practice Reported by Staff of LAUNCH-Supported Home Visiting Programs As a Result of Involvement in LAUNCH By Cohort <sup>a</sup> and Year of Implementation					
	Cohort 1 (6 grantees)			Cohort 2 (11 grantees)	
	Year 1	Year 2	Year 3	Year 1	Year 2
# programs implemented	4	6	6	13	15
# programs administering provider survey (%)	3 (75%)	4 (66%)	5 (83%)	11 (85%)	13 (87%)
# providers responding to survey	35	35	27	62	60
<b>Providers reporting “substantial change” as a result of involvement in LAUNCH-supported program</b>					
Knowledge of children’s socio-emotional and behavioral health and development	69%	62%	49%	24%	38%
Knowledge of available options for follow-up services for children with mental or behavioral health issues	65%	59%	66%	17%	29%
Use of mental health consultation for children with mental or behavioral health issues	64%	55%	49%	19%	30%
Use of screening/assessment of children in their work setting	55%	68%	42%	16%	31%
<b>Providers reporting “some change” as a result of involvement in LAUNCH-supported program</b>					
Knowledge of children’s socio-emotional and behavioral health and development	18%	31%	46%	40%	43%
Knowledge of available options for follow-up services for children with mental or behavioral health issues	30%	25%	28%	55%	39%
Use of mental health consultation for children with mental or behavioral health issues	31%	16%	42%	14%	33%
Use of screening/assessment of children in their work setting	34%	8%	35%	43%	32%

<sup>a</sup> No provider outcome data were reported by Cohort 3 grantees from Year 1 implementation

Note that data from retrospective pre-post surveys provide limited evidence about provider outcomes. In the absence of data from comparable groups of non-LAUNCH providers, we cannot attribute changes in providers to the LAUNCH supports. These findings have to be treated as suggestive. If, over time, evaluators report similar findings for providers across years and across cohorts of providers, the evidence will be considered stronger that Project LAUNCH is contributing to an enhanced workforce.

<sup>8</sup> The response rates were above 80 percent for each of the two time points for each cohort with the exception of Cohort 1, Year 1, when the response rate was 45 percent.

## 2.3 Family Support Programs

### *Summary of Key Findings in Family Support Programs*

The vast majority of grantees in Cohorts 1, 2 and 3 are supporting at least one family support program in their communities, and nearly half of the grantees are supporting multiple family support activities. Across the three cohorts and multi-year implementation period, the LAUNCH-supported family support programs have served approximately 7,000 families. The majority of the LAUNCH-supported family support programs are newly initiated under LAUNCH. Among the family support programs that are providing parent education or family intervention, the majority (64 percent) are using models that have been identified as having substantial or emerging evidence.

LAUNCH supported workforce enhancement for staff in 40 percent of the family support programs. Workforce training was provided on children's socio-emotional development, and screening and assessment of children's mental and behavioral health, and on options for referrals for children where screening identifies concerns. Across the three cohorts and multi-year implementation period, 916 staff participated in at least one LAUNCH-supported training. Many of the 61 percent of programs that did not receive LAUNCH-supported training were not candidates for LAUNCH training because (a) they were new programs in which staff training was conducted by certified trainers as opposed to LAUNCH-supported trainers, and (b) the program models already included a focus on children's socio-emotional development.

The extent of changes in knowledge and practice reported by the staff in the family support programs was, on average, lower than for the home visitors and more variable across cohorts and implementation years: Higher proportions of providers reporting change in Cohorts 1 and 3, and in the first year of implementation.

#### 2.3.1 LAUNCH-Supported Family Support Programs: Types of Programs and Types of LAUNCH Support

At the time the LAUNCH projects began, there were family support programs operating in all of the LAUNCH communities. Most of these programs were locally-developed as opposed to national brands or evidence-based models. Moreover, most of the grantees noted that there were ongoing concerns with the level of parent engagement in many of the programs. Getting parents to participate in the programs was a challenge, because the programs were long, were not culturally responsive to the language and/or cultural characteristics of different parts of the community, or were not focused on the needs that families themselves could identify.

Starting in the first year of implementation, the majority of the LAUNCH grantees (15 of 23, or 65 percent) supported one or more family support programs, which included newly-implemented programs supported by LAUNCH and existing family support programs that LAUNCH enhanced. New programs were introduced when gaps existed in the community service system. Family support programs included parent education programs, short-term mental health treatment, and services planning and coordination. Across all of the cohorts and the multiple implementation years, 52 different family support activities have been supported by LAUNCH grantees. This number reflects that half of the grantees supported more than one family support program. As shown in Exhibit 2.3.1, in each succeeding implementation year, LAUNCH grantees continued to expand the number of family support programs being offered in their communities. Whereas with home visiting programs, LAUNCH grantees most often enhanced existing programs, the opposite was true for family support programs. Between 65 percent and 70 percent of the family support programs being supported by LAUNCH were newly-initiated (Exhibit 2.3.1).

Exhibit 2.3.1 Number of New and Existing Family Support Programs <sup>a</sup> Supported by LAUNCH by Cohort and Year of Implementation			
Cohort/type of home visiting program (# grantees in cohort)	Year 1 23 grantees	Year 2 17 grantees	Year 3 6 grantees
<b>Cohort 1 (6 grantees)</b>	4 grantees (67%)/ 11 programs	6 grantees (100%)/ 17 programs	6 grantees (100%)/ 19 programs
New	6 (55%)	11 (63%)	13 <sup>b</sup> (66%)
Enhanced	5 (45%)	6 (37%)	6 (34%)
<b>Cohort 2 (11 grantees)</b>	8 grantees (72%)/ 19 programs	10 grantees (91%)/ 28 programs	NA
New	11 (58%)	18 (64%)	NA
Enhanced	8 (42%)	10 (36%)	NA
<b>Cohort 3 (6 grantees)</b>	3 grantees (50%)/ 5 programs	NA	NA
New	4 (80%)	NA	NA
Enhanced	1 (20%)	NA	NA
<b>All cohorts</b>	15 grantees from Cohorts 1-3 (65%)/35 programs	15 grantees from Cohorts 1-2 (88%)/45 programs	6 grantees from Cohort 1(100%)/19 programs
New	21 (60%)	29 (64%)	13 (66%)
Enhanced	14 (40%)	16 (36%)	6 (34%)

<sup>a</sup> Includes parenting education, short-term mental health treatment and family assessment and referral services

LAUNCH grantees implemented and supported multiple program models (Exhibit 2.3.2). The models varied in their focus, whether they were primary prevention programs versus programs for referred families, and the delivery method (working one-on-one with individual families or with small groups of parents of children with behavioral concerns). For the 28 programs that provided parent education or clinically-focused programs (first two categories in Exhibit 2.3.2), 18 (64%) used models for which there was emerging or substantial evidence of effectiveness.

### 2.3.2 LAUNCH Enhancements of Existing Family Support Programs

Seventeen of the family support programs supported by Project LAUNCH were existing programs rather than newly-initiated ones. For ten of these programs, grantees funded expansions of the program to serve more families. For the remaining seven programs, grantees introduced enhancements to the program itself. The most common enhancement by LAUNCH grantees was translation of materials and hiring of bilingual staff (100 percent of enhanced programs) (Exhibit 2.3.3).

Exhibit 2.3.2 Family Support Program Models Supported by LAUNCH <sup>a</sup>			
Program Focus	Family Support Program Model	# of programs (n = 52)	Evidence Base <sup>a</sup>
Families referred for parent pr child mental or behavioral health concerns (1-on-1 or small group)	Circle of Security	1	Emerging support
	Parent Child Interaction Therapy (PCIT)	2	Well-supported
	Primary Project	1	Well-supported
	Trauma Recovery and Empowerment Model (TREM)	1	Emerging support
	Valley Intervention Program (local model)	1	Limited/No support
Parent Education/ primary prevention (group)	Centering Pregnancy	2	Limited/No support
	Centering Parenting	2	Limited/No support
	Chicago Parent Program	2	Moderate support
	Incredible Years BASIC Parent Program	7	Well-supported
	Newborn Behavioral Observation	1	Moderate support
	Nurturing Parenting Programs: ABCs for Parents, Nurturing Parents	2	Limited/No support
	Parenting Wisely	1	Emerging support
	Positive Behavior Support	1	Limited/No support
	Strengthening Multiethnic Families and Communities	3	Moderate support
	Locally-developed models	6	None
Case Management	Family Navigation/Coordination	6	Limited/No support
	Wraparound Case Management	1	Limited/No support
Parent Leadership/ Advocacy	Parent Cafes (Strengthening Families framework)	2	Limited/No support
	Parent leadership/engagement training	2	Limited/No support
Mental Health Treatment	Short-term clinical intervention services	6	NA
Parent information	Parent help line	2	NA

<sup>a</sup> See Appendix B, Exhibit B.3 for sources and description of evidence rating criteria.

Exhibit 2.3.3 Enhancements of Existing Family Support Programs by LAUNCH Grantees (n = 7 programs <sup>a</sup> )	
Type of Enhancement	# of family support programs (% of enhanced programs)
Staff training on socio-emotional screening measures	3 (43%)
Mental health consultation for family support staff	1 (14%)
Enhancement of the cultural competence of program through translation of materials into Spanish, hiring bilingual (Spanish-English) staff or translators	7 (100%)
Added child development component to parenting group	1 (14%)

<sup>a</sup> Sample includes existing family support programs into which Project LAUNCH grantees introduced program enhancements.

### 2.3.3 Families Served in LAUNCH-Supported Family Support Programs

Across the three cohorts and multiple years of intervention, more than 7,000 families participated in LAUNCH-supported family support programs (Exhibit 2.3.4). This is a much larger number of families served than the number served in home visiting programs. The difference reflects the individual family focus and intensity of home visiting compared with the often time-limited family support programs that can enroll multiple families simultaneously. Further, as a result of the short duration of the family support programs, grantees can sponsor multiple family support groups in a single year.

Exhibit 2.3.4 Number of Families Served by LAUNCH-Supported Family Support (FS) Programs by Cohort and Year of Implementation				
Cohort / # of grantees	Year 1 # families served (# FS programs)	Year 2 # additional families served (# FS programs)	Year 3 # additional families served (# FS programs)	All Years Total # families served (# FS programs)
Cohort 1 (6 grantees)	618 (11)	1391 (17)	1377 (19)	3386 (19)
Cohort 2 (11 grantees)	930 (19)	2544 (28)	NA	3474 (28)
Cohort 3 (6 grantees)	207 (5)	NA	NA	207 (5)
All cohorts	1755 (35)	3979 (45)	1377 (19)	7067 (52)

### 2.3.4 Workforce Enhancement for Staff in LAUNCH-Supported Family Support Programs

All LAUNCH grantees provided training to staff in one or more of the family support programs they were implementing. The training was intended to enhance staff understanding of children's socio-emotional development and their knowledge of how to assess children's mental and behavioral health and options for referrals for children where there are concerns. Increasing the skills and knowledge of the family support program staff has the objective not only of improving the staff ability to work with parents and children around mental and behavioral health in informed and effective ways, but also to change the child service system in more permanent ways that could sustain the benefits of LAUNCH beyond the grant period. Exhibit 2.3.5 shows the frequency of training topics. Topics covered were understanding children's socio-emotional development and how to assess it (26 and 28 percent, respectively), and strategies for engaging parents in programs and services for their children and families (26 percent).

Exhibit 2.3.6 shows the number of family support program staff for whom LAUNCH supported training during each of the implementation years. LAUNCH offered training to 22 of the family support programs (39 percent). In total, across the three cohorts during the multiple years of implementation, over 900 family support program staff received training.

Exhibit 2.3.5 Topics of LAUNCH-Supported Training for Family Support (FS) Programs by Cohort Across Year of Implementation							
	# Family Support Programs Addressing Topic (% Family Support Programs)						Working with Families
	Milestones in Children's Development		Screening/Assessment of Children's Development		Options for Children with Mental/Behavioral Health Concerns		
	Cognitive	Socio-Emotional	Cognitive	Socio-Emotional	Treatment	Referral	
Cohort 1 (6 grantees)	9 (47%)	10 (53%)	3 (16%)	10 (53%)	3 (16%)	5 (26%)	11 (58%)
Cohort 2 (11 grantees)	4 (15%)	4 (15%)	4 (15%)	3 (11%)	4 (15%)	4 (15%)	4 (15%)
Cohort 3 (6 grantees)	0	0	0	1 (20%)	0	0	0
All cohorts (23 grantees)	6 (12%)	13 (26%)	6 (12%)	14 (28%)	6 (12%)	9 (18%)	13 (26%)

Exhibit 2.3.6 Number of Family Support Staff Offered LAUNCH-Supported Training by Cohort and Year of Implementation							
	Year 1		Year 2		Year 3		All Years
	# FS programs with training (% FS programs)	# program staff trained	# FS programs with training (# FS programs)	# program staff trained	# FS programs with training (# FS programs)	# program staff trained	# program staff trained
Cohort 1 (6 grantees)	6 (55%)	34	7 (41%)	188	8 (42%)	379	601
Cohort 2 (11 grantees)	7 (37%)	128	12 (43%)	187	NA	NA	315
Cohort 3 (6 grantees)	2 (40%)	32	NA	NA	NA	NA	32
All cohorts	15 (43%)	194	19 (42%)	375	8 (42%)	379	916

### 2.3.5 Self-Reported Outcomes for Providers in LAUNCH-Supported Family Support Programs

As discussed in the section on home visiting, outcomes for providers as a result of the workforce enhancement strategies are a key objective of Project LAUNCH. Grantees assessed provider outcomes using surveys that ask providers to report on changes in their knowledge, skills and practices related to children’s mental and behavioral health issues, as a result of their participation LAUNCH-supported training or other supports. In the first two years of implementation, grantees all used retrospective pre-post surveys to collect data on provider changes. These surveys are administered at the end of the year. There is no baseline survey; instead, providers estimate the amount of change that has occurred since their involvement in LAUNCH. To date, none of the local evaluations is currently studying effects on LAUNCH providers using a comparison group design.

As described above, only 7 of the 17 family support programs experienced enhancements through Project LAUNCH. There was substantial variation in provider responses across cohorts and implementation years. In general, higher percentages of staff in the Cohort 1 and the Cohort 3 programs reported “some” or “substantial” change in their knowledge and practice, compared with Cohort 2. In Cohorts 1 and 3, between 47 percent and 97 percent of staff reported “some” or “substantial” change in their knowledge and practice, depending on the year of implementation. The corresponding percentages among Cohort 2 staff ranged from 46 percent to 71 percent reporting knowledge and practice, compared with Cohort 2. In Cohorts 1 and 3, between 47 percent and 97 percent of staff reported “some” or “substantial” change. As was true for the home visitors, the staff in family support programs were more likely to report changes in knowledge compared with changes in practices. The level of change reported by family support staff was, in general, lower than the changes reported by home visitors.

Exhibit 2.3.7 presents the responses on the SAMHSA survey for family support staff in Cohorts 1 and 2 only; none of the Cohort 3 family support programs measured provider outcomes in the first year of implementation. As noted previously, in the absence of data from comparable groups of non-LAUNCH providers, we cannot attribute changes in providers to the LAUNCH supports. These findings have to be treated as suggestive. If, over time, evaluators report similar findings for providers across years and across cohorts of providers, the evidence will be considered stronger that Project LAUNCH is contributing to an enhanced work force.

Exhibit 2.3.7 Changes in Knowledge and Practice Reported by Staff of LAUNCH-Related Family Support Programs As a Result of Involvement in LAUNCH By Cohort and Year of Implementation						
	Cohort 1 (6 grantees)			Cohort 2 (11 grantees)		Cohort 3 (6 grantees)
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 1
# programs implemented	12	16	17	19	27	5
# programs with provider responses (% of programs)	3 (25%)	9 (56%)	13 (76%)	9 (47%)	8 (30%)	1 (20%)
# providers who completed survey	27 <sup>a</sup>	56 <sup>a</sup>	85 <sup>a</sup>	45 <sup>a</sup>	18 <sup>a</sup>	16 <sup>a</sup>
<b>Providers reporting "substantial change" as a result of involvement in LAUNCH-related program:</b>						
Knowledge of children's socio-emotional and behavioral health and development	64%	51%	16%	40%	40%	19%
Knowledge of available options for follow-up services for children with mental or behavioral health issues	57%	36%	21%	18%	42%	19%
Use of mental health consultation for children with mental or behavioral health issues	56%	28%	36%	16%	21%	13%
Use of screening/assessment of children in their work setting	81%	31%	22%	11%	19%	13%
<b>Providers reporting "some change" as a result of involvement in LAUNCH-related program:</b>						
Knowledge of children's socio-emotional and behavioral health and development	33%	31%	72%	22%	22%	69%
Knowledge of available options for follow-up services for children with mental or behavioral health issues	4%	23%	50%	42%	29%	63%
Use of mental health consultation for children with mental or behavioral health issues	6%	19%	22%	41%	25%	63%
Use of screening/assessment of children in their work setting	8%	18%	58%	46%	37%	44%

<sup>a</sup> Response rates for the provider samples at the six time periods are 50%, 57%, 71%, 55%, 59%.

## 2.4 Mental Health Consultation

### *Summary of Key Findings in Mental Health Consultation*

The LAUNCH grantees have implemented mental health consultation in a number of settings in the community child and family services system. Consistent with the LAUNCH objectives, grantees have initiated mental health consultation programs in early care and education (preschool) settings and in elementary schools. On a smaller-scale, a few grantees are implementing mental health consultation in other settings, such as home visiting, Child Protective Services or human service agencies. In all of these programs, LAUNCH has funded a trained mental health consultant (either a licensed clinical or a master's level social worker or counselor) to work with staff in multiple ways, including building staff competencies in the area of mental and behavioral health, supporting staff in evaluating and developing plans for individual parents or children with mental health concerns, and providing some short-term intervention for individuals. In addition, especially in home visiting, the mental health consultants are providing reflective supervision for staff, to discuss families or children about whom the provider has concerns and to support staff in coping with the stress and burden of working with very at-risk families.

Thirteen of the grantees (56 percent) implemented mental health consultation in early childhood care settings. Across the implementation period, grantees in the three cohorts worked with more than 70 early childhood programs and 120 staff. All of the grantees that supported mental health consultation provided training to early childhood staff as part of the consultation activities. Topics included children's socio-emotional development, on strategies for working with children exhibiting challenging behavior, on curricula

such as Incredible Years that promote positive social behavior among children, and on physical environments that supported children's prosocial behavior. Training was offered multiples times during a year, which focused on children's typical and atypical development in the socio-emotional and cognitive domains, screening and assessment, and strategies for engaging families. On average, individual early childhood staff attended between four and five trainings in a year. The early childhood staff in Cohort 1 programs reported more change in their skills and knowledge.

Six of the grantees (26 percent) implemented mental health consultation, working with 14 elementary schools. Grantees typically worked with only one or two schools in their communities. As part of the consultation programs in schools in two of the sites, the mental health consultants provided training to school staff to enhance their understanding of children's socioemotional development and screening of children with behavioral concerns. Typically, school staff did not have frequent direct interaction with the mental health consultants, who more often worked with individual children referred for evaluation or with counseling staff in the school. Possibly as a result, on average, smaller proportions of school staff reported LAUNCH-related changes in their knowledge or practices, compared with early childhood staff who participated in mental health consultation.

Five of the grantees initiated mental health consultation in home visiting programs. A comparison of the responses from home visitors in programs that had access to mental health consultation with home visitors who did not provides evidence of the positive effect of the clinical supervision and support. Substantially more of the home visitors who received mental health consultation reported change in their use of mental health consultation (82 percent versus 54 percent among home visitors not receiving mental health consultation).

#### 2.4.1 Mental Health Consultation in Multiple Settings

Two of the core Project LAUNCH prevention and promotion strategies involved introducing mental health consultation into existing service settings: into early childhood education and care settings, at both the preschool and elementary school levels, and into primary care settings. One of the innovations of Project LAUNCH was using this same approach with home visiting programs, as described earlier. In each of these settings, the mental health consultation models included multiple components (Exhibit 2.4.1), including supports for providers such as additional training and reflective supervision and supports for children and families, such as case consultation and developmental assessments. Regardless of the setting, most of the mental health consultation programs included training for providers on topics related to parent and child mental/behavioral health. Also, most of the mental health consultants offered individual case consultation for children identified by the providers as having behavioral or mental health concerns. Components that differed across settings included (a) the role of the mental health consultant in working directly with providers through reflective supervision, which was seen primarily in home visiting; (b) use of a specific curriculum as a framework for mental health consultation with providers, which was seen primarily in preK settings; and (c) the co-location of the mental health consultant in the setting on a regular basis.

#### 2.4.2 Mental Health Consultation in Early Childhood Education and Care Settings

##### Types of LAUNCH Mental Health Consultation Programs

One of the five core LAUNCH prevention and promotion strategies is mental health consultation for providers in settings where children are being served. Although this strategy was originally conceived as applying primarily to education settings—child care, preschools, family child care, and elementary schools, the LAUNCH grantees expanded mental health consultation into other settings, including home visiting programs, family support programs, and social service agencies. As discussed in the *Cross-Site Evaluation of Project LAUNCH: Findings from the First Year of Implementation* (Gwaltney, Goodson, and Walker, 2013), mental health consultation generally had a

Exhibit 2.4.1 Proportion of Project LAUNCH Mental Health Consultation Programs by Component and Setting									
Setting for mental health consultation	Preferred Qualifications of Mental Health Consultant		Services Provided by Mental Health Consultant					Delivery of Consultation	
	Licensed clinician (vs. social worker, MA-level)	Specialization in early childhood	Reflective supervision with providers (group and one-on-one)	Workforce development on child/family mental/behavioral health	Case consultation	One-on-one short-term therapy for client	Developmental assessments	Consultation based on/framed by curriculum model	Mental health consultant co-located in program setting
Home visiting programs (n = 11)	N = 100%	N = 0%	N = 81% <sup>a</sup>	N = 100% <sup>b</sup>	N = 100%	N = 22%	N = 36%	N = 0%	N = 0%
Early childhood education & care (preK) (n = 20)	N = 47%	N = 25%	N = 5% <sup>c</sup>	N = 80% <sup>e</sup>	N = 90%	N = 0%	N = 75%	N = 45% <sup>e</sup>	N = 15%
Elementary schools (K – grade 3) (n = 10)	N = 20%	N = 20%	N = 0%	N = 90% <sup>f</sup>	N = 90%	N = 0%	N = 50%	N = 10%	N = 20%
Primary care providers (n = 17)	N = 41%	N = 18%	N = 0%	N = 71% <sup>g</sup>	N = 65%	N = 0%	N = 59%	N = 0%	N = 41%

<sup>a</sup> Average frequency of reflective supervision = 2.2 times/month

<sup>b</sup> Examples of training topics include motivational interviewing, Compassion fatigue, Boundary setting, childhood trauma, building healthy relationships, domestic violence, depression, substance abuse, immigration, anxiety

<sup>c</sup> Average frequency of reflective supervision = 1 time/month

<sup>d</sup> Examples of training topics include developmental plan, children’s planning, dealing with children with challenging behaviors, child resilience, child planning, mental health consultation

<sup>e</sup> Incredible Years, DECA, PBIS, Second Step

<sup>f</sup> Examples of training topics include kindergarten transition, bullying, impact of trauma on children, regulatory challenges for children, providing a psychologically safe classroom environment

<sup>g</sup> Examples of training topics include adverse childhood experiences and their impacts, developmental pediatrics, promoting resilience, cultural competency, child abuse and intervention, substance abuse and its impacts on prenatal development, identifying depression in child and adults, parenting children with challenging behaviors, regulatory and sensory processing in infants and children, maternal depression and anxiety, effective discipline in the early years, toxic stress and ACE

slower roll-out than the family support and home visiting strategies. Challenges that grantees faced in developing and implementing consultation models included the extended time and effort required to establish collaborative relationships and infrastructure in primary care and early care and education settings, especially where the collaborating organizations did not have histories of cross-agency cooperation.

At the time of the LAUNCH grants, very few grantees reported that their communities had existing mental health consultation activities in early childhood education and care settings or in schools. In a few sites, there was a limited amount of mental health consultation services being provided to selected early childhood programs (Head Start being the notable example<sup>9</sup>), but none of the grantees reported a widespread mental health consultation system in place across other early childhood care settings at the time of LAUNCH. By the end of the first year of implementation, 10 of the 23 grantees (43 percent) had initiated mental health consultation in early care settings. By the end of the second year of implementation the number of grantees in Cohorts 1 and 2 implementing mental health consultation grew from 9 to 13 (76 percent of the 17 grantees) (Exhibit 2.4.2). Across the three cohorts, 13 grantees implemented mental health consultation in more than 70 early childhood education and care programs. Six of these same grantees also provided mental health consultation to a total of 14 elementary schools.

Exhibit 2.4.2 Size of LAUNCH Mental Health Consultation Programs in Early Childhood Settings by Cohort and Year of Implementation									
	Year 1			Year 2			Year 3		
	# (%) grantees	# ECE settings	# providers	# (%) grantees	# ECE settings	# providers	# (%) grantees	# ECE settings	# providers
Cohort 1 (6 grantees)	2 (33%)	9	55	4 (66%)	16	109	4 (66%)	28	113
Cohort 2 (11 grantees)	7 (64%)	34	326	9 (82%)	59	255	NA	NA	NA
Cohort 3 (6 grantees)	1 (17%)	4	5	NA	NA	NA	NA	NA	NA
All cohorts <sup>d</sup>	10 (43%)	47	380	13 (76%)	75	364	4 (66%)	28	113

In early childhood education and care settings, the grantees implemented different approaches to mental health consultation. Grantees offered one or more of three levels of consultation. One level of consultation involved general consultation to teachers and/or administrators on topics such as typical and atypical child development, social-emotional development, or classroom environments that

<sup>9</sup> Head Start programs have performance standards related to supporting children’s mental health. Programs must work collaboratively with parents to obtain information about their child’s mental health, help parents understand mental health issues, and support parents’ participation in needed mental health interventions. Programs must also obtain the services of mental health professionals to “enable timely and effective identification of and intervention in family and staff concerns about a child’s mental health” and provide mental health consultation on “how to design and implement program practices responsive to the identified behavioral and mental health concerns of an individual child or group of children, promote children’s mental wellness by providing group and individual staff and parent education on mental health issues, assist in providing special help for children with atypical behavior or development, and utilize other community mental health resources, as needed” (ACF, 2012).

promote the development of social and emotional skills. The consultation was typically focused on providers, but some consultations also provided parent education sessions. This type of consultation was not targeted to specific characteristics of the setting but offered mental health-related information that was broadly applicable. Consultants also provided program-specific consultation on programmatic issues such as staff relationships, parent-staff relationships, or programming and curriculum. A second level involved child-specific consultation with staff and possibly parents about individual children in the program with behavior concerns. The consultant might observe or assess the child and meet with the child's parents as well as teachers, and could make referrals for additional evaluation or services. The third level, which includes the most intensive consultation activities, involved short-term mental health treatment for a child or a parent-child pair.

The type of consultation differed across the 14 mental health consultation programs being implemented by the LAUNCH grantees:

- In two, the programs provided only general consultation;
- In nine, the programs provided general consultation and child-specific consultation; and
- In three, the programs general consultation, child-specific consultation, as well as short-term mental health treatment for individual children with behavioral or mental health concerns.

Three of the grantees reported using the Georgetown Model in their mental health consultation. The rest did not report having a named model. Seven of the grantees supported a specific socio-emotional early childhood curriculum as part of the programmatic consultation. These included Second Step (2 grantees) and Incredible Years (5 grantees). In addition, one grantee reported using the CSEFEL framework for their mental health consultation.

The mental health consultants were clinically-trained and had specializations in early childhood mental health and development. The extent to which the mental health consultants were embedded in the early childhood settings varied by program. All of the consultation programs offered the services of the mental health consultant on an as-needed basis. In three of the programs, this was the only way that the consultant was available to the early childhood programs. However, in eight of the programs, the consultant was physically present at an early childhood site one day a week. In three programs, the mental health consultant was sited at the early childhood program on a more full-time basis.

Grantees varied substantially in the size of their mental health consultation program in early childhood settings (Exhibit 2.4.1). Over the first two years of implementation, grantees worked with as few as 2 early childhood programs and as many as 13. As a group, the 10 Cohort 1 and Cohort 2 grantees that provided mental health consultation in their first year of implementation worked with 44 different early childhood programs; in the second year of implementation, 13 grantees offered consultation to a total of 71 early childhood programs. Note that although this increase suggests that, overall, LAUNCH grantees expanded their mental health consultation into additional early childhood programs over time, this expansion characterized only some of the grantees. Two of the grantees reported experiencing difficulties implementing their mental health consultation at the level they had planned: One of the grantees discontinued its mental health consultation entirely, and three others were in the process of restructuring their program based on initial problems engaging child care settings as planned. Most of the grantees had difficulty expanding their consultation beyond the initial set of programs with which they worked.

Grantees reported that introducing mental health consultation into school settings was challenging. Only six grantees implemented this strategy, and all of these grantees began their mental health consultation in the second year of implementation. These grantees have used different approaches in partnering with schools. One grantee provided the on-call services of a clinician to elementary schools in their community; teachers could ask for a consultation on children who were exhibiting challenging behaviors, and the clinician would go to the school to meet with the teacher and, if appropriate, the parent(s). Another grantee arranged for a mental health clinician who was working with the grantee to also spend time working with school staff on staff professional development covering mental health-related topics and to conduct assessments of children about whom teachers had concerns. A third grantee arranged for a mental health clinician to be at the school on a scheduled basis, when they would be available for classroom observations and consultation. Finally, the fourth grantee trained mental health clinicians to work with teachers on ways to organize classrooms and manage student behavior to reduce student behavior problems.

**2.4.3 Workforce Enhancement for Staff in Early Childhood Education and Care Programs as Part of LAUNCH Mental Health Consultation**

Provider training was one component of the mental health consultation activities. The mental health consultants provided training to providers on topics such as typical and atypical child development, children’s socio-emotional development and environmental conditions that support children’s healthy social development. All of the Cohort 1 and 2 grantees who supported mental health consultation in early childhood settings provided training to early childhood staff as part of the consultation activities. The training was offered to all staff in the participating early childhood centers. The training involved multiple sessions each year. On average, individual early childhood staff attended four to five training sessions over a year. This meant that over three years of implementation, there were 900 early childhood education staff attending the trainings in Cohort 1 programs participating in mental health consultation and 500 in Cohort 2.

The topics of the staff training included information on typical and atypical development in the domains of children’s socio-emotional functioning, behavioral health, and cognitive development; screening and assessment in both of these domains; and strategies for engaging and working with families (Exhibit 2.4.3).

Exhibit 2.4.3 Topics of Training for Early Childhood Education Program Staff as Part of LAUNCH Mental Health Consultation (MHC) for Cohorts 1 and 2 <sup>a</sup>	
Training topics	# grantees (% grantees offering mental health consultation)
<b>Child development</b>	
Socio-emotional development	9 (90%)
Cognitive development	7 (70%)
<b>Screening/ assessment measures</b>	
Socio-emotional development	7 (70%)
Cognitive development	5 (50%)
<b>Options</b>	
Treatment	4 (40%)
Referral	6 (60%)
Engaging, working with families	7 (70%)

<sup>a</sup> The Cohort 2 site implementing mental health consultation in early childhood education programs did not provide training in the first year of implementation.

#### 2.4.4 **Self-Reported Outcomes for Early Childhood Education Providers in Programs Receiving LAUNCH Mental Health Consultation**

As described earlier, grantees administered a short SAMHSA-provided survey to the early childhood staff that were the recipients of the mental health consultation, asking about changes in knowledge and practice as a result of their involvement in LAUNCH.<sup>10</sup> Staff in the early childhood programs receiving mental health consultation were asked to indicate the extent of change (no change, a little change, some change, or substantial change) in each of four areas that they had experienced as a result of their involvement in LAUNCH. The four areas on which providers rated their level of change were their knowledge of children’s socio-emotional development; their knowledge of referral options in their community for children identified as having behavioral or mental health concerns; their use of mental health consultation for children with behavioral or mental health concerns; and the use of screening in their practices.

The percentage of early childhood staff reporting “substantial” change in knowledge or practice as a result of their involvement in the LAUNCH mental health consultation ranged from 32 percent to 75 percent (Exhibit 2.4.4). Providers in Cohort 1 sites reported more change, compared with providers in Cohort 2 sites. Across both cohorts, the highest percentage of staff reported change in their use of screening or assessment of children as a result of the LAUNCH mental health consultation.

#### 2.4.5 **Mental Health Consultation in Elementary Schools**

##### **Types of LAUNCH Mental Health Consultation Programs**

Prior to LAUNCH, grantees reported that the mental health services that operated in schools focused on children with identified special needs. The largest gap in services that grantees identified in discussions with school administrators was consultation on children with mental health or behavior concerns that potentially could be ameliorated through short-term intervention or changes in the classroom environment without referring the child for full-scale evaluation for special education services. Despite identifying school partners for mental health consultation activities, LAUNCH grantees met many challenges in introducing mental health consultation into schools.

Grantees typically established mental health consultation programs one school at a time. For the majority, the introduction of mental health consultation into schools appears to have been a strategy newly-initiated after the LAUNCH project began in a community. On the other hand, in four of the sites, LAUNCH leveraged a pre-existing relationship between a school or schools and the partner organization that LAUNCH had selected to conduct the mental health consultation. These pre-existing relationships helped facilitate Project LAUNCH’s access to schools. LAUNCH grantees typically selected one or two schools in their community to initiate discussions about mental health consultation activities. If schools expressed an interest, LAUNCH grantees began the process of establishing a relationship as a foundation for bringing a LAUNCH-supported mental health consultant into the school, to work in a coordinated way with the counselors and teachers.

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<sup>10</sup> Limited conclusions can be drawn from these data from retrospective pre-post surveys without a comparison group. Findings from the surveys are suggestive of LAUNCH-related outcomes, but are not evidence of program effects. Also, the fact that response rates at some of the timepoints were low is another reason for caution in interpreting the response as evidence that LAUNCH participation is related to changes in the full sample of participating providers.

Exhibit 2.4.4 Changes in Knowledge and Practice Reported by Staff of Early Childhood Education and Care Programs Receiving LAUNCH Mental Health Consultation (MHC) By Cohort and Implementation Year						
	Cohort 1 (6 grantees)			Cohort 2 (11 grantees)		Cohort 3 (6 grantees)
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 1
# MHC programs implemented	2	3	4	4	7	1
# programs with provider responses (%)	0	2 (66%)	2 (50%)	3 (75%)	3 (43%)	0
# providers responding to survey	NA	26	47	10	19	NA
Providers reporting " <i>substantial change</i> " as a result of involvement in LAUNCH mental health consultation:						
Knowledge of children's socio-emotional and behavioral health and development	NA	53%	52%	28%	34%	NA
Knowledge of available options for follow-up services for children with mental or behavioral health issues	NA	59%	48%	28%	32%	NA
Use of mental health consultation for children with mental or behavioral health issues	NA	49%	75%	28%	46%	NA
Use of screening/assessment of children in their work setting	NA	39%	68%	28%	48%	NA
Providers reporting " <i>some change</i> " as a result of involvement in LAUNCH mental health consultation:						
Knowledge of children's socio-emotional and behavioral health and development	NA	25%	46%	22%	50%	NA
Knowledge of available options for follow-up services for children with mental or behavioral health issues	NA	29%	48%	11%	43%	NA
Use of mental health consultation for children with mental or behavioral health issues	NA	31%	25%	11%	20%	NA
Use of screening/assessment of children in their work setting	NA	56%	24%	39%	23%	NA

<sup>a</sup> Response rates for providers at each timepoint with respondent data were 48%, 97%, 79% and 62%.

At the end of the first year of implementation, three grantees (13 percent) had initiated mental health consultation services with one or more elementary schools in their communities. In the second year of implementation, three additional grantees started working with elementary schools. No additional Cohort 1 grantees initiated mental health consultation in schools in their third year of implementation. Across the three cohorts, mental health consultation services were delivered in 14 elementary schools.

Mental health consultation in schools required a similar multi-level approach to the work in early childhood. The clinicians provided general consultation to teachers and/or counselors on topics such as typical and atypical child development, social-emotional development, or classroom environments that promote the development of social and emotional skills. This type of consultation was not targeted to specific characteristics of the classroom environment or the children in the classroom but offered mental health-related information that was broadly applicable. Consultants also provided program-specific consultation on issues such as instruction and curriculum related to positive social and emotional behavior for children. More targeted activities in the schools included consultation with staff about individual children in the program with behavior concerns. The consultant might observe or assess the child, meet with the child's parents as well as teachers, and could make referrals for additional evaluation or services. Finally, the most intensive consultation activities involved short-term mental health treatment for a child or a parent-child pair. In all nine of the mental health consultation programs being implemented by LAUNCH grantees in the three cohorts, the mental health consultant provided general consultation; five of the consultation programs also provided child-specific consultation; and two programs also provided short-term mental health treatment for

individual children with behavioral or mental health concerns. One of the grantees used the Georgetown model for their mental health consultation, but the other grantees developed their own models for delivering consultation in schools.<sup>11</sup>

All of the mental health consultants were licensed clinicians with special training in young child mental health and development. The extent to which the mental health consultants were embedded in the elementary school settings varied across programs. Although all of the consultation programs offered the services of the mental health consultant on an as-needed basis, in two of the programs, the consultant was physically present at the school one or two days a week, on a regular basis.

#### 2.4.6 Workforce Enhancement for Staff in Elementary Schools as Part of LAUNCH Mental Health Consultation

Training for school staff on mental health-related issues was a component of the mental health consultation program for two of the grantees. In those programs, the mental health consultants provided training to staff on a variety of topics: children's cognitive and socio-emotional development and appropriate screening in these domains, options for treatment and referral services in the community for children who screen positive for serious behavioral concerns, and strategies for engaging and working with families.<sup>12</sup>

#### 2.4.7 Self-Reported Outcomes for Staff in Elementary Schools Receiving LAUNCH-Supported Mental Health Consultation

As described earlier, grantees administered a short SAMHSA-provided survey to the staff (primarily teachers) in the elementary schools where the mental health consultation programs were being implemented, asking about pre-post changes in knowledge and practice as a result of their involvement in the LAUNCH services.<sup>13</sup> School staff were asked to indicate the extent of change (no change, a little change, some change, or substantial change) in each of four areas that they had experienced as a result of their involvement in LAUNCH. The four areas on which providers rated their level of change were their knowledge of children's socio-emotional development; their knowledge of referral options in their community for children identified as having behavioral or mental health concerns; their use of mental health consultation for children with behavioral or mental health concerns; and the use of screening in their practices.

The sample sizes for the surveys were very small: Across all cohorts and years of implementation, results are available from only two of the nine mental health consultation programs and 32 staff total. This is another reason these data must be interpreted very cautiously.

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<sup>11</sup> One of the grantees implemented two mental health consultation programs. The first involved clinicians working with teachers and referred children, as described above. The second program was a set of activities for parents whose children were entering kindergarten, to help the families support their child's experience a positive and successful transition.

<sup>12</sup> In the LAUNCH portal, grantees reported the topics staff received training on. No data are available on the type of staff trained or their demographics. The cross-site evaluation also did not survey staff about their satisfaction with the training.

<sup>13</sup> These retrospective pre-post data need to be interpreted cautiously. Without a comparison group, the findings have to be seen as suggestive rather than confirmatory evidence of how LAUNCH may have affected the workforce in the elementary schools in the community.

On average, about a third of the school staff reported “substantial” change in knowledge or practice since their involvement in the LAUNCH mental health consultation. Another third reported “some” change in knowledge and smaller proportions (around a quarter) reported “some” change in their use of mental health consultants and use of screening.

**2.4.8 Mental Health Consultation in Home Visiting Programs**

One of the unique strategies adopted by a subset of the LAUNCH grantees is the introduction of mental health consultation to staff in the LAUNCH-supported home visiting programs. Six LAUNCH grantees provided mental health consultation to existing home visiting programs in their communities. Across the six grantees, more than 100 home visitors participated in mental health consultation (Exhibit 2.4.5).

Exhibit 2.4.5 Size of LAUNCH Programs to Integrate Mental Health Consultation in Home Visiting Programs by Cohort and Year of Implementation						
	Year 1		Year 2		Year 3	
	# grantees providing MHC	# home visitors	# grantees providing MHC	# home visitors	# grantees providing MHC	# home visitors
Cohort 1 (6 grantees)	2	24	2	24	2	24
Cohort 2 (11 grantees)	2	60	2	78	NA	NA
Cohort 3 (6 grantees)	2	22	NA	NA	NA	NA
All cohorts <sup>b</sup>	6	106	4	102	2	24

<sup>a</sup> This includes staff from a LAUNCH-supported family support program that also is receiving the services of the mental health consultant  
<sup>b</sup> Total number of grantees varies by year of implementation: 23 in Year 1 (all 3 cohorts), 17 in Year 2 (cohorts 1 & 2), and 6 in Year 3 (cohort 1 only).

In five of the six programs, the mental health consultants were licensed clinicians with training in infant mental health and developmental disorders. In the sixth program, the consultant was a licensed social worker.<sup>14</sup> These staff provided a range of types of support, consultation, and training to the home visitors. These included:

- Reflective supervision of home visitors (individual and group), to allow home visitors a time and safe environment to reflect on their practice, problem-solve about issues in their own work and in their families’ lives, and begin to use themselves as therapeutic agents for their own personal stress and/or sense of isolation;
- Training (typically group) on specific mental health-related issues, such as treatment planning and intervention strategies, family resilience, approaches for helping families with trauma, grief, and loss;
- Consultation on specific cases;
- Going out with home visitors to families where the home visitors feels the need for additional professional support in dealing with a mental health issue; and
- Offering short-term mental health treatment to families referred by the home visitors.

<sup>14</sup> The home visiting program was being implemented in a community in which licensed clinicians were rare. The supervisor of the home visiting program, who was a trained social worker, led the reflective practice for the home visitors, who themselves were mostly paraprofessionals.

***Reflective Supervision, Consultation, and Training  
Provided by Mental Health Consultants in Home Visiting Programs***

The consultation provides reflective group supervision to home visitors that becomes a “partnership for learning” in which the home visitors and the trained specialist in infant mental health and developmental disorders examine, think, problem-solve, expand and deepen the work with the children and families as well as heighten self- and affective-awareness to refine the capacity of the practitioners. The aims of the reflective supervision include, but are not limited to: increased understanding of the complexity of the presenting needs, greater flexibility and range in intervention strategies, heightened empathy and attunement, greater self-awareness, and recognition that “how you are is as important as what you do.” In addition to consultation, which includes case-specific discussions and didactic portions, the home visitors also have opportunities to request training around designated topics and specific case consultations. The former will be content driven and have a greater didactic as well group learning focus and may be organized around a specific case/clinical material, possibly with accompanying video footage, focused on problem-solving, treatment planning, and strategies.

**2.4.9 Outcomes for Home Visitors Receiving Mental Health Consultation**

Exhibit 2.4.5 presents the reports from home visitors who participated in mental health consultation about changes in knowledge and practice since LAUNCH began (Exhibit 2.4.6).<sup>15</sup> Between a quarter and a third of the home visitors reported *substantial* change in both knowledge and practice. Another 50 percent of the home visitors reported *some* change.

Exhibit 2.4.6 Home Visitor-Reported Changes in Knowledge and Practice for Home Visitors Participating in LAUNCH Mental Health Consultation Across Cohorts and Years of Implementation	
	Home Visitors Receiving Mental Health Consultation
# home visiting programs with mental health consultation	6
# programs with provider responses (%)	6
# providers responding to survey <sup>a</sup>	139
Knowledge of children’s socio-emotional and behavioral health and development	28%
Knowledge of available options for follow-up services for children with mental or behavioral health issues	33%
Use of mental health consultation for children with mental or behavioral health issues	34%
Use of screening/assessment of children in their work setting	23%
Knowledge of children’s socio-emotional and behavioral health and development	58%
Knowledge of available options for follow-up services for children with mental or behavioral health issues	54%
Use of mental health consultation for children with mental or behavioral health issues	48%
Use of screening/assessment of children in their work setting	40%

<sup>a</sup> Response rate for the home visitors who received mental health consultation was 73%.

<sup>15</sup> In the absence of a control group, retrospective pre-post reports on self-reported changes in providers cannot be interpreted as evidence of a LAUNCH outcome. Further, the results reflect the reports of only six home visitors, which adds another reason to treat the findings as exploratory evidence.

#### 2.4.10 Mental Health Consultation in Other Settings

In addition to extending mental health consultation to home visiting, a small number of the grantees are also offering the services of a mental health consultant to providers in other settings. One grantee is offering mental health consultation to staff of a parent-training program, another is offering consultation to staff in a county social services agency, and a third initiated but subsequently stopped providing mental health consultation to staff in the county Child Protective Services office. There are scarce data at this point to evaluate the viability and the benefits to providers of these efforts, but the cross-site evaluation will follow the models to determine if they are continued or even expanded over the next implementation years.

## 2.5 Integration of Behavioral Health in Primary Care

### *Summary of Key Findings on Integration of Behavioral Health in Primary Care*

Eleven of the LAUNCH grantees are implementing programs to integrate mental health into primary care. Most of the integration programs (75 percent) involve the physical co-location of the LAUNCH-supported mental health staff in community health care settings. In nine of the programs, LAUNCH mental health staff conduct follow-up assessments of children who have been identified as at risk, based on routine screening as part of the visit to the doctor. The mental health staff also meet with the medical staff and families who have been assessed to discuss the results of the evaluation and to determine an appropriate follow-up plan.

All of the grantees provided training to the staff in the health care settings as part of the integration programs. Across cohorts and implementation years, LAUNCH grantees provided training to more than 1,400 staff on topics such as appropriate referrals for children with behavioral/mental health concerns, resources in the community for children with mental/behavioral health concerns, and strategies for family engagement and working with families to help them understand/support children's healthy development.

On average, the majority of the staff in the medical settings involved in the LAUNCH integration programs reported "some" or "substantial" change in their knowledge of children's socio-emotional development and appropriate referrals and in their use of mental health consultation and systematic screening and assessment.

As discussed in an earlier cross-site evaluation report (Gwaltney, Goodson, and Walker, 2013), grantees experienced a number of challenges in initiating programs to integrate behavioral health in primary care, including the need to build infrastructure to integrate screening and follow-up supports into pediatric practices (for example, infrastructure around distributing screening instruments, supporting parents with language or literacy barriers, scoring completed tools, providing feedback to providers in a useful and timely manner, and linking with on-site mental health consultation support), which required commitment, planning, and dedication of staff time and resources. In addition, grantees reported challenges in dedicating the time and resources for cultivating collaborative relationships with the medical culture and changing the mindset of the clinicians to prevention modalities as well as treatment; issues with pediatricians finding time in their practices for both in-service training or consultation with a mental health professional about a child with mental or behavioral health concerns; and the need to determine reimbursement and billing procedures for developmental screening and mental health services for young children in the primary care setting.

#### 2.5.1 Efforts to Integrate Behavioral Health in Primary Care Offices

At the end of the first year of implementation, 10 grantees had initiated activities to integrate behavioral health into primary care (2 each in Cohorts 1 and 3 (33%) and 6 in Cohort 2 (54%)). By

the end of the second year of implementation, one additional Cohort 1 grantee began activities to integrate behavioral health into primary care. In Year 3, for Cohort 1 only, one more grantee started integration of behavioral health into medical care. Most of the grantees focused the integration activities in a small number of health centers. As a group, the grantees implemented mental health integration activities in 16 health care offices in the first year of implementation; for Cohorts 1 and 2, the number of health care offices increased from 7 to 28 in the second year of implementation (although this number decreased in the second half of the year because two of the grantees encountered set-backs in implementation) (Exhibit 2.5.1). Across all cohorts and years of implementation, grantees worked with 31 health care offices, in which more than 300 staff participated in the integration efforts. The health offices that received the mental health consultation services ranged in size from large urban health centers with more than 20,000 children enrolled, to smaller health offices with fewer than 100 families enrolled.

Exhibit 2.5.1 LAUNCH Programs to Integrate Behavioral Health (IBH) in Primary Care by Cohort and Year of Implementation									
	Year 1			Year 2			Year 3		
	# grantees providing IBH	# health care settings	# staff involved	# grantees providing IBH	# health care settings	# staff involved	# rantees providing IBH	# health care settings	# staff involved
Cohort 1 (6 grantees)	2	4	84	3	8	90	4	11	91
Cohort 2 (11 grantees)	6	11	191	6	20 <sup>a</sup>	216	NA	NA	NA
Cohort 3 (6 grantees)	2 <sup>b</sup>	1	5	NA	NA	NA	NA	NA	NA
All cohorts (23 grantees)	10	16	280	11	28	306	4	11	91

<sup>a</sup> In the second half of this year, in Cohort 2, the number of health care offices participating in the integration activities dropped from 20 to 11, and the number of staff involved decreased as well, from 216 144.their integration activities

<sup>b</sup> One of the grantees did not report number of health care offices in which they were implementing mental health integration or the number of medical staff who participated in the mental health consultation in the first year of implementation.

Grantees reported that integration of behavioral health into primary care was challenging. The primary reason grantees cited was because doctors were too busy to add additional tasks, such as conducting or reviewing screening results and developing a referral plan, or attending training. Even when LAUNCH grantees got consultation activities off the ground, doctors didn’t always use them. In fact, by the end of second year of implementation of integration of mental health, two of the programs had to drop their integration program, because of lack of participation by medical staff.

The mental health consultation activities that were developed by the grantees varied across a number of key features (Exhibit 2.5.2). The majority of the grantees (75 percent) sited the mental health staff in the health center, often on a full time-basis. The majority conducted screening and/or assessments of both children and parents, and held consultations with the health care staff and individual families about the results of the assessments and plans for addressing family needs or risks. As part of the integration programs, the mental health staff also provided training to the staff in the health care settings.

Exhibit 2.5.2 Features of LAUNCH Programs to Integrate Behavioral Health (IBH) in Primary Care # Grantees (% of 12 Grantees that Implemented Integration of Behavioral Health)								
Relationship of Mental Health Staff and Health Care Setting			Screening/Assessment by LAUNCH Mental Health Staff			Consultation		Training
MH staff sited full-time in primary care office	MH staff on-site 1-2 days per week	MH staff available on request	Children/ Parents referred by primary care staff <sup>a</sup>	All Children/ Parents in primary care office	None	Health Care Staff	Families	Health Care Staff
8 (67%)	2 (17%)	2 (17%)	8 (75%)	1 (8%)	3 (25%)	8 (67%)	8 (67%)	9 (75%)

<sup>a</sup> Based on routine screening/assessment by health care staff

<sup>a</sup> One grantee did not report screening numbers for the first year of implementation

**2.5.2 Workforce Enhancement for Staff in Primary Care Settings Participating in LAUNCH Integration of Behavioral Health**

All of the grantees offered training to medical staff on mental health-related topics as part of their consultation activities. Across cohorts and implementation years, LAUNCH grantees provided training to more than 1,400 staff.<sup>16</sup> The number of staff trained increased each year, as additional grantees began to implement integration activities. At the end of the first year of implementation, the eight grantees in Cohorts 1, 2 and 3 provided training to 400 staff. At the end of the second year of implementation, 7 grantees in Cohorts 1 and 2 provided training to 680 staff. At the end of the third year of implementation, four Cohort 1 grantees trained 340 staff. The most frequently offered training topic was options for treatment and referral for children with emotional or behavioral concerns, which was reported by a majority of the 10 grantees implementing integration activities. The second most frequent training topic, reported by half of the grantees, was understanding children’s socio-emotional development and appropriate screening measures.

**2.5.3 Self-Reported Outcomes for Staff in Primary Care Offices Participating in LAUNCH Integration of Behavioral Health**

Grantees administered a short SAMHSA-provided survey to the medical staff in the primary care offices involved in integrating behavioral health in primary care. The surveys asked about pre-post changes in knowledge and practice as a result of their involvement in the LAUNCH services.<sup>17</sup>

Staff at the participating primary care offices were asked to indicate the extent of change (no change, a little change, some change, or substantial change) in each of four areas that they had experienced as a result of their involvement in LAUNCH. The four areas on which staff rated their level of change were their knowledge of children’s socio-emotional development; their knowledge of referral options in their community for children identified as having behavioral or mental health concerns; their use of mental health consultation for children with behavioral or mental health concerns; and the use of

<sup>16</sup> Staff may be double-counted, since training counts were reported quarterly, and grantees could have offered training to the same staff multiple times in a year or over two or three years, depending on the cohort.

<sup>17</sup> It is important to underscore the limited conclusions that can be drawn from this kind of retrospective pre-post measure. The absence of data from comparable groups of non-LAUNCH providers severely restricts any assumptions that pre-post differences in LAUNCH providers represent program effects. Also, the response rate for the sample of primary care staff was low, particularly for Cohort 1 primary care staff, adding another reason to view the results cautiously.

screening in their practices. Survey results are available for staff from programs in Cohorts 1 and 2, at the end of the second year of implementation (Exhibit 2.5.3). Although most of the Cohort 1 and 2 grantees who were implementing integration activities reported some results, the average response rate was quite low for Cohort 1 programs (32 percent); the corresponding response rate for Cohort 2 programs was substantially better (65 percent). On average, the majority of the staff reported “some” or “substantial” change in knowledge and practices as a result of their involvement in the LAUNCH integration programs.

Exhibit 2.5.3 Changes in Knowledge and Practice Reported by Staff in Health Care Settings Participating in LAUNCH Integration of Behavioral Health into Primary Care by Cohort <sup>a</sup> Across All Years of Implementation		
	Cohort 1 (Years 2 – 3 <sup>b</sup> )	Cohort 2 (Years 1 – 2)
# grantees implementation integration of behavioral health in primary care	4	5
# grantees with responses from primary care staff participating in integration (%)	3	4
# staff responding to survey <sup>a</sup>	10	394
<b>Staff reporting “substantial change” as a result of involvement in LAUNCH mental health consultation</b>		
Knowledge of children’s socio-emotional and behavioral health and development	64%	28%
Knowledge of available options for follow-up services for children with mental or behavioral health issues	33%	43%
Use of mental health consultation for children with mental or behavioral health issues	39%	32%
Use of screening/assessment of children in their work setting	13%	44%
<b>Staff reporting “some change” as a result of involvement in LAUNCH mental health consultation</b>		
Knowledge of children’s socio-emotional and behavioral health and development	26%	44%
Knowledge of available options for follow-up services for children with mental or behavioral health issues	23%	74%
Use of mental health consultation for children with mental or behavioral health issues	42%	24%
Use of screening/assessment of children in their work setting	57%	21%

<sup>a</sup> Neither of the Cohort 3 programs reported provider outcomes for the first year of implementation.

<sup>b</sup> No data on provider outcomes were reported for the first year of implementation.

<sup>c</sup> Response rates in Cohort 1 was 35% and in Cohort 2, 65%.

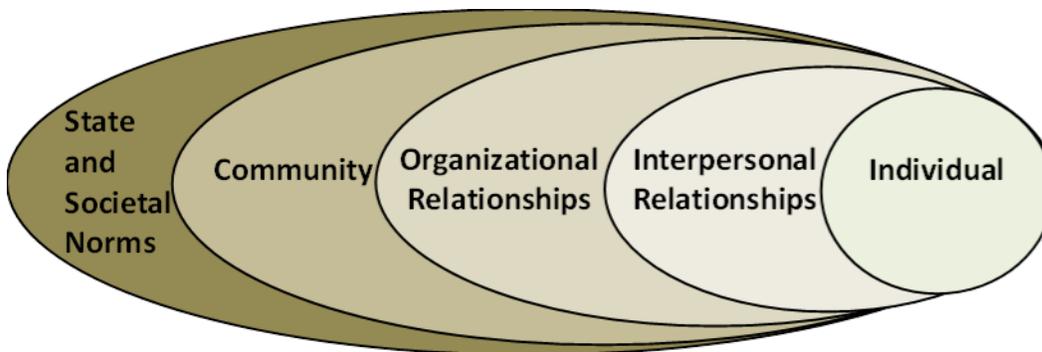
### 3. Infrastructure Development and Systems Change

#### 3.1 Systems Theory As It Applies to Project LAUNCH

Project LAUNCH focuses on both service delivery and systems development. While the majority of grant funds goes toward delivery of community-level services, grantees also are engaged in activities to enhance the state and community<sup>18</sup> early childhood delivery systems. Grantees aim not only to expand access to high quality, culturally-appropriate, evidence-based programs for at-risk families, but also to enhance the systems that deliver services and the legislative and organizational policies and practices that influence children’s developmental and health outcomes.

A social-ecological model provides the framework for Project LAUNCH and emphasizes the systems factors that affect overall health (Figure 3.1.1 below). The core principles of this framework are that health is influenced not only by individual behavior, but also by organizational, community, and state/societal conditions (Stokol, 1992; 1996). The social-ecological framework has been used to guide the design of many comprehensive, multi-level intervention approaches. For example, the social-ecological framework was used to design multi-level interventions to reduce smoking rates among adults in the U.S. (Bonnie et al., 2007). Policy measures, social marketing, and community-level interventions guided by the framework, such as those implemented through the Massachusetts Tobacco Control Program, have been found to have dramatic impacts on rates of tobacco use (Koh et al., 2005).

**Figure 3.1.1 Social-Ecological Framework for Systems Change**



Source: Adapted from CDC, 2012 (<http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html>).

The above framework addresses the dynamic interface between individuals, organizations, communities, and their social and physical environments and speaks to the need for multi-level interventions for improving health outcomes. The theory is that community wellness requires collaborative efforts among various public and private partners to bring about environmental changes and changes in individual behaviors. The framework, which is derived from systems theory, provides a way to approach the individual and contextual factors that affect family functioning and the health of young children. It helps to focus efforts not just on specific interventions, but also on systems

<sup>18</sup> Wherever “community” is referenced, it includes all LAUNCH communities, including the LAUNCH-funded tribal grant community.

changes that support and ultimately lead to improvements in children's health from birth and over the lifespan.

For Project LAUNCH, the sustained improvement in parent and child outcomes is expected to require changes at all levels of the social-ecological framework. The following are examples of actions taken by Project LAUNCH grantees at each level:

- **Individual:** Home visiting and family support programs, two core strategies of Project LAUNCH, help to give parents and caregivers the skills they need to nurture their child's cognitive and emotional development and connect them to other resources in their communities.
- **Interpersonal Relationships:** Encouraging strong relationships through peer mentoring and peer-led programs (e.g., parent cafés) and parent classes or group meetings (e.g., in programs such as Incredible Years and Parents As Teachers) helps parents develop problem-solving skills and healthy relationships.
- **Organizational Relationships:** Building collaborative relationships among provider organizations, across disciplines or systems (e.g., primary care and mental health), and among community and state agencies (e.g., through participation on Young Child Wellness Councils) encourages development of a system of care and a coordinated and strong infrastructure to support young children and their families and a qualified early childhood workforce.
- **Community:** Social marketing and other communications strategies help to foster healthy community environments by promoting a vision of young child wellness and educating community members, including parents, about the importance of the early years of life to healthy child development, as well as later educational and economic outcomes.
- **State and Societal Norms:** Collaboration and coordination among agencies and health policies (e.g., universal screening of young children for developmental and social-emotional problems; Medicaid reimbursement for selected LAUNCH services) provide support for local communities, individual health and sustainability. In addition, societal norms and social, economic, and health policies provide a foundation for community, tribal, state, and individual health.

System-level changes are expected to occur in Project LAUNCH at state, tribal, and community levels. However, given the short time many of these projects have been in operation (e.g., Cohort 3 grantees had been funded for just a year and Cohort 2 grantees for two years at the time of this report) and the challenges to implementing systems enhancements, these changes may not be fully evident until the end of the grant period, or even later. Change often requires individuals and organizations to do something they have not done before (e.g., alter long-standing practices and beliefs). Moreover, the length of time needed to change policies can be a deterrent to program directors (Glanz et al., 2008), as the time required can outlast program funding periods and upset organizational stability at a time when other changes (e.g., budget cutbacks) also affect organizational structures and practices. Policies also may not be within the control of health professionals, and change may require a political process. Moreover, while some individuals and organizational leaders may be enthusiastic supporters of change, others may be resistant, creating a barrier to the change process.

To address some of these barriers Project LAUNCH provided a six-month (Cohorts 1 and 2) or nine-month (Cohort 3) period to ensure time for the development of an environmental scan and strategic plan. This planning period offered Project LAUNCH states, tribes, and communities time to agree on a vision for their early childhood systems and identify the systems development activities they wanted

to undertake during the grant period. Almost all grantees included infrastructure development and systems change initiatives in their strategic plans (Gwaltney, Goodson, and Walker, 2013).

In Project LAUNCH, systems change encompasses a range of actions that map onto the social-ecological framework and can be grouped into the following broad categories:

- **Changes in interorganizational relationships**—e.g., development of data systems, referral systems, and data sharing agreements;
- **Changes in community systems and support**—e.g., development of community collaboratives or partnerships; advocacy to build political support at both the community and state levels; and building awareness of healthy child development.
- **Changes in state and other societal policies and norms**—e.g., development of partnerships at the state level that facilitate adoption of policies that ensure the quality of services for young children and families, such as those requiring evidence-based programming for young children; Medicaid reimbursement for services; universal screening of young children using standardized tools; and upgrades in the early childhood workforce development systems.

Systems development activities and accomplishments that can be attributed, in whole or in part, to Project LAUNCH through September 2011 are discussed in the sections below. The findings presented in these sections are based on review and analysis of qualitative data collected from interviews with state project directors (Cohorts 1 and 2) and LAUNCH coordinators (all cohorts); quantitative and qualitative data submitted by grantees to the Web-based portal; and qualitative data presented in grantees' end-of-year reports.

Grantees report the composition of their child wellness councils annually in the portal. The following discussion of the councils' composition is therefore mainly derived from these data. During key informant interviews, we inquired about the top three initiatives led by the council, the councils' successes and challenges, and accomplishments related to systems change. We also culled information from grantee reports to supplement the interview data. In analyzing these qualitative data, we used an inductive approach to identify themes in the data. For example, thematic analysis included categorizing state and community systems initiatives to identify the types of initiatives in which grantees were engaged. Common themes were also identified in grantees' reports of successes and challenges. The themes that emerged are summarized below. As the cross-site evaluation continues and additional data are collected, we will continue to build on and, if needed, modify the themes presented in this report.

## 3.2 State and Community Young Child Wellness Councils

### *Summary of Key Findings*

All grantees have formed Young Child Wellness Councils at the community (all cohorts) and state (Cohorts 1 and 2) levels. Most grantees reported that they created a new advisory group at the state level and community levels for LAUNCH (82 and 83 percent, respectively). Membership on the YCWs across all grantees at the state and community levels is diverse representing 27 different sectors at the state level and 29 sectors at the community level. The average number of organizations, or agencies, represented on state YCWs was 17 across two LAUNCH cohorts (Cohorts 1 and 2). The average number of organizations/agencies on community YCWs was 22 across all three cohorts.

YCWCs have taken on a variety of initiatives that fall into the following six categories: program development, awareness/dissemination, coordination/collaboration, training, sustainability/financing, and other. Most of the initiatives in these six categories are ongoing, although grantees noted some early successes. These included perceived increases in collaboration across agencies and programs, expansion of training for providers supported by LAUNCH and others within the community, and progress toward or completion of a sustainability plan (the latter, in a small number of grantees).

Challenges have also been noted. At the community level, these challenges included the time needed to define the purpose of the YCWCs and to gain commitment from members. While increased collaboration was perceived as an important systems outcome at both the state and community levels, several grantees noted that past histories of not working together made some community members skeptical of being able to operate successfully as a YCWC. Another challenge for some was getting the right people to the table, including parents and individuals with decision-making authority.

At the state level, some grantees indicated that busy schedules and individuals' involvement on more than one advisory group meant that attendance at meetings was inconsistent. The fiscal crisis in states also has created staffing shortages, making it more difficult for YCWC members to come to meetings because of other demands on their time. As a result, some state (and community) YCWCs have moved to quarterly or bimonthly meetings.

Project LAUNCH grantees were required to create collaborative entities—Young Child Wellness Councils (YCWC)—at both the state and community levels and include organizations on the YCWCs from across the state and community early childhood system. The YCWCs for Project LAUNCH are intended to give members ownership of the systems change process and the opportunity to design a comprehensive strategy for improving outcomes for young children and families. By assembling a diverse group of stakeholders to participate in YCWCs, grantees have brought individuals and organizations together to work in a collaborative process to implement systems change.

Eighteen grantees (82 percent) reported that they had created a new advisory group at the state level to function as the LAUNCH YCWC. For the other four grantees, an existing council or advisory group such as the ECCS council or another group that focused on early childhood issues acted as the YCWC. At the community level, four grantees (17 percent) used an existing body as their YCWC, or created a workgroup or subcommittee of an existing group for Project LAUNCH.

### 3.2.1 Organizational Composition of State and Community YCWCs

In the first year of LAUNCH Cohort 1 and 2 grantees began seeking participation from organizations and agencies that focus on the needs of young children. For example, the highest representation on state YCWCs for the five Cohort 1 grantees in Year 1 included public health (100%), other state government (100%), elementary education (100%), and Medicaid (80%). Representation on the community YCWCs for Cohort 1 in Year 1 included health care providers (100%), early childhood education providers (100%), and behavioral health services for young children (100%).

Representation on the state and community YCWCs for the eleven Cohort 2 grantees show a similar pattern of engagement. For example, agencies' representation on the state YCWC was highest for public health (91%), mental health (91%), state government (82%), behavioral health services for young children (82%), and health care providers (82%). Likewise, the Cohort 2 YCWCs included representation from most of these same organizations. Unlike the state YCWCs, however, the community YCWCs included representation from early childhood education (91%), child welfare (82%), advocacy groups (82%), and elementary education (82%). In Year 1, representation of family members on the community YCWCs was higher for Cohort 2 grantees as compared to grantees in Cohort 1. Data for state and community YCWC representation were collected through the Web

portal questionnaires. Grantees were asked to identify the sectors that the YCWC member agency/organization represented.

On average, grantees have increased participation on state and community YCWCs over their grant period (Exhibit 3.2.1).<sup>19</sup> Across all years, an average of 17 agencies and organizations have participated on state YCWCs; 22 agencies, on average, are represented on community YCWCs. The composition of some councils has also become more diverse over time, and all YCWCs at both state and community levels have broad representation from many different sectors. Across grantees, YCWCs have members representing 27 sectors at the state level (Exhibit 3.2.2) and 29 sectors at the community level (Exhibit 3.2.3). Most notably, after initial challenges to recruit family members, 69 percent of all grantees had parents or family members on their state YCWC, and 78 percent of grantees had parents or family members on their community YCWCs at the end of September 2011 (see number of grantees for Cohort 1-Year 3, Cohort 2-Year 2, and Cohort 3-Year 1).

Although diversity of representation is similar for state and community councils (Exhibits 3.2.2 and 3.2.3), differences in the breadth of representation exists. For example, 81 percent of the state YCWCs have representation from Medicaid, compared to 39 percent of community YCWCs. This is likely explained by Medicaid being a program administered at the state level, and Medicaid reimbursement policies being decided by the state Medicaid agency in negotiation with the federal Centers for Medicare and Medicaid Services (CMS). On the other hand, representation from substance abuse prevention agencies is greater on community-level YCWCs, where 74 percent of all YCWCs and less than one third of state YCWCs have representatives from these agencies. Other sectors that are more represented on community YCWCs than state YCWCs include child care organizations (83 percent of grantees vs. 56 percent), county/city government (83 percent vs. 38 percent), the faith community (43 percent vs. 6 percent), and businesses (39 percent vs. 19 percent). Almost all of grantees (87%) had a state/tribal government representative on the local community council.

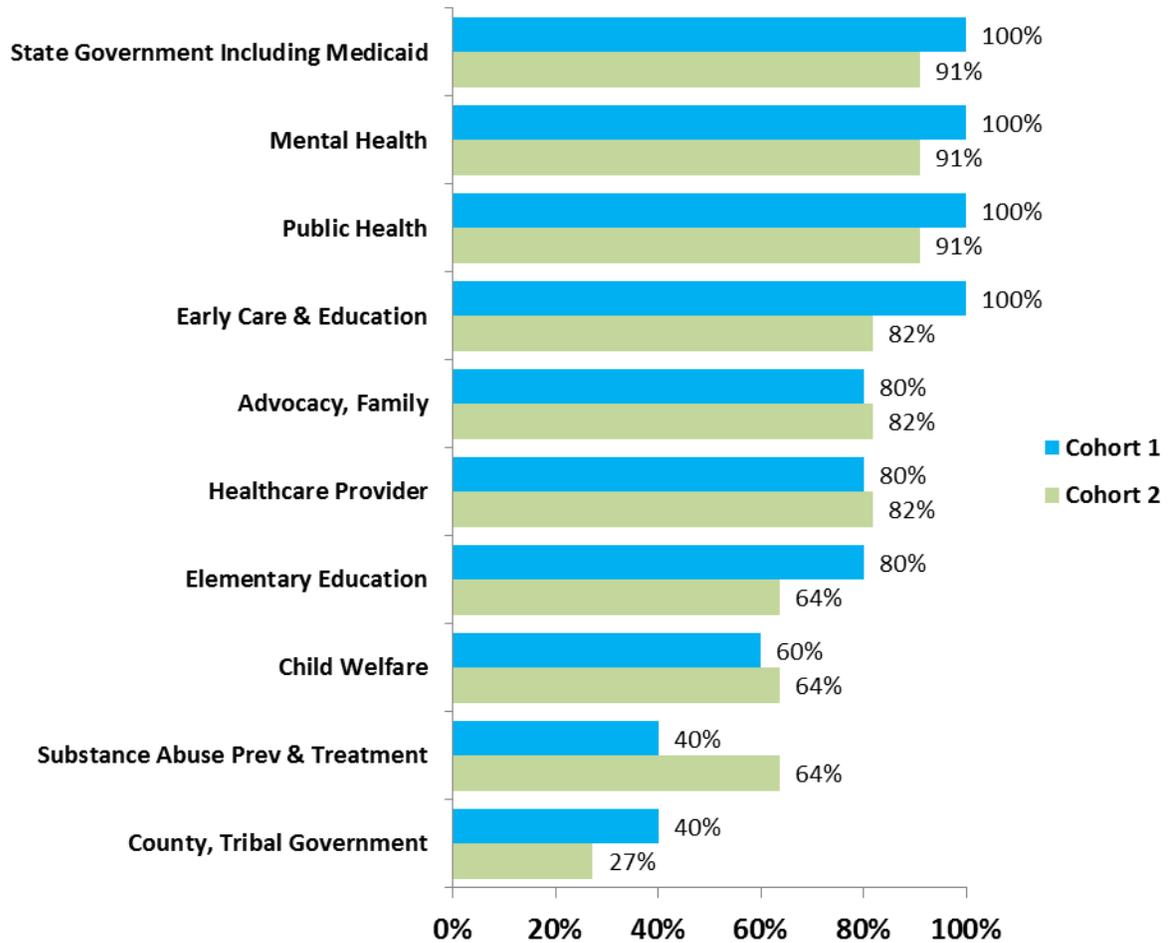
Exhibit 3.2.1 Average Number of Organizations/Agencies Represented on Young Child Wellness Council By Cohort and Year of Implementation <sup>a, b</sup>								
	State YCWC (16 grantees)				Community YCWC (23 grantees)			
	Year 1	Year 2	Year 3	Average Across All Years	Year 1	Year 2	Year 3	Average Across All Years
Cohort 1 (6 grantees)	13	13	14	13	16	17	24	19
Cohort 2 (11 grantees)	18	21	NA	19	24	26	NA	24
Cohort 3 (6 grantees)	NA	NA	NA	NA	21	NA	NA	21
All cohorts <sup>a</sup>	16	18	14	17	20	23	24	22

<sup>a</sup> Number of organizations/agencies has been rounded to the nearest whole number.

<sup>b</sup> Total number of grantees varies by year of implementation: 23 in Year 1 (all 3 cohorts), 17 in Year 2 (cohorts 1 & 2), and 6 in Year 3 (cohort 1 only). The composition of the Tribal grant's Young Child Wellness Council is shown on Exhibit 3.2.2.

<sup>19</sup> One grantee in Cohort 2 had selected a new LAUNCH community in September 2011 and therefore is not included in this analysis.

**Exhibit 3.2.2**  
**Percent of LAUNCH Grantees with Representation from Key Sectors on State Child Wellness Councils by Cohort for Year 1<sup>a,b,c</sup>**

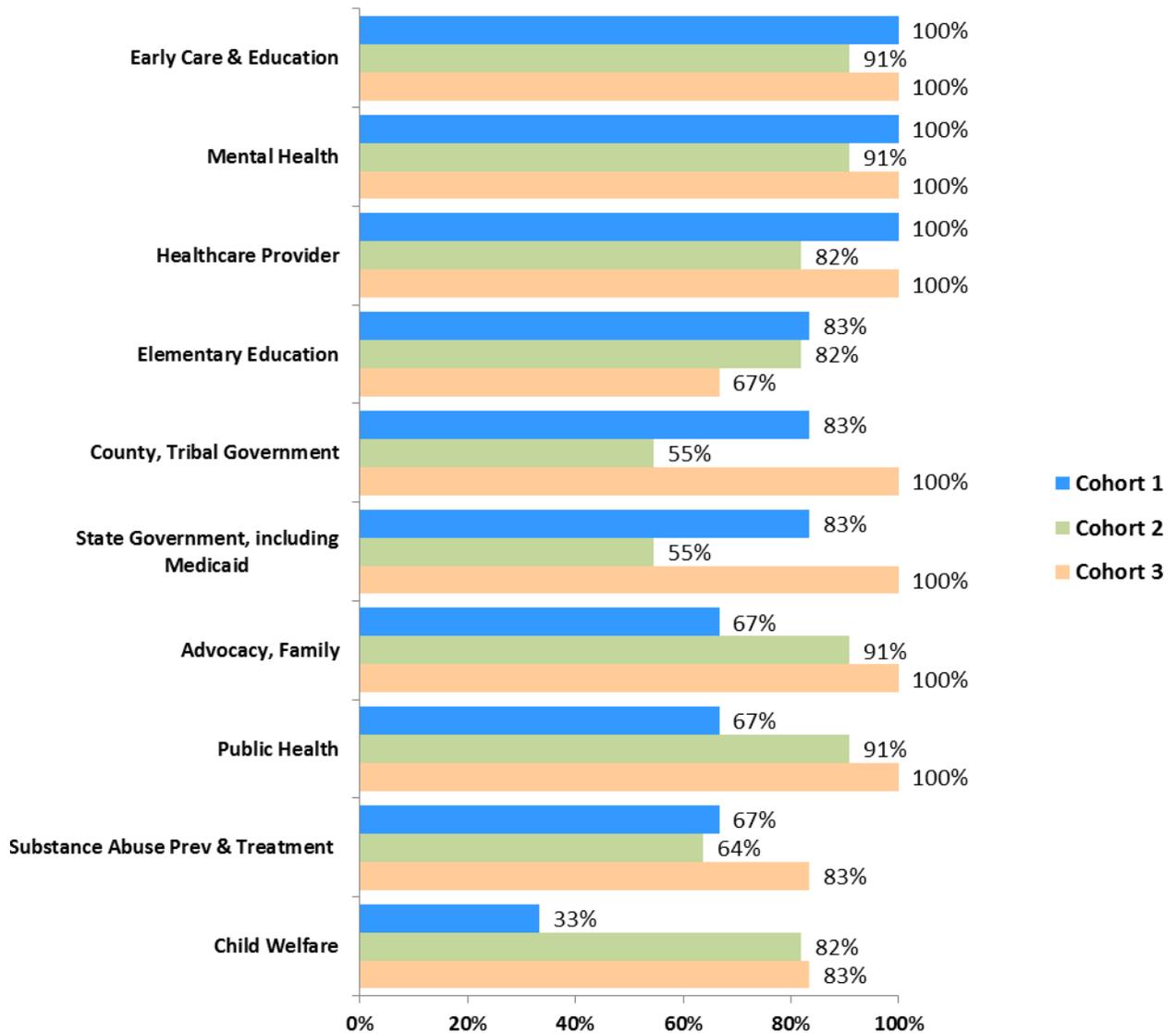


<sup>a</sup> N= 16 for Cohort 1 and 2.

<sup>b</sup> Mental Health category includes Mental Health and Child Behavioral Services

<sup>c</sup> Parent or Family Member and Advocacy groups were combined for ease of display.

**Exhibit 3.2.3**  
**Percent of LAUNCH Grantees with Representation from Key Sectors on Community Child Wellness Councils by Cohort for Year 1<sup>a,b,c</sup>**



<sup>a</sup> N=23 grantees in Cohorts 1-3.

<sup>b</sup> Mental Health category includes Mental Health and Child Behavioral Services

<sup>c</sup> Parent or Family Member and Advocacy groups were combined for ease of display

Both the community and state YCWCs have parents or family members represented on the councils. Council meetings are often scheduled during business hours, when agency and professional staff can attend. Parents who are not also professionals generally cannot attend council meetings without compensation and other supports such as childcare. Although securing family involvement in child wellness councils has been challenging for many grantees, it remains a priority. YCWCs continue efforts to engage family members, by reaching out to parents through other community organizations or LAUNCH-supported services.

### 3.2.2 Grantees Self-Reported Top Three Key YCWC Initiatives

Most community and state YCWCs have selected specific initiatives to work on. Based on information collected through interviews, the initiatives grantees deemed most important are shown in Exhibit 3.2.4 below. Data reported in Exhibit 3.2.4 were collected through the interview question, “From your perspective, what are the three most important initiatives that the Community/State Child Wellness Council has focused on to date?” The initiatives vary in scope from those focused on expanding representation on the YCWC to include parents, to ensuring that programs and services were started within each of the five LAUNCH strategies, working on policies related to reimbursement for developmental screening and mental health consultation services, and developing plans for the sustainability of LAUNCH beyond the grant period. The initiatives are organized into six categories: awareness/dissemination, program development, collaboration/coordination, training, sustainability/financing, and other. The categories of initiatives identified by the largest number of grantees included program development, sustainability, collaboration, and training.

YCWCs played an important role in identifying and working on a wide range of LAUNCH initiatives. During interviews, informants were asked to identify the top three initiatives that the YCWC was working on. The top three categories can be seen as the initiatives into which grantees were putting the most effort or highest priority at the time of the interviews. However, it does not mean that other initiatives are not being addressed.

### 3.2.3 Successes and Challenges Associated with State and Community YCWCs

LAUNCH grantees have identified both challenges and successes in working with their YCWCs. As noted earlier, parent involvement on the community YCWC was an initial challenge, but several grantees said their success at engaging parents has been a significant accomplishment in the first year or two of their grant program and having parents on the YCWC now brings a different perspective to the discussion. In general, increased collaboration and information sharing both at the state and community levels have also been a success. Almost all grantees stated that their state and community YCWCs have helped to facilitate collaboration across programs and agencies. For some communities, this has been a significant change in practice.

In summary, the YCWCs have helped to change *organizational relationships* as well as *community and state support* for programs that support young children’s social-emotional development and overall health. Many grantees reported that the within- and cross-system and program collaboration that has been facilitated and fostered by the formation of state and community YCWCs has been one of the major accomplishments of LAUNCH. As noted by one grantee, the “YCWC continues to grow as a major force for change for children birth to 8 in the community... collaboration, joint training, joint planning and implementation of interventions stand out in the life of the council.” Many LAUNCH communities have also formed partnerships with state agencies and included state representatives on their community YCWCs. One grantee noted the value of these relationships: “Collaboration remains our most important tool. Our state agency partners are another forum for recognizing the significance of collaboration to change outcomes.” Finally, another grantee commented on the value of collaboration to the sustainability of their LAUNCH-supported evidence-based programs: “The importance of maintaining and improving collaboration is the best investment in sustainability and change that exists.”

Exhibit 3.2.4 Initiatives of the State and Community Young Child Wellness Councils, 2010-2011		
Initiative	State YCWC <sup>20</sup>	Community YCWC <sup>21</sup>
Program Development	<ul style="list-style-type: none"> <li>Participating in development of Early Learning Plan (Cohort 1)</li> <li>Working toward selection of universal screening tools and implementation of universal developmental screening (Cohorts 1 and 2)</li> <li>Adoption of Infant and Early Child Mental Health Endorsement system (Cohort 2)</li> <li>Development and implementation of quality rating system (Cohort 2)</li> <li>Promoting use of standard developmental screening tool (Cohort 2)</li> <li>Creating a community of practice for home visiting (Cohort 2)</li> </ul>	<ul style="list-style-type: none"> <li>Development of a mental health consultation program/model (Cohort 1)</li> <li>Starting up programs within LAUNCH service strategy (e.g., MHC, home visiting) (Cohorts 2 and 3)</li> <li>Developing a plan with a local network to screen and support older children (age 5-8) (Cohort 2)</li> <li>Implementing services in a new setting (i.e., a housing project) (Cohort 2)</li> <li>Creating a focus on implementation of evidence-based programs and fidelity (Cohort 2)</li> <li>Implementing screening for mental health problems (Cohort 3)</li> <li>Developing resource materials for providers and families (Cohort 3)</li> </ul>
Sustainability/Financing	<ul style="list-style-type: none"> <li>Sustainability planning by looking at changes to reimbursement/ billing practices and policies (Cohort 1)</li> <li>Fiscal mapping project to demonstrate to policymakers how LAUNCH strategies contribute to cost savings (Cohort 1)</li> <li>Reimbursement policies (e.g., related to Telehealth) (Cohort 2)</li> <li>Creation of infant mental health association (Cohort 2)</li> </ul>	<ul style="list-style-type: none"> <li>Developing an action plan for sustaining LAUNCH services (Cohort 1)</li> <li>Working on policy issues related to reimbursement (Cohort 2)</li> <li>Working toward sustainability of LAUNCH strategies (Cohort 2)</li> <li>Examining ways to increase and sustain programming for children and families (Cohort 3)</li> </ul>
Collaboration/Coordination	<ul style="list-style-type: none"> <li>Coordination of LAUNCH with other grant programs (MIECHV, Race to the Top) (Cohort 2)</li> </ul>	<ul style="list-style-type: none"> <li>Development of a common language across all partners (Cohort 1)</li> <li>Increasing and sustaining collaboration across providers/programs (Cohort 3)</li> </ul>
Awareness/Dissemination	<ul style="list-style-type: none"> <li>Development of public awareness activities/campaign (Cohort 2)</li> </ul>	<ul style="list-style-type: none"> <li>Making parents aware of services in the community (Cohort 1)</li> <li>Dissemination of information about Project LAUNCH (Cohort 2)</li> <li>Implementation of a child wellness public awareness campaign (Cohort 2)</li> </ul>
Training	<ul style="list-style-type: none"> <li>Statewide training on ASQ for ECE providers (Cohort 1)</li> </ul>	<ul style="list-style-type: none"> <li>ACEs trauma awareness training for providers (Cohort 2)</li> <li>Training primary care providers on developmental screening (Cohort 2)</li> <li>Training in screening and assessment</li> </ul>
Other	<ul style="list-style-type: none"> <li>Dissemination of developmental screening record booklets to families (Cohort 1)</li> </ul>	<ul style="list-style-type: none"> <li>Development of a strategic plan for LAUNCH (Cohort 3)</li> <li>Getting family representation on YCWC (Cohorts 1 and 3)</li> </ul>

Information on successes and challenges was collected through yearly telephone interviews, and for Cohort 1 and 2 grantees, from one site visit conducted at the end of each grantee's second year.

<sup>20</sup> For the state YCWCS there were 5 grantees in Cohort 1 and 11 grantees in Cohort 2.

<sup>21</sup> For the community YCWCs, there were 6 grantees in Cohort 1; 11 grantees in Cohort 2; and 6 grantees in Cohort 3)

Community and state coordinators responded to the question, “To date, what has been the most important Project LAUNCH accomplishments related to community/state systems change?”

### Community Successes

Respondents provided the following comments about the successes of the YCWCs:

- “We have brought together a lot of different community members. This is new to [our community], because in the past there was not a lot of togetherness.” [Cohort 1 ]
- “We are building strong relationships. We now have a different definition of ‘collaboration.’ There is more trust now [within the community]; no one program is given priority. We are keeping the importance of early childhood in the forefront of people’s minds, so the end result is happy, healthy families.” [Cohort 2]

“The [community] council brings everybody together. It provides an open forum to raise issues and talk it out with providers. It allows providers to network and identify services they may not be aware of.” [Cohort 3]

- “LAUNCH has brought an enhanced version of community coordination and collaboration. The YCWC is connecting people across disciplines such as substance abuse prevention and early care and education. The community is appreciating working together. It is a new notion. LAUNCH is responsible.” [Cohort 3]

### State Successes

The state coordinators reported that bringing or keeping state agencies together to develop and sustain a strategy for young children was a success. Comments included:

- “The ECCS plan has been the overall framework and driver for change. The [council] is a group of people who have previously been on advisory groups. They are invested and have the momentum to move forward.” [Cohort 2]
- “The Council has brought people together to share information and learn about other initiatives, activities...members are very committed...and involved in setting goals and objectives, and sharing information from other agencies.” [Cohort 1]
- “There is open communication...the governor’s office participation is good.” [Cohort 2]
- “Having the council helps coordination and collaboration...it decreases silos.” [Cohort 1]

### 3.2.4 State- and Community-Level Challenges

While the YCWCs have been successful in most communities, grantees have also experienced challenges. To identify the challenges community and state coordinators were asked to respond to the question, “To date, what have been the most significant challenges in implementing community/state systems change?” Several grantees indicated that the YCWCs have gone through a developmental process. In some instances, it took time to interest community members, state agency representatives, and others to join the YCWC and for the council to “find its real purpose.” “Collaboration takes time” was a frequent comment at both the community and state level. For several grantees, past histories of not working together and, as another grantee noted, “skeletons in the closet” made some community members skeptical of being successful as a YCWC. Others indicated that the right people were not at the table. In one case, it was noted that individuals on the YCWC did not have decision making authority and therefore were unable to “move things forward.” With regard to the state YCWC, in

particular, grantees indicated that busy schedules and individuals' involvement on more than one advisory group has led to inconsistent attendance at meetings. In addition, the fiscal crisis has created staffing shortages within state agencies, putting additional demands on the remaining staff and making it more difficult for YCWC members to come to meetings. Some state and community, YCWCs have moved to quarterly or bimonthly meetings due to the demands on people's time.

Further, "getting everyone on the same page at a time of budget cuts" has been difficult. As one grantee put it, programs are looking out for their own interests now, and it is harder to work together toward a comprehensive system when budgets are tight. Other challenges related to changes in leadership were also noted:

- "The leadership change within our health department was challenging. It affected momentum, and made it hard to keep attendance [on the state YCWC] up. It was also challenging to make [the YCWC] relevant enough to people to keep them engaged. We had to decide on the right frequency. We now have quarterly meetings." [Cohort 2]
- "In the beginning, the [state] council included big system thinkers...more recently, due to state budget cuts and turnover, the Council was not allowed to meet." [Cohort 1]
- "The governor changed and the interest shifted away from LAUNCH. Early childhood issues and mental health are not the current governor's agenda. We're now trying to figure out how the [state YCWC] fits in with other early childhood system building advisory groups." [Cohort 1]

Even with these challenges, for most grantees, the YCWCs at both the state and community levels have been essential to accomplishing important systems changes. While many systems change initiatives are ongoing, as noted earlier, the YCWCs have brought together key leaders and other stakeholders that can influence early childhood policy and practice. Changes in these systems areas have the potential to positively affect outcomes for young children and families.

### 3.3 LAUNCH-supported System Enhancements

#### *Summary of Key Findings*

The majority of grantees reported progress toward systems change at both the state and community levels. State successes included work toward selecting and implementing universal developmental screening and selecting screening tools, improving coordination across programs and agencies, and workforce development initiatives that involve training early childhood providers beyond the LAUNCH community and bringing an infant and early childhood mental health endorsement system to the state. Community successes included increased collaboration among provider organizations, increased use of data in decision making, a greater focus on trauma-informed care, expanded referral systems, and, in a few communities, policy changes related to reimbursement and access to care.

Despite the time required to implement systems change, most grantees claim important systems enhancements as a result of Project LAUNCH, including changes in *interorganizational relationships, community and state support, and organizational and legislative policies* at both the state and community levels. Data for LAUNCH-supported system enhancements were collected through yearly telephone interviews and one site visit at the end of each grantee's second year. During interviews, grantees were asked questions about policies, practices, relationships, and other activities grantees are pursuing to create and support system change. Data on LAUNCH-supported system enhancements were also collected from grantees' annual program reports.

### 3.3.1 State Successes

At the state level, Cohort 1 and 2 grantees have cited enhanced program quality, expanded access to services, and improvements in identifying children and families with developmental and mental health needs. Developmental screening initiatives were the most common systems change activity across LAUNCH grantees at the state level. States are responding, in part, to a 2006 policy statement published by the American Academy of Pediatrics recommending that all children be screened during well child visits at before 30 months of age, using a standardized developmental screening tool. In some cases, LAUNCH grantees are also continuing work that was started under previous initiatives such as the Early Childhood Comprehensive System (ECCS) program. In one state, for example, the LAUNCH project director participates in a collaborative effort to create a state Early Learning Plan and in system planning to ensure developmental screening across programs. The state's recently funded Race to the Top program includes developmental screening, and the state is "exploring options for state data systems" to maintain screening data. In another state, the state YCWC has made recommendations to the state's Early Learning Council for a "suite of child and family screening tools" within five domains—maternal health/mental health, family well-being, general development, behavioral/psychosocial health, and physical health—for universal, statewide implementation.

Improved coordination across agencies and programs has also been acknowledged as an accomplishment as a result of Project LAUNCH. One grantee identified "reducing duplicative services" as a goal and noted that communication and coordination across programs—a first step toward this goal—is beginning to occur. "Bringing everyone together to develop a strategic plan and common vision," according to one grantee, has fostered collaboration. Another grantee stated that "with the interagency coordinating council, people now get together to talk about what needs to be done" across the system. Discussions across grantees have covered a range of topics, including development of a referral database, providing training on children's mental health to all early childhood providers, and identifying LAUNCH strategies that can serve as models for other communities. One project director said that LAUNCH is "playing a catalyst role and bringing more attention to early childhood mental health and models for service delivery."

Workforce development is another ongoing systems improvement activity supported by Project LAUNCH. In one state, LAUNCH is collaborating with the MIECHV program to develop a community of practice for all home visitors in the LAUNCH community and the three MIECHV target sites. The state is advocating for training on infant and early childhood mental health for all home visitors. In at least one state, efforts are ongoing to bring an Infant and Early Childhood Mental Health Endorsement System to the state and LAUNCH staff are involved in this activity. In other states, LAUNCH is facilitating training on the ASQ for early care and education workers statewide, working to expand training for primary care providers on integrating developmental screening in their practices, and providing a webinar series for early childhood, mental health, and child abuse and neglect prevention partners on a range of topics including cultural competence and evaluation tools. LAUNCH staff have also participated in the development of a web-based professional development registry that enables families applying for public assistance to submit and check the status of their applications online and to access information about child care providers in the state, including their qualifications, education, and training certification.

Most systems changes are ongoing, and while there are early successes, as evidenced above, systems change initiatives are continuing with leadership from the state project director and the state YCWC, often in partnership with other state programs or agencies.

### 3.3.2 Community Successes

At the community level, increased collaboration among organizations as a result of LAUNCH is a theme repeated across many grantees. One grantee noted that, for the first time, there was a united voice—across agencies and disciplines—advocating for prevention and early intervention strategies for young children. Similarly, another grantee indicated that providers are talking now about the “health of the whole child and whole family” and about the integration of social-emotional health in settings that serve young children and their families. A third grantee spoke about the new enthusiasm for serving the birth to age 8 population.

The increase in data-driven decision making was also cited as a community-level systems change by two grantees. Providers are working collaboratively to make data-driven decisions about needed services, including developmental screening. Several grantees also noted the increased focus on trauma-informed care. One grantee has provided training to early childhood providers on adverse childhood experiences (ACEs). Another grantee said LAUNCH has initiated “many conversations about trauma”; providers are now recognizing the effects of trauma in children’s and families’ lives. A third grantee said that LAUNCH has helped increase the community’s awareness of trauma’s impact on young children and their parents. New service strategies such as mental health consultation are also seen as a significant LAUNCH accomplishment.

Some grantees have expanded referral systems within their community with support from Project LAUNCH. For example, two grantees have enhanced the 211 system that connects parents, child care providers, health professionals, school staff and other professionals to services and supports by expanding early childhood-focused resource and referral information. At least one grantee has developed a community-level data system within the youth and family services agency that is helping providers track families over time.

Financing and reimbursement for some services (e.g., developmental screening and assessment) have presented challenges in LAUNCH communities and have raised questions about the ability to sustain some LAUNCH strategies (e.g., mental health consultation) when grant funding is no longer available. However, a few grantees have made significant strides in this policy area, with one grantee using LAUNCH funds in the first year of the grant to support a process to get children enrolled or on the waiting list for autism services under the state’s autism waiver. Another grantee has been successful in obtaining reimbursement for mental health consultation when a child screens positive on a child wellness screen. This has made mental health consultation sustainable at one LAUNCH-supported clinical site. However, another site participating in LAUNCH within the same community has yet to obtain reimbursement for mental health consultation because they are part of a different hospital network. Other grantees are continuing to work on Medicaid and other reimbursement structures, including:

- Collaborating with state agency directors, including Medicaid, to activate behavioral health billing codes that would allow reimbursement for mental health consultation in primary care;
- Exploring third party reimbursement for parent education;
- Working on reimbursement and incentives for providers to implement developmental screening;
- Using LAUNCH as a pilot for sustainability of family navigation services using enhancement rates approved for federally qualified health centers (FQHCs);

- Making a formal recommendation to the state’s Medicaid Redesign Team that the Medicaid program adopt a standardized quality measure on pediatric developmental screening within its established quality assurance/improvement system; and
- Identifying potential EPSDT policy changes that are needed for Medicaid reimbursement and expanding those authorized to bill Medicaid for developmental screening and EPSDT services.

Finally, most staff in Cohorts 1 and 2, who have been funded at both the state and local levels, report several advantages of having a state component. State staff reported that the state YCWC could take the learnings from the local level to scale in other communities within the state and could work on systems change that has a broader impact across the child-serving system. Comments from state project directors and other state staff funded through LAUNCH included the following:

- “It would be vastly different [if the state were not part of the LAUNCH grant]. State involvement allows us to reach a larger population. We would have great programs without the state, but the programs would be implemented on a much smaller scale.” [Cohort 2]
- “If monies went directly to the community, it would be hard to get the attention of the state to work on and change policies that impact the community. We need state buy-in and support to implement the policy changes needed to sustain the work in the community and spread it across the state.” [Cohort 2]
- “We have access to the right players who understand how the state systems work. We can help address local needs and assist local programs navigate through the state system.” [Cohort 2]
- Teaching primary care providers about social-emotional health has required leadership from the state. [Cohort 1]

The majority of staff in the LAUNCH community reported that the work would not be sustainable without the state involvement and support:

- “The state and governor’s office involvement in LAUNCH gives this program credibility. It makes it apparent that what’s happening with LAUNCH is important and the state is behind it. It’s a really important part of our success.” [Cohort 1]
- “We wouldn’t be where we are [without the state]. The state needs insight from the LAUNCH community, and the community needs support from the state for policy change. It’s a two-way street.” [Cohort 1]
- “LAUNCH would be less sustainable and have a much narrower reach. The LAUNCH community is informing state policy.” [Cohort 2]
- “Conversations about reimbursement and care coordination need to bring state staff to the table. We can’t move the local agenda forward without state colleagues. We would have been dead in the water.” [Cohort 2]

Only three LAUNCH community coordinators reported that state involvement has not been important to their activities at the community level.

### 3.4 Other/Additional Training (not directly related to service strands)

#### *Summary of Key Findings*

Thirteen LAUNCH grantees (57 percent) offered training to providers in their community other than the LAUNCH providers. Altogether, these grantees offered 106 different trainings, in which 3,800 providers participated. The number of providers trained may include duplicated counts as providers may participate in multiple trainings. The provider groups that were most often the focus for these community trainings were early childhood education providers and health care providers. In addition to offering training to community providers, two of the LAUNCH grantees also enhanced the skills of staff who render LAUNCH-funded services by supporting attendance at conferences and national meetings on infant, young child and adult mental health, and cultural issues in the needs of children and families.

Most grantees focused training efforts on LAUNCH-supported services. In addition to training on specific service modalities and related topics, a number of sites offered community training. The majority of these community trainings were conducted by one Cohort 2 grantee.

As reported in the previous chapter, LAUNCH provided training to providers as part of their support for services for families and children (in home visiting, family support, in early childhood education programs and schools as part of mental health consultation, and in health care settings as part of the integration activities). LAUNCH also provided additional training to providers in their community who were unaffiliated with a LAUNCH-supported service but who were part of the child and family service system. These trainings covered a variety of mental-health related topics. Their overall objective was to enhance the knowledge and skills of the workforce in the community and to develop system-wide collaboration and coordination in terms of a framework for approaching child and family services. Across all cohorts and years of implementation, 13 of the LAUNCH grantees (57 percent) provided training to providers in their communities. Just over 3,800 providers participated in 106 different trainings (Exhibit 3.4.1). (Note that one of the grantees was responsible for more than half of the trainings; the other grantees typically offered a few community trainings in any intervention year.)

Exhibit 3.4.1 Number of Trainings and Number of Individuals Trained Through LAUNCH-Supported Community Training by Cohort and Year of Implementation (N=23 Grantees)								
	Year 1		Year 2		Year 3		All Years	
	# trainings (% grantees offering training)	# trained						
Cohort 1 (6 grantees)	1 (17%)	2	7 (33%)	184	12 (33%)	311	20	497
Cohort 2 (11 grantees)	6 (36%)	334	77 <sup>b</sup> (81%)	2834	NA	NA	83	3168
Cohort 3 (6 grantees)	3 (33%)	138	NA	NA	NA	NA	3	138
All cohorts <sup>a</sup>	10 (30%)	474	84 (65%)	3018	12 (33%)	311	106	3803 (57%)

<sup>a</sup> Total number of grantees varies by year of implementation: 23 in Year 1 (all 3 cohorts), 17 in Year 2 (cohorts 1 & 2), and 6 in Year 3 (cohort 1 only).

<sup>b</sup> The total includes 57 community trainings reported by a single grantee in Year 2.

The provider groups most often participating in LAUNCH-supported training were early childhood education staff and health care providers (Exhibit 3.4.2). The topics most often addressed were child development generally and socio-emotional development and screening specifically (Exhibit 3.4.3).

In addition to the training that LAUNCH provided to members of the child and family service agencies and programs in their communities, two of the grantees also funded opportunities for their own staff to enhance their skills, through attendance at local and national conferences and other professional meetings on child and family mental-health related topics. Across the years of implementation, these grantees sent staff to 22 conferences or meetings. Local meetings included Early Childhood Reading Readiness Training, Enhancing the Skills and Confidence of Early Child Care Professionals, and Parent Child Assistance Program (Univ. of WA case management). LAUNCH staff attended national conferences such as Strive to Thrive Before Five/Project ABC

Exhibit 3.4.2 Number of LAUNCH Trainings Targeting Different Provider Groups in Community <sup>a, b</sup> by Cohort and Year of Implementation							
Provider Groups	Cohort 1 (6 grantees)			Cohort 2 (11 grantees)		Cohort 3 (6 grantees)	All Cohorts
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 1	All Years
Parents	0	1	0	1	4	0	6
Early childhood program staff	0	3	3	3	13	2	24
School staff	0	1	1	0	6	0	8
Home visitors	0	0	0	2	8	1	10
Health care providers	1	2	4	2	12	1	22
Mental health professionals	0	1	2	2	7	1	13
Local agency staff	0	1	2	1	5	1	10
State agency staff	0	1	0	2	5	2	10

<sup>a</sup> Many trainings included multiple participants groups, which results in some double-counting in the tallies in the exhibit.

<sup>b</sup> For 11 of the trainings supported by one of the grantees, the number and affiliations of the participating providers was not known.

Exhibit 3.4.3 Frequency of Topics of LAUNCH Trainings for Community Providers Across Cohorts by Year of Implementation <sup>a</sup>			
Training Topic	Year 1 (23 grantees)	Year 2 (17 grantees)	Year 3 (6 grantees)
Child development	1	16	10
Socio-emotional development	1	15	8
Family engagement	2	15	2
Infant/young child mental health	1	15	2
Parent training	0	18	0
Provider support (inter-staff communication and relationship-building, health promotion)	0	11	0
Screening/assessment of child development	4	3	0
Parent-child relationship	1	2	2
Child abuse and neglect	1	3	0
Other	0	3	0
All topics	11	101	24

<sup>a</sup> Some trainings covered multiple topic areas, so total # of trainings across topics is larger than the total number of discrete trainings.

Conference, Touchpoints National Forum Workshops, the Governor’s Conference on Child Abuse Prevention, and the National Conference on Substance Abuse, Child Welfare, and the Courts.

LAUNCH staff also attended trainings related to the special developmental and mental health needs of children and families in cultural groups in the communities in which LAUNCH is being implemented (e.g., Somali and Native American). Of the 136 topics reported by grantees across all cohorts, 27 (20%) focused on child development, 24 (18%) on social-emotional development, 19 (14%) focused on family engagement, 18 (13%) focused on infant/young child mental health, and 18 (13%) focused on parent training.

As seen in Exhibits 3.4.2 and 3.4.3, Cohort 2 grantees conducted more trainings than other cohorts. As stated earlier, one grantee was responsible for more than half the trainings. If the trainings conducted by that grantee are removed, the number of trainings was similar across cohorts. Cohort 1 grantees conducted most training activities in the third year of funding. As other cohorts reach their third year, data on the number of trainings will be examined to determine if this is a pattern. For example, the increase in community training might be a step taken to ensure sustainability of services and practices to support healthy young child development.

### 3.5 Public Awareness Activities

#### *Summary of Key Findings*

A majority of grantees reported implementing public awareness activities at either the community or state level, and often both. Their public awareness activities are focused on increasing knowledge and awareness of healthy child development and available community resources. In addition, some grantee activities are directed toward gaining public, including political, support for programs and policies that contribute to children’s cognitive development and physical and emotional health and well-being. Awareness campaigns are the most common type of awareness activity supported by Project LAUNCH. Campaigns have involved developing and distributing informational materials, sponsoring advertisements, and holding awareness-raising events, especially in observance of Children’s Mental Health Awareness Day.

Data for public awareness activities were collected through the questions, “Is Project LAUNCH supporting any media campaigns or community outreach activities at the State level?” and “What types of media and/or products are part of the campaign/outreach strategy?” as well as review of grantee end-of-year reports. Public awareness activities supported by LAUNCH grantees are intended to increase knowledge and awareness of healthy child development and available community resources. Grantee activities are also focused on gaining public, including political, support for programs and policies that contribute to children’s cognitive development and physical and emotional health and well-being. A majority of grantees reported implementing public awareness activities at either the community or state level, and often both (Exhibit 3.5.1). Awareness campaigns were the most common type of awareness activity supported by Project LAUNCH and included developing and/or distributing informational materials—e.g., brochures and flyers informing families and providers about LAUNCH direct services and other resources available in the community. Other awareness campaigns included: sponsoring advertisements for the Text4Baby service, conducting a public education blitz on Shaken Baby Syndrome, supporting movie theater advertisements on infant development, and providing materials for primary care providers to help initiate conversations with parents about emotional wellness. Five grantees also participated in events around children’s mental health and emotional wellness by promoting and organizing local activities to observe National Children’s Mental Health Awareness Day.

Exhibit 3.5.1 Number and Percent of Grantees Supporting Awareness Campaigns or Outreach Activities as Part of Project LAUNCH By Cohort				
	Cohort 1 (6 grantees)	Cohort 2 (11 grantees)	Cohort 3 (6 grantees)	All Cohorts
Community level	4 (17%)	11 (100%)	3 (50%)	15 (65%)
State level	2 (33%) <sup>a</sup>	6 (55%)	NA	8 (47%)

<sup>a</sup>There are five state grantees in Cohort 1. Information from the one tribal grantee is included with the community-level data.

Additional forms of public outreach included disseminating materials at community health fairs; door-to-door outreach in selected neighborhoods; providing posters, brochures, and newsletters focused on social/emotional health and development and available community resources in the community to pediatric clinics and other primary care offices, and giving presentations to targeted groups in the community (e.g., on the importance of social and emotional health and developmental screening). Other grantees presented to schools, community groups, local businesses, a hospital department of psychiatry, and a university to inform and promote LAUNCH strategies, tools, and participation on the local YCWC. Some grantees were engaged in community outreach activities that they did not identify as outreach or awareness campaigns. Other grantees noted that media campaigns and outreach were not their areas of expertise, and technical assistance may be necessary to optimize the use and effectiveness of outreach at both the state and community levels.

### 3.6 Sustainability Activities

#### *Summary of Key Findings*

Fewer than half of grantees (39 percent) are developing sustainability plans for their LAUNCH programs at the community level. For those grantees working on sustainability, activities are centered around three key efforts: (1) workforce development beyond LAUNCH-supported providers, (2) pursuit of funding opportunities, and (3) securing reimbursement for services currently supported by Project LAUNCH.

While a number of grantee activities were focused on sustaining LAUNCH strategies within the LAUNCH community or broadening implementation beyond the target community, relatively few grantees (39 percent) had developed or were in the process of developing a formal sustainability plan (Exhibit 3.6.1). Only two grantees in Cohort 2 have a formal sustainability plan in place, and seven grantees (2 in Cohort 1; 4 in Cohort 2; and 1 in Cohort 3) have sustainability plans in development. In several cases, state and community coordinators stated that their activities were planned with replication in mind. These grantees thought of the local site as a demonstration of what could be done in other communities. Although most grantees began working toward sustainability in the first few years of their grants, completion of sustainability plans did not occur. Technical assistance may be helpful in assisting grantees to achieve sustainability for LAUNCH services and systems efforts.

In 2011, grantees' work on sustainability of LAUNCH strategies centered around a few key efforts: (1) workforce development beyond LAUNCH-supported providers, (2) pursuit of funding opportunities, and (3) securing reimbursement for services currently supported by Project LAUNCH (Exhibit 3.6.2). Twenty grantees (87 percent) reported providing trainings to others in the community beyond staff who were supported by Project LAUNCH. Training topics included developmental screening, Parent Café "Table Host" training for local parents, evidence-based curriculums, and developmental milestones of young children. Several broad categories of community members

participated in LAUNCH-sponsored workforce development activities; these included pediatric primary care providers and staff, early childhood education teachers and staff, home visitors, public school staff, parent educators, public school teachers, and mental health providers.

To help ensure sustainability of programs after LAUNCH funding ends, five grantees reported submitting applications for the U.S. Department of Education's "Race to the Top" initiative. Grantees also pursued other opportunities such as federal and state home visiting funds, a "Thrive by Five" community momentum grant, federal block grant funds to expand services in other settings (e.g., more public schools throughout the state), and a private foundation grant to expand developmental screening statewide. One grantee has placed computer kiosks in primary care waiting rooms for parents to complete developmental screens. The kiosks, which will remain after LAUNCH grant funding ends, serve as a model for implementing developmental screening that they hope neighboring communities will replicate. Another grantee developed a Web application for developmental screening to be completed and archived electronically, allowing pediatric clinics to continue to offer screens when LAUNCH funding ends.

Exhibit 3.6.2 Illustrative Sustainability Activities By Cohort and Year of Implementation <sup>a</sup> .			
	Cohort 1	Cohort 2	Cohort 3
Workforce development (beyond LAUNCH providers)	<ul style="list-style-type: none"> <li>• Newborn Observation training for local home visitors, doulas, midwives, and pediatric primary care providers (1)</li> <li>• Training for teachers, child care providers, and health care providers on developmental screens, teaching strategies, and developmental milestones (3)</li> </ul>	<ul style="list-style-type: none"> <li>• Training for school, child care, and other community social service staff on developmental screening and addressing challenging behaviors (3)</li> <li>• Working with non-LAUNCH-supported child care centers to implement evidence-based curriculums (1)</li> <li>• Professional development seminars at the state level for parent educators and other who work with parents (1)</li> <li>• Cognitive Behavioral Therapy training community-wide for mental health providers (1)</li> <li>• Passage of state legislation requiring state health department to provide informational materials concerning maternal mental health to health care providers serving pregnant, postpartum and post-pregnancy loss patients (1)</li> </ul>	<ul style="list-style-type: none"> <li>• Provided training on developmental screening and assessment to child care, mental health, child welfare, pediatric primary care providers; home visitors; and Medicaid representatives (5)</li> <li>• Provided training on an evidence-based parenting education program to 85 parent educators, including beyond the LAUNCH community (1)</li> <li>• Provided training on maternal depression screening to primary care providers and staff (1)</li> <li>• Provided Incredible Years Teacher Training and training on the CSEFEL model to early childhood teachers (3)</li> </ul>
Pursuit of funding opportunities	<ul style="list-style-type: none"> <li>• Applied for MIECHV funding to continue services when LAUNCH ends (1)</li> <li>• Local partners collaborating to write grants for continued funding of LAUNCH strategies (1)</li> <li>• Applied for Race to the Top grant to expand direct services statewide and support integration of mental health in primary care (1)</li> <li>• Applied for Thrive by Five community momentum grant (1)</li> </ul>	<ul style="list-style-type: none"> <li>• Applied for MIECHV funding (2)</li> <li>• Secured state home visiting funds to increase home visiting workforce capacity (1)</li> <li>• Applied for Race to the Top grant (4)</li> <li>• Awarded federal block grant funds to expand LAUNCH-supported services (1)</li> <li>• Partnered with local AAP and awarded foundation grant to expand developmental screening throughout state (1)</li> <li>• Secured funding through a partnership with a local counseling services organization to provide MHC to a local elementary school (1)</li> </ul>	NA
Securing reimbursement for services	<ul style="list-style-type: none"> <li>• Created cross-institutional billing for some services (1)</li> </ul>	<ul style="list-style-type: none"> <li>• Submitted a recommendation on developmental screening to state's Medicaid Redesign Team (1)</li> <li>• Holding conversations with state Medicaid agency about policy changes needed to activate behavioral health billing codes that would allow expansion of mental health consultation in primary care (2)</li> </ul>	NA
Other	<ul style="list-style-type: none"> <li>• Developed Web application for developmental screening to be completed and archived electronically, allowing pediatric clinics to continue to offer screens when LAUNCH funding ends (1)</li> </ul>	<ul style="list-style-type: none"> <li>• Local council adopted the logo of early childhood wellness campaign, helping to sustain their effort after LAUNCH (1)</li> </ul>	NA

<sup>a</sup>Total number of grantees varies by year of implementation: 23 in Year 1 (all 3 cohorts), 17 in Year 2 (cohorts 1 & 2), and 6 in Year 3 (cohort 1 only).

## 4. Next Steps for the Cross-Site Evaluation

In the last year of the cross-site evaluation, the CSE team will continue to obtain data from grantees about the services they are implementing within each LAUNCH strategy and the numbers of children and families served. The CSE team will also conduct interviews with state and community participants in LAUNCH to continue to document systems change activities and enhancements to the child-serving system at the state and community levels that can be attributed to Project LAUNCH. Data will be presented by implementation year, as well as cumulated over time. Trends and patterns discerned from qualitative data will also be refined as the cross-site evaluation collects and analyzes these additional data.

A final report for the cross-site evaluation will be prepared in Spring 2014. In addition to cumulative findings on implementation of LAUNCH-supported services, the final report will present an analysis of child and parent outcomes using results from grantees' quasi-experimental design studies. A challenge for the CSE will be to combine outcome estimates from different types of programs, measuring different domains of child development and potentially using different measures within any domain. At the same time, based on a review of the current local evaluation plans from the 24 LAUNCH sites, there are likely to be only a small number of estimates of child or parent outcomes in local evaluations that represent quasi-experimental studies of individual programs or services.

The CSE will also have a second source of estimates on child outcomes—the set of special studies being conducted by a subset of the sites using supplemental evaluation funding from SAMHSA. To increase the extent of more rigorous evidence on child and family outcomes, SAMHSA awarded additional funds to grantees on a competitive basis. To be eligible for the funds, the grantees needed to propose population studies of child outcomes. As a result of this funding, the CSE expects to have a set of child outcomes from 10 studies in 6 sites, which will help the cross-site evaluation answer the overall outcome question, what is the effect of Project LAUNCH on the health and well-being of young children in the Project LAUNCH communities?, and to assess whether the goals of the program have been met.

Each of the special studies employs a rigorous design that will allow the CSE to make causal attributions about the effect of LAUNCH on the child outcomes measured. As shown in Exhibit 4.2.1, these studies will produce findings on child outcomes in four main areas: kindergarten readiness (measured at the end of preschool or at kindergarten entry); academic performance in grades K – 3; birth and other health outcomes and early developmental outcomes for newborns and infants and toddlers, and child maltreatment. The findings from the special studies are scheduled to be reported starting with two studies ending in fall 2013, three studies ending in spring 2014, three studies ending in fall 2014, and two studies ending in spring 2015. (More detailed information about the designs of the special studies is provided in Appendix E.)

The CSE will also summarize the evidence on provider outcomes in the CSE final report. Similarly to the extent of evidence on child and parent outcomes, the CSE expects to have few, if any, estimates for provider outcomes based on quasi-experimental studies. The majority of local evaluations will provide, at best, pre-post data on provider knowledge and practices and many will provide only outcomes measured at a single, post time point. Because limiting the analysis to estimates will result in minimal evidence of LAUNCH effects on providers, for the provider outcomes only, we will also summarize findings of pre-post changes that are reported in the individual local evaluations, providing strong caveats about the level of evidence represented by these data. The results for

providers will include a description of the ways that LAUNCH might have influenced the providers in the sample, e.g., through provision of mental health consultation, training on screening, etc., and whether the providers in the sample are doctors, clinicians, or paraprofessionals. By creating a standardized change score, we will be able to combine results for provider changes across survey questions on different scales. We will also create average standardized change scores for different kinds of provider outcomes.

Exhibit 4.2.1 LAUNCH Special Studies: Child Outcome Domain Assessed and Schedule for Reporting Child Impacts				
Reporting Time Frame	Outcome Domain			
	Pre-Kindergarten Development/School Readiness	Academic Performance/ School Behavior	Birth and Infant Development	Child Maltreatment
Fall 2013	<i>Study 1: K entry<sup>a</sup></i> <ul style="list-style-type: none"> <li>School readiness (district developed assessment of 24 readiness skills)</li> </ul>		<i>Study 8: Birth<sup>a</sup></i> <ul style="list-style-type: none"> <li>Birth outcomes (birth weight, time in intensive care)</li> </ul>	
Spring 2014	<i>Study 2: 1 – 5 years<sup>a</sup></i> <ul style="list-style-type: none"> <li>Cognitive and language development (PPVT, Boehm-3, Bayley)</li> <li>Social skills (SSIS)</li> </ul> <i>Study 3: End of preschool</i> <ul style="list-style-type: none"> <li>School readiness (state developmental checklist in 9 domains)</li> </ul>	<i>Study 5: K – Gr 3<sup>a</sup></i> <ul style="list-style-type: none"> <li>Academic performance (State test, retention in grade)</li> <li>School-related behavior concerns (absences, suspensions/ expulsions)</li> </ul>	<i>Study 9: 0 – 1 year<sup>a</sup></i> <ul style="list-style-type: none"> <li>Birth outcomes (birth weight, time in intensive care)</li> <li>Use of acute health care</li> </ul>	
Fall 2014		<i>Study 6: Gr 2<sup>a</sup></i> <ul style="list-style-type: none"> <li>Academic performance (State reading test; retention in grade)</li> <li>School behavior concerns</li> </ul>		<i>Study 10: 0 – 8 years<sup>a</sup></i> <ul style="list-style-type: none"> <li>Rates of substantiated abuse or neglect</li> </ul>
Spring 2015	<i>Study 4: K entry<sup>a</sup></i> <ul style="list-style-type: none"> <li>School readiness in literacy &amp; numeracy (Measures of Academic Performance (MAP))</li> </ul>	<i>Study 7: Gr 1<sup>a</sup></i> <ul style="list-style-type: none"> <li>Academic performance in literacy &amp; numeracy (Measures of Academic Performance (MAP))</li> <li>School behavior (absences, suspensions/ expulsions)</li> </ul>		

<sup>a</sup> Child age at time of outcome measurement

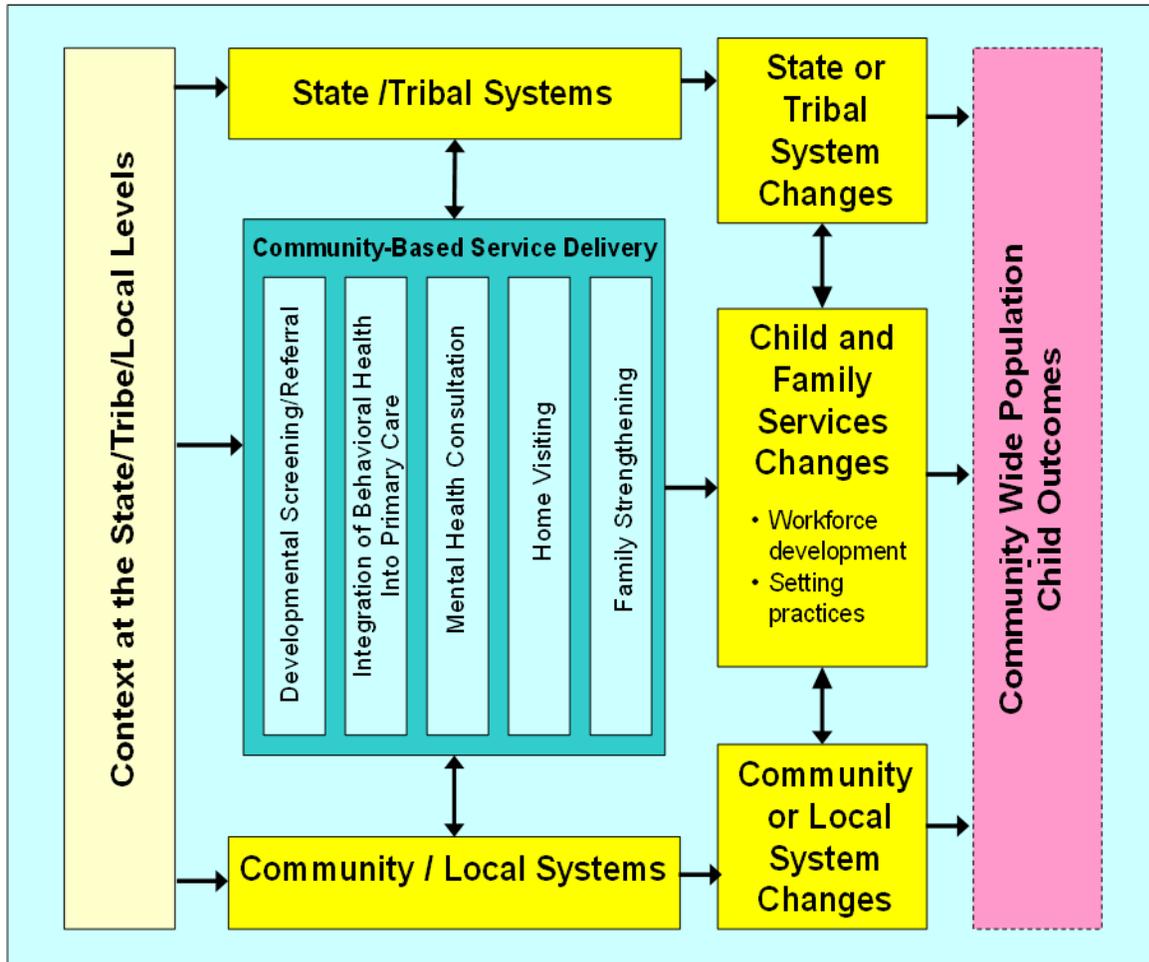
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## Appendix A: Project LAUNCH Grantees

Grantee State	Grantee Agency	Project LAUNCH Community
<b>Cohort 1</b>		
Arizona	AZ Department of Health Services	Two zip codes in Phoenix
Maine	ME Department of Health and Human Services	Washington County
New Mexico	NM Department of Health	Santa Fe County
Rhode Island	RI Department of Health	City of Providence
Washington	WA State Department of Health	Yakima County
Wisconsin	Red Cliff Band of Lake Superior Chippewa	Red Cliff Reservation
<b>Cohort 2</b>		
California	CA Department of Public Health	East Oakland
District of Columbia	DC Department of Health	Wards 7 and 8
Illinois	IL Department of Human Services	Four communities on Chicago's West side: East and West Garfield Park and North and South Lawndale
Iowa	IA Department of Public Health	Seven zip codes in inner city Des Moines
Kansas	KS Department of Health and Environment	Finney County
Massachusetts	MA Department of Public Health	Boston
Michigan	MI Department of Community Health	Saginaw County
New York	NY Department of Health	Three communities in Westchester County: Yonkers, Ossining, and Port Chester
North Carolina	NC Division of Public Health	Guilford County
Ohio	OH Department of Health	Four counties of rural Appalachian Ohio: Athens, Hocking, Vinton, and Meigs
Oregon	OR Department of Human Services	Deschutes County
Wisconsin	WI Department of Health Services	Eight zip codes in Milwaukee
<b>Cohort 3</b>		
Colorado	North Colorado Health Alliance	Weld County
Connecticut	Wheeler Clinic, Inc.	New Britain
Missouri	Curators of the University of Missouri	Boone County
New York	Fund for Public Health in New York	East Harlem and Hunts Point
Oregon	Multnomah Education Service District	Multnomah County
Texas	Aliviane, Inc.	Three Census tracts within El Paso County and City

## Appendix B: Cross-Site Evaluation Logic Model



## Appendix C: LAUNCH-Supported Home Visiting Models

**APPENDIX Exhibit C.1: Descriptions of Home Visiting Program Models and Approaches Supported by LAUNCH Grantees**

Home Visiting Model	Goals and Source of Information on Model
Center on the Social and Emotional Foundations for Early Learning (CSEFEL)	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://csefel.vanderbilt.edu/">http://csefel.vanderbilt.edu/</a></li> </ul> </li> <li>• Center develops materials and provides technical assistance to programs interesting in adopting CSEFEL practices</li> <li>• Goals: support of social and emotional development, prevention of challenging behaviors</li> </ul>
Child First	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://www.childfirst.net/">http://www.childfirst.net/</a></li> </ul> </li> <li>• Home-based intervention targeting young children based on theories of brain development</li> <li>• Visits conducted by developmental clinician (master's degree) and care coordinator (bachelor's degree)</li> <li>• Goals: prevention of emotional, developmental, learning problems in children; prevention of abuse and neglect</li> </ul>
Early Head Start	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://www.ehsnrc.org/AboutUs/ehs.htm">http://www.ehsnrc.org/AboutUs/ehs.htm</a></li> </ul> </li> <li>• Federally-funded community-based program for low income families</li> <li>• Goals: prenatal care for pregnant women, improved development of very young children, increased healthy family functioning.</li> <li>• Four major program components: home visits, parent education, health service, and child care</li> </ul>
First Born® Program (FBP)	<ul style="list-style-type: none"> <li>• Source of Information:                             <ul style="list-style-type: none"> <li>○ <a href="http://www.lanlfoundation.org/First-Born/">http://www.lanlfoundation.org/First-Born/</a></li> </ul> </li> <li>• Founded by Vicki Johnson</li> <li>• Hospital-based home visiting program (during pregnancy and up to child's third year) by trained professionals</li> <li>• Goal: increase health of women pregnant for the first time, prenatal care, reduction of risk factors, increase in protective factors</li> </ul>
Healthy Families (America)	<ul style="list-style-type: none"> <li>• Source of information                             <ul style="list-style-type: none"> <li>○ <a href="http://www.healthyfamiliesamerica.org/home/index.shtml">http://www.healthyfamiliesamerica.org/home/index.shtml</a></li> </ul> </li> <li>• Targeting at-risk families, provide services during pregnancy and up until child's birth</li> <li>• Goals: reduce maltreatment, increase prenatal care, mother-child relationships, school readiness, access to medical care</li> <li>• Required training of all HFA staff</li> </ul>
Help Me Grow (HMG)	<ul style="list-style-type: none"> <li>• Source of Information:                             <ul style="list-style-type: none"> <li>○ <a href="http://www.helpmegrownational.org/index.php">http://www.helpmegrownational.org/index.php</a></li> </ul> </li> <li>• Began in Hartford, Connecticut, in 1998 and followed by national expansion</li> <li>• Provides health care and developmental services to pregnant woman and newborns</li> <li>• Goals: identification of children at risk for developmental and behavioral problems, reduction of risks, increase parenting skills</li> </ul>

**APPENDIX Exhibit C.1: Descriptions of Home Visiting Program Models and Approaches Supported by LAUNCH Grantees**

Home Visiting Model	Goals and Source of Information on Model
Home Instruction for Parents of Preschool Youngsters (HIPPY)	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://www.hippyusa.org">http://www.hippyusa.org</a></li> </ul> </li> <li>• Home visiting program using role-play curriculum facilitated by community-based visitor and supervised by professional coordinator</li> <li>• Home visiting and group meetings</li> <li>• Goals: increase parental involvement, self-confidence, self-reliance</li> </ul>
Nurse-Family Partnership	<ul style="list-style-type: none"> <li>• Source of information                             <ul style="list-style-type: none"> <li>○ <a href="http://www.nursefamilypartnership.org/">http://www.nursefamilypartnership.org/</a></li> </ul> </li> <li>• Nurse home visiting program for first-time mothers</li> <li>• Visits begin during pregnancy and extend until child is age 2</li> <li>• Preparation for pregnancy, delivery, and infant care</li> <li>• Goals: improvement in health, education, and economic self-sufficiency</li> </ul>
Parents as Teachers (PAT)	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://www.parentsasteachers.org/">http://www.parentsasteachers.org/</a></li> </ul> </li> <li>• Curriculum and training program for health, education, and social services targeting parents and young children</li> <li>• Trained professionals work with parents and children from birth to kindergarten</li> <li>• Goals: increase parental involvement in child’s health development and school readiness</li> </ul>
Positive Behavioral Intervention and Support (PBIS)	<ul style="list-style-type: none"> <li>• Source of information                             <ul style="list-style-type: none"> <li>○ <a href="http://www.crisisprevention.com/PBIS.aspx">http://www.crisisprevention.com/PBIS.aspx</a></li> </ul> </li> <li>• System geared toward behavioral analysis and change with a person-centered approach</li> <li>• Used in varied settings: school-based interventions, home visiting programs, etc.</li> <li>• Goals: increase pro-social behaviors, decrease problem behaviors</li> </ul>
Promoting First Relationships	<ul style="list-style-type: none"> <li>• Source of Information:                             <ul style="list-style-type: none"> <li>○ <a href="http://pfrprogram.org/">http://pfrprogram.org/</a></li> <li>○ <a href="http://www.ncast.org/PFR_Research.html">http://www.ncast.org/PFR_Research.html</a></li> </ul> </li> <li>• Founded by Jean F. Kelley, Ph.D. (University of Washington)</li> <li>• Based on attachment theory</li> <li>• Goals: social, emotional, behavioral, language and cognitive growth in young children</li> </ul>

**APPENDIX Exhibit C.1: Descriptions of Home Visiting Program Models and Approaches Supported by LAUNCH Grantees**

Home Visiting Model	Goals and Source of Information on Model
Promoting Maternal Mental Health during Pregnancy	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://www.ncast.org/index.cfm?fuseaction=category.display&amp;category_id=26">http://www.ncast.org/index.cfm?fuseaction=category.display&amp;category_id=26</a></li> </ul> </li> <li>• Set of materials that can be used by health care providers, home visitors, and others providing services to pregnant women</li> <li>• 56 activities that can be facilitated in hospital or home setting</li> <li>• Goals: support women with the emotional and psychological challenges of pregnancy; develop healthy mother-child relationships</li> </ul>
Touchpoints	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://www.brazeltontouchpoints.org">http://www.brazeltontouchpoints.org</a></li> </ul> </li> <li>• Theory of child development initiated by Dr. T. Berry Brazelton at Children’s Hospital in Boston</li> <li>• Goals: improve parent-child relationships, increase mother’s understanding of developmental growth</li> <li>• Utilized by pediatricians, nurses, early educators, home visitors, and others</li> </ul>
Video-feedback Intervention to Promote Positive Parenting Program (VIPP)	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://www.marinusvanijzendoorn.com/video-feedback-intervention-vipp">http://www.marinusvanijzendoorn.com/video-feedback-intervention-vipp</a></li> <li>○ <a href="http://www.ucl.ac.uk/educational-psychology/resources/CS2Corbett.pdf">http://www.ucl.ac.uk/educational-psychology/resources/CS2Corbett.pdf</a></li> </ul> </li> <li>• Attachment-based intervention developed by scholars at Leiden University in the Netherlands</li> <li>• Support of parent through analysis of video recordings of parent-child interactions. Trained intervener analyses video before home visit, watches with parent, and provides feedback</li> <li>• Goal: increase parental sensitivity, mother-child attachment</li> </ul>

**APPENDIX Exhibit C.2: LAUNCH Home Visiting Program Models: Evidence of Effectiveness**

Home Visiting Program Model	Focal Outcomes	Evidence of Effectiveness <sup>a22</sup>
<b>Substantial Evidence</b>		
Nurse-Family Partnership	Improved health; fewer subsequent pregnancies; increased intervals between births; maternal employment; improved school readiness	Office of Planning, Research, and Evaluation (OPRE)/ Home Visiting Evidence of Effectiveness (HVEE): 26-28 favorable impacts on primary outcomes The Office of Juvenile Justice and Delinquency Prevention (OJJDP): Exemplary National Registry of Evidence-based Programs and Practices (NREPP): Consistent evidence of positive results [Quality of research: 3.2-3.5/4.0] Promising Practices Network (PPN): Proven California Evidence-Based Clearinghouse (CEBP): Top Tier CEBC: Well supported Strengthening America's Families (SAF): Exemplary II Child Trends: Mixed findings
Promoting First Relationships	Social, emotional, behavioral, language and cognitive growth	Multiple individual studies found positive changes in provider behavior <sup>i</sup> and caregiver sensitivity and knowledge <sup>ii</sup> .
Early Head Start	Health, school readiness, economic sufficiency, violence and neglect, parenting	OPRE/HVEE: 4 favorable impacts on primary outcomes PPN: Proven CEBP: Promising CEBC: Promising
Healthy Families (America)	Child maltreatment; prenatal care; Improved parent-child interaction & school readiness; self-sufficiency; access to health care	OPRE/HVEE: 10-14 favorable impacts on primary outcomes OJJDP: Effective CEBP: Well-supported CEBC: Evidence fails to demonstrate effect SAF: Model Child Trends: Found (Health Families–NY) to work
Home Instruction for Parents of Preschool Youngsters (HIPPIY)	School readiness; later academic achievement; parental involvement in child's education	OPRE/HVEE: 4 favorable impacts on primary outcomes CEBP: Supported CEBC: Supported SAF: Model Child Trends: Mixed findings

<sup>22</sup> The Office of Juvenile Justice and Delinquency Prevention: OJJDP; Home Visiting Evidence of Effectiveness :HVEE; Office of Planning, Research, and Evaluation: OPRE; National Registry of Evidence-based Programs and Practices: NREPP; Promising Practices Network: PPN; California Evidence-Based Clearinghouse: CEBP; and Strengthening America’s Families: SAF.

APPENDIX Exhibit C.2: LAUNCH Home Visiting Program Models: Evidence of Effectiveness		
Home Visiting Program Model	Focal Outcomes	Evidence of Effectiveness <sup>a22</sup>
		SAF: Model Child Trends: Mixed findings
Parents as Teachers (PAT)	Education	OPRE/HVEE: 5 favorable impacts on primary outcomes OJJDP: Promising NREPP: Some evidence of positive results [Quality of research: 3.0-3.4/4.0] PPN: Promising CEBC: Promising SAF: Model Child Trends: Mixed findings
<b>Emerging Evidence</b>		
Child First	Emotional disturbance, developmental and learning problems, and abuse and neglect	OPRE/HVEE: 1 study with 16 favorable impacts on primary outcomes
First Born® Program (FBP)	Prenatal care	Multi-year outcome evaluation is currently being conducted by Dr. M. Rebecca Kilburn and RAND Corporation
Video-feedback Intervention to Promote Positive Parenting Program (VIPP)	Parental sensitivity, mother-child attachment	Multiple individual studies with positive effects on parental sensitivity in the Netherlands <sup>iii</sup> and in Lithuania <sup>iv</sup> .
<b>Limited/No Evidence</b>		
Help Me Grow	Early identification, prenatal health, infant health	No existing evaluations of program effectiveness

<sup>a</sup> See Appendix Exhibit C.4 for explanation of evidence standards

Appendix Exhibit C.3: Frameworks Adopted by Home Visiting Programs and Evidence of Effectiveness		
Framework	Focal outcomes	Evidence of Effectiveness
Positive Behavioral Intervention and Support (PBIS)	Child behaviors	No formal evaluations in home visiting programs have been found
Promoting maternal mental health during pregnancy	Emotional and psychological health, mother-child relationship	No formal evaluations have been found
Touchpoints	Parent-child relationships, child development	Singer, MD, Jayne, Jessica Goldenberg, MA, and Elisa Vele-Tabador, Ph.D, eds. A Review of the Early Care and Education Literature: Evidence Base for Touchpoints; Brazelton Touchpoints Center Executive Summary. Brazelton Touchpoints Center. Print.
Center on the Social and Emotional Foundations for Early Learning (CSEFEL)	Social, emotional, and behavioral development	No evaluations of studies were reported on CSEFEL website

**APPENDIX Exhibit C.4: Rating Criteria for Evidence of Effectiveness of Home Visiting Program Models**

Source of Rating Criteria	Description of Rating Criteria
Office of Planning, Research and Evaluation (OPRE), Home Visiting Evidence of Effectiveness (HomVEE)	<p>This report included reviews of 11 program models selected based on several criteria including but not limited to:</p> <ul style="list-style-type: none"> <li>• Research design (RCT, QED, implementation study)</li> <li>• Target population (pregnant women, birth to age 5)</li> <li>• Inclusion of eight appropriate outcomes</li> <li>• Evaluation of named home visiting program model</li> </ul> <p>Review listed number of favorable impacts on primary outcome measures</p> <ul style="list-style-type: none"> <li>• Primary measures are outcomes measured through direct observation, direct assessment, administrative data, or self-reported data collected using a standardized (normed) instrument.</li> </ul>
Office of Juvenile Justice and Delinquency Prevention (OJJDP)	<p><b>Exemplary:</b></p> <ul style="list-style-type: none"> <li>• Demonstrate robust empirical findings</li> <li>• Reputable conceptual framework</li> <li>• Experimental design</li> </ul> <p><b>Effective:</b></p> <ul style="list-style-type: none"> <li>• Adequate empirical findings</li> <li>• Sound conceptual framework</li> <li>• Quasi-experimental design</li> </ul> <p><b>Promising:</b></p> <ul style="list-style-type: none"> <li>• Promising (perhaps inconsistent) empirical findings</li> <li>• Reasonable conceptual framework</li> <li>• Limited evaluation design (single group pre- post-test) that requires causal confirmation</li> </ul>
SAMHSA National Registry of Evidence-based Programs and Practices (NREPP)	<p>Selected reviewers focus on quality of research and report key findings within an intervention summary.</p> <ul style="list-style-type: none"> <li>• Quality of research: Reviewers use a scale of 0.0 to 4.0 (4.0 = highest rating) and consider reliability of measures, validity of measures, intervention fidelity, missing data and attrition, potential confounding variables, appropriateness of analysis</li> <li>• Report of key findings: Reviewers report a summary of results across individual evaluations per outcome of interest.</li> </ul>
Promising Practices Network (PPN)	<p><b>Proven:</b></p> <ul style="list-style-type: none"> <li>• Program must directly impact PPN identified indicators</li> <li>• At least one outcome is changed by at least 20% or 0.25 standard deviations</li> <li>• At least one outcome with a substantial effect size is statistically significant at the 5% level</li> <li>• Study design uses an experimental or quasi-experimental design</li> <li>• Sample size of evaluation exceeds 30 in treatment and comparison groups</li> <li>• Program evaluation is publicly available</li> </ul>

**APPENDIX Exhibit C.4: Rating Criteria for Evidence of Effectiveness of Home Visiting Program Models**

Source of Rating Criteria	Description of Rating Criteria
	<p><b>Promising:</b></p> <ul style="list-style-type: none"> <li>• Program impacts an intermediary outcome for which there is evidence that it is associated with one of the PPN indicators</li> <li>• Outcome change is significant at the 10% level</li> <li>• Change in outcome is more than 1%</li> <li>• Study has a comparison group, but it may exhibit some weaknesses</li> <li>• Sample size of evaluation exceeds 10 in both the treatment and comparison groups</li> <li>• Program evaluation is publicly available</li> </ul> <p><b>Not Listed on the Site:</b> Does not meet qualifications for promising category</p>
<p>Coalition for Evidence-Based Policy (CEBP)</p>	<p><b>Top Tier:</b></p> <ul style="list-style-type: none"> <li>• Interventions shown in well-conducted randomized controlled trials, preferably conducted in typical community settings, to produce sizeable, sustained benefits to participants and/or society</li> </ul> <p><b>Near Top Tier:</b></p> <ul style="list-style-type: none"> <li>• Interventions shown to meet all elements of the Top Tier standard in a single site, and only need one additional step to qualify as Top Tier – a replication trial establishing that the sizeable, sustained effects found in that site generalize to other sites</li> </ul> <p><b>Promising:</b></p> <ul style="list-style-type: none"> <li>• Been found to be promising</li> </ul>
<p>California Evidence-Based Clearinghouse (CEBC)</p>	<p><b>(1) Well-Supported:</b></p> <ul style="list-style-type: none"> <li>• No evidence suggesting program causes harm on recipients compared to its likely benefits</li> <li>• Program has a book, manual, etc. describing specific program components and method for administering</li> <li>• At least two rigorous randomized controlled trials (RCTs) settings demonstrate the practice to be superior to comparisons. RCTs have been reported in published, peer-reviewed literature</li> <li>• Sustained effects for one year post-treatment</li> <li>• Use of valid, reliable outcome measures administered consistently and accurately</li> <li>• If multiple outcome studies have been conducted, the overall weight of the evidence supports the benefit of the practice</li> </ul> <p><b>(2) Supported:</b></p> <ul style="list-style-type: none"> <li>• No evidence suggesting program causes harm on recipients compared to its likely benefits</li> <li>• Program has a book, manual, etc. describing specific program components and method for administering</li> <li>• At least one rigorous randomized controlled trial (RCTs) demonstrates the practice to be superior to comparisons. RCTs have been reported in published, peer-reviewed literature.</li> <li>• Sustained effects for 6 months post-treatment</li> <li>• Use of valid, reliable outcome measures administered consistently and accurately</li> <li>• If multiple outcome studies have been conducted, the overall weight of the evidence supports the benefit of the practice</li> </ul>

**APPENDIX Exhibit C.4: Rating Criteria for Evidence of Effectiveness of Home Visiting Program Models**

Source of Rating Criteria	Description of Rating Criteria
	<p><b>(3) Promising:</b></p> <ul style="list-style-type: none"> <li>• No evidence suggesting program causes harm on recipients compared to its likely benefits</li> <li>• Program has a book, manual, etc. describing specific program components and method for administering</li> <li>• At least one study utilizing some form of control has shown the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice. The study has been reported in published, peer-reviewed literature</li> </ul> <p>If multiple outcome studies have been conducted, the overall weight of evidence supports the benefit of the practice</p>
<p>Strengthening America's Families (SAF)</p>	<p><b>Exemplary I:</b></p> <ul style="list-style-type: none"> <li>• Experimental design with randomized sample and replication by an independent investigator</li> <li>• Outcome data from the numerous research studies show clear evidence of program effectiveness</li> </ul> <p><b>Exemplary II:</b></p> <ul style="list-style-type: none"> <li>• Experimental design with randomized sample</li> <li>• Outcome data from studies show evidence of program effectiveness</li> </ul> <p><b>Model:</b></p> <ul style="list-style-type: none"> <li>• Experimental or quasi-experimental design with few/no replications</li> <li>• Outcome data indicate program effectiveness; data are not as strong in demonstrating program effectiveness</li> </ul> <p><b>Promising:</b></p> <ul style="list-style-type: none"> <li>• Limited research and/or employs non-experimental designs</li> <li>• Data appear promising but requires confirmation using scientific techniques</li> <li>• Theoretical base and/or some other aspect of the program is sound</li> </ul>
<p>Child Trends</p>	<p><b>Found to Work:</b></p> <ul style="list-style-type: none"> <li>• Programs in this category have <i>positive and significant</i> impacts on a particular infant, child, or youth outcome</li> </ul> <p><b>Mixed Findings:</b></p> <ul style="list-style-type: none"> <li>• Programs in this category have <i>varied impacts</i> either on particular outcomes or at different times or for varied subgroups</li> <li>• For example, a program that results in significant improvements in behavior problems at post-test but has no impact at a one-year follow-up would be rated as having "mixed findings"</li> <li>• A program that works for one subgroup of participants but not for another subgroup (on a particular outcome) would also receive a "mixed findings" rating</li> </ul> <p><b>Not Proven to Work:</b></p> <ul style="list-style-type: none"> <li>• Programs in this category have <i>non-significant or marginally significant</i> impacts on particular child or youth outcomes</li> </ul>

**Appendix D: LAUNCH-Supported Family Support Models**

**APPENDIX Exhibit D.1: Descriptions of Family Support Program Models and Approaches Supported by LAUNCH Grantees**

Family Support Model	Goals and Source of Information on Model
Centering Health Care Institute Model	<ul style="list-style-type: none"> <li>• Source of Information                             <ul style="list-style-type: none"> <li>○ <a href="https://www.centeringhealthcare.org/">https://www.centeringhealthcare.org/</a></li> </ul> </li> <li>• Group health care delivery model</li> <li>• Incorporates assessment, education, support</li> <li>• Includes 13 essential elements</li> </ul>
Centering Parenting	<ul style="list-style-type: none"> <li>• Source of information                             <ul style="list-style-type: none"> <li>○ <a href="https://www.centeringhealthcare.org/pages/centering-model/parenting-overview.php">https://www.centeringhealthcare.org/pages/centering-model/parenting-overview.php</a></li> </ul> </li> <li>• Group setting with 6-7 mother/child dyads facilitated by a Healthcare Provider</li> <li>• Six to seven sessions within baby's first year</li> <li>• Care providers are credentialed in family medicine or are a team of pediatrics and women's health to provide this comprehensive care package</li> <li>• Includes well-woman care and well-baby care</li> <li>• Three main areas of focus                             <ul style="list-style-type: none"> <li>○ health assessment</li> <li>○ education</li> <li>○ support</li> </ul> </li> <li>• Training of health care provider is available</li> </ul>
Centering Pregnancy	<ul style="list-style-type: none"> <li>• Source of information                             <ul style="list-style-type: none"> <li>○ <a href="https://www.centeringhealthcare.org/pages/centering-model/pregnancy-overview.php">https://www.centeringhealthcare.org/pages/centering-model/pregnancy-overview.php</a></li> </ul> </li> <li>• Eight to twelve women with similar gestational ages meet in group facilitated by health care provider</li> <li>• Three main areas of focus                             <ul style="list-style-type: none"> <li>○ health assessment</li> <li>○ education</li> <li>○ support</li> </ul> </li> <li>• 10 sessions throughout pregnancy and early postpartum</li> <li>• The healthcare provider within the group space completes a physical health assessment for each woman during the session</li> </ul>
Chicago Parenting Program	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://www.chicagoparentprogram.org/blog/wp-content/uploads/cpp_prevention_science.pdf">http://www.chicagoparentprogram.org/blog/wp-content/uploads/cpp_prevention_science.pdf</a></li> </ul> </li> <li>• Developed by Rush University</li> <li>• Based on Webster-Stratton model (Incredible Years)</li> <li>• Goals: health promotion and prevention program</li> </ul>

**APPENDIX Exhibit D.1: Descriptions of Family Support Program Models and Approaches Supported by LAUNCH Grantees**

Family Support Model	Goals and Source of Information on Model
	<ul style="list-style-type: none"> <li>• Topics include child-centered time, the importance of family routines and traditions, using praise and encouragement, using rewards for challenging behavior, setting clear limits, following through on limits, establishing consequences, using ignore and distract strategies, time-out, stress management, and problem-solving skills with adults.</li> <li>• Weekly group sessions with video material, discussion, practice assignments</li> <li>• 11 weekly meetings and one booster session about 1-2 months later</li> <li>• Sessions take place at agency-based day care centers</li> </ul>
Circle of Security	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://circleofsecurity.net/">http://circleofsecurity.net/</a></li> </ul> </li> <li>• Visual based approach to improving parenting with a foundation in attachment theory</li> <li>• Training is for practitioners on how to use COS "protocol"</li> </ul>
Effective Black Parenting Program	<ul style="list-style-type: none"> <li>• Source of information                             <ul style="list-style-type: none"> <li>○ <a href="http://www.ciccparenting.org/cicc_EBPdesc_312.aspx">http://www.ciccparenting.org/cicc_EBPdesc_312.aspx</a></li> </ul> </li> <li>• Culturally relevant skill building program for African American parents</li> <li>• Groups meet in community settings (e.g., schools, churches, agencies)</li> <li>• 15-30 parents meet in small groups for 15 30-hour sessions</li> <li>• Trained instructor facilitates sessions</li> <li>• Goals: improved parent-child relationships, increase quality of parenting</li> </ul>
Incredible Years	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://www.incredibleyears.com/index.asp">http://www.incredibleyears.com/index.asp</a></li> <li>○ <a href="http://www.episcenter.psu.edu/ebp/incredible">http://www.episcenter.psu.edu/ebp/incredible</a></li> </ul> </li> <li>• Developed by Dr. Carolyn Webster-Stratton, Professor and Director of the Parenting Clinic at the University of Washington</li> <li>• Three comprehensive, multifaceted, and developmentally based curricula for parents, teachers, and children.</li> <li>• BASIC parent series has separate programs for parents with children ages 0-2, 3-6, 6-12; emphasizes parenting skills known to promote children's social competence and reduce behavior problems.</li> <li>• ADVANCE parent series emphasizes interpersonal skills.</li> <li>• Group-based programs with leaders who must have a course in child development and should have training in social learning theory</li> <li>• Teacher training emphasizes effective classroom management skills.</li> </ul>

**APPENDIX Exhibit D.1: Descriptions of Family Support Program Models and Approaches Supported by LAUNCH Grantees**

Family Support Model	Goals and Source of Information on Model		
	<ul style="list-style-type: none"> <li>• Child program (“Dinosaur Curriculum”) emphasizes skills such as emotional literacy, empathy or perspective taking, friendship skills, anger management, interpersonal problem-solving, school rules and how to be successful at school. One version of the curriculum is a “pull out” treatment program for small groups of children (4-6 per group) presenting with conduct problems. The other is a classroom-based preventive program designed to be delivered to all students two to three times a week.</li> <li>• Goals: promote children’s social competence, emotional regulation and problem solving skills and reduce their behavior problems</li> </ul>		
Newborn Behavioral Observation	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://www.brazelton-institute.com/clnbas.html">http://www.brazelton-institute.com/clnbas.html</a></li> </ul> </li> <li>• Influenced by T. Berry Brazelton and modeled after Neonatal Behavioral Assessment Scale (NBAS)</li> <li>• An observational system containing 18 neurobehavioral observations conducted jointly by clinician and parent targeting children from birth to 3<sup>rd</sup> month of life</li> <li>• Designed to help both parents and pediatric professionals</li> <li>• Observational system can be integrated into home visits</li> </ul>		
Nurturing Parenting Program	<ul style="list-style-type: none"> <li>• Source of information                             <ul style="list-style-type: none"> <li>○ <a href="http://www.nurturingparenting.com/">http://www.nurturingparenting.com/</a></li> </ul> </li> <li>• Developed by Stephen J. Bavolek, Ph.D.</li> <li>• Family centered program to foster parenting skills and decrease abuse and neglect</li> <li>• Four levels of prevention: 1) Primary: education, 2) Secondary: intervention, 3) Tertiary: treatment, 4) Comprehensive: program</li> <li>• Targeting children from birth to age 18</li> <li>• Offered in group, home, or combination of settings</li> </ul> <table border="1" data-bbox="464 976 1925 1187"> <tr> <td data-bbox="464 976 772 1187">ABC's for Parents (Primary level)</td> <td data-bbox="772 976 1925 1187"> <ul style="list-style-type: none"> <li>• Source of information:                                     <ul style="list-style-type: none"> <li>○ <a href="http://www.familyconnectionsco.org/nurturing_parenting_program">http://www.familyconnectionsco.org/nurturing_parenting_program</a></li> </ul> </li> <li>• For parents and their children ages 4-8</li> <li>• Meetings scheduled once a week for 7 weeks</li> <li>• Supports come in group discussions, interactive activities, and video format</li> <li>• Goal: promotion of success in school</li> </ul> </td> </tr> </table>	ABC's for Parents (Primary level)	<ul style="list-style-type: none"> <li>• Source of information:                                     <ul style="list-style-type: none"> <li>○ <a href="http://www.familyconnectionsco.org/nurturing_parenting_program">http://www.familyconnectionsco.org/nurturing_parenting_program</a></li> </ul> </li> <li>• For parents and their children ages 4-8</li> <li>• Meetings scheduled once a week for 7 weeks</li> <li>• Supports come in group discussions, interactive activities, and video format</li> <li>• Goal: promotion of success in school</li> </ul>
ABC's for Parents (Primary level)	<ul style="list-style-type: none"> <li>• Source of information:                                     <ul style="list-style-type: none"> <li>○ <a href="http://www.familyconnectionsco.org/nurturing_parenting_program">http://www.familyconnectionsco.org/nurturing_parenting_program</a></li> </ul> </li> <li>• For parents and their children ages 4-8</li> <li>• Meetings scheduled once a week for 7 weeks</li> <li>• Supports come in group discussions, interactive activities, and video format</li> <li>• Goal: promotion of success in school</li> </ul>		
Parent Child Interaction Therapy (PCIT)	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://pcit.phhp.ufl.edu/">http://pcit.phhp.ufl.edu/</a></li> </ul> </li> <li>• Developed by Sheila Eyberg while at Oregon Health Sciences University (OHSU) beginning in the late 1960s</li> <li>• Treatment for conduct-disordered young children based on attachment and social learning theory</li> <li>• Parents meet individually with therapists and are taught skills to establish a nurturing and secure relationship with their child while increasing their child’s prosocial behavior and decreasing negative behavior</li> </ul>		

APPENDIX Exhibit D.1: Descriptions of Family Support Program Models and Approaches Supported by LAUNCH Grantees	
Family Support Model	Goals and Source of Information on Model
	<ul style="list-style-type: none"> <li>• Not time-limited, training ends when parents demonstrate mastery and children reach level of compliance                             <ul style="list-style-type: none"> <li>○ Structure includes three types of sessions: assessment, teaching with modeling and roleplaying, coaching with bug-in-ear feedback approach during parent-child interactions</li> </ul> </li> </ul>
Parenting Wisely	<ul style="list-style-type: none"> <li>• Source of information                             <ul style="list-style-type: none"> <li>○ <a href="http://www.parentingwisely.com/">http://www.parentingwisely.com/</a></li> <li>○ <a href="http://www.familyworksinc.com/">http://www.familyworksinc.com/</a></li> </ul> </li> <li>• <a href="#"><u>Online or CD-ROM course delivery format for parents (to purchase by parents directly or to access through an agency with course subscriptions)</u></a></li> <li>• Targeting children ages 3-18</li> <li>• lessen drug and alcohol abuse in youth, school and homework problems, delinquency and other problem behaviors, family conflict, and more"</li> </ul>
Positive Behavior Support	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://www.apbs.org/new_apbs/intro_presentations.aspx">http://www.apbs.org/new_apbs/intro_presentations.aspx</a></li> </ul> </li> <li>• Based on research from social, behavioral, and biomedical sciences</li> <li>• Multi-tiered model of support established for parents and school-personnel</li> <li>• Goals: reduce behavioral challenges, increase independence, ensure the development of constructive behaviors</li> </ul>
Positive Parenting Program (PPP)	<ul style="list-style-type: none"> <li>• Source of information                             <ul style="list-style-type: none"> <li>○ <a href="http://www.triplep-america.com/">http://www.triplep-america.com/</a></li> </ul> </li> <li>• Based on self-regulation and also draws on social learning, cognitive-behavioral and developmental theory</li> <li>• Five levels of programs with increasing intensity based on individual family needs</li> <li>• Goals: prevention of social, emotional and behavioral problems in childhood, prevention of child maltreatment, strengthening of parenting and parental confidence</li> <li>• Training is targeted to individuals and organizations that serve families and consists of multiple courses</li> <li>• enrollees are required to have degree in health, education, or social services and to have some knowledge in child or adolescent development</li> </ul>
Primary Project	<ul style="list-style-type: none"> <li>• Source of information                             <ul style="list-style-type: none"> <li>○ <a href="http://www.childrensinstitute.net/programs/primary-project">http://www.childrensinstitute.net/programs/primary-project</a></li> </ul> </li> <li>• School-based program for teachers and parents of children, PK-Grade 3, experiencing problems in school</li> <li>• Goals: reduce social, emotional, and school adjustment difficulties, and enhance learning skills</li> <li>• Components include: screening/detection, child engages in weekly meetings with trained paraprofessionals</li> <li>• Paraprofessionals receive initial training and ongoing consultation from a school mental health professional</li> </ul>

**APPENDIX Exhibit D.1: Descriptions of Family Support Program Models and Approaches Supported by LAUNCH Grantees**

Family Support Model	Goals and Source of Information on Model				
<p>Strengthening Families Program</p>	<ul style="list-style-type: none"> <li>• Source of information                             <ul style="list-style-type: none"> <li>○ <a href="http://www.strengtheningfamiliesprogram.org/">http://www.strengtheningfamiliesprogram.org/</a></li> </ul> </li> <li>• Developed by Dr. Kumpfer and Dr. Molgaard , Iowa State University in 1980s and has been modified in length and format over the years</li> <li>• Goals: reduce problem behaviors, delinquency, and alcohol and drug abuse in children; improve social competencies and school performance</li> </ul> <table border="1" data-bbox="464 516 1925 831"> <tr> <td data-bbox="464 516 772 831"> <p>Parent Cafés</p> </td> <td data-bbox="772 516 1925 831"> <ul style="list-style-type: none"> <li>• Source of information:                                     <ul style="list-style-type: none"> <li>○ <a href="http://www.cssp.org/community/constituents-co-invested-in-change/community-and-parent-cafes">http://www.cssp.org/community/constituents-co-invested-in-change/community-and-parent-cafes</a></li> <li>○ <a href="http://www.strengtheningfamiliesillinois.org/downloads/Parent%20Cafe%20FAQ%20General.pdf">http://www.strengtheningfamiliesillinois.org/downloads/Parent%20Cafe%20FAQ%20General.pdf</a></li> </ul> </li> <li>• Developed by Strengthening Families and based on World Café model</li> <li>• Parent-lead group with aim of preventing child abuse and neglect</li> <li>• Groups are formed within pre-existing contexts (e.g., daycare centers, churches, etc.)</li> <li>• Discussion centered around “protective factors”</li> </ul> </td> </tr> <tr> <td data-bbox="464 831 772 1076"> <p>Strengthening Families Program: Family Skills</p> </td> <td data-bbox="772 831 1925 1076"> <ul style="list-style-type: none"> <li>• Source of information:                                     <ul style="list-style-type: none"> <li>○ <a href="http://www.strengtheningfamilies.org/html/programs_1999/06_SFP.html">http://www.strengtheningfamilies.org/html/programs_1999/06_SFP.html</a></li> </ul> </li> <li>• 14 2-hour session training program</li> <li>• Three courses on parent skills, children’s skills and family life skills</li> <li>• Parents and children take one course separately and one together</li> <li>• Goals: prevention of substance abuse, conduct disorders, and depression in children and parents; improving parenting skills and family relationships</li> </ul> </td> </tr> </table>	<p>Parent Cafés</p>	<ul style="list-style-type: none"> <li>• Source of information:                                     <ul style="list-style-type: none"> <li>○ <a href="http://www.cssp.org/community/constituents-co-invested-in-change/community-and-parent-cafes">http://www.cssp.org/community/constituents-co-invested-in-change/community-and-parent-cafes</a></li> <li>○ <a href="http://www.strengtheningfamiliesillinois.org/downloads/Parent%20Cafe%20FAQ%20General.pdf">http://www.strengtheningfamiliesillinois.org/downloads/Parent%20Cafe%20FAQ%20General.pdf</a></li> </ul> </li> <li>• Developed by Strengthening Families and based on World Café model</li> <li>• Parent-lead group with aim of preventing child abuse and neglect</li> <li>• Groups are formed within pre-existing contexts (e.g., daycare centers, churches, etc.)</li> <li>• Discussion centered around “protective factors”</li> </ul>	<p>Strengthening Families Program: Family Skills</p>	<ul style="list-style-type: none"> <li>• Source of information:                                     <ul style="list-style-type: none"> <li>○ <a href="http://www.strengtheningfamilies.org/html/programs_1999/06_SFP.html">http://www.strengtheningfamilies.org/html/programs_1999/06_SFP.html</a></li> </ul> </li> <li>• 14 2-hour session training program</li> <li>• Three courses on parent skills, children’s skills and family life skills</li> <li>• Parents and children take one course separately and one together</li> <li>• Goals: prevention of substance abuse, conduct disorders, and depression in children and parents; improving parenting skills and family relationships</li> </ul>
<p>Parent Cafés</p>	<ul style="list-style-type: none"> <li>• Source of information:                                     <ul style="list-style-type: none"> <li>○ <a href="http://www.cssp.org/community/constituents-co-invested-in-change/community-and-parent-cafes">http://www.cssp.org/community/constituents-co-invested-in-change/community-and-parent-cafes</a></li> <li>○ <a href="http://www.strengtheningfamiliesillinois.org/downloads/Parent%20Cafe%20FAQ%20General.pdf">http://www.strengtheningfamiliesillinois.org/downloads/Parent%20Cafe%20FAQ%20General.pdf</a></li> </ul> </li> <li>• Developed by Strengthening Families and based on World Café model</li> <li>• Parent-lead group with aim of preventing child abuse and neglect</li> <li>• Groups are formed within pre-existing contexts (e.g., daycare centers, churches, etc.)</li> <li>• Discussion centered around “protective factors”</li> </ul>				
<p>Strengthening Families Program: Family Skills</p>	<ul style="list-style-type: none"> <li>• Source of information:                                     <ul style="list-style-type: none"> <li>○ <a href="http://www.strengtheningfamilies.org/html/programs_1999/06_SFP.html">http://www.strengtheningfamilies.org/html/programs_1999/06_SFP.html</a></li> </ul> </li> <li>• 14 2-hour session training program</li> <li>• Three courses on parent skills, children’s skills and family life skills</li> <li>• Parents and children take one course separately and one together</li> <li>• Goals: prevention of substance abuse, conduct disorders, and depression in children and parents; improving parenting skills and family relationships</li> </ul>				
<p>Trauma Recovery and Empowerment Model Support (TREM)</p>	<ul style="list-style-type: none"> <li>• Source of information:                             <ul style="list-style-type: none"> <li>○ <a href="http://nrepp.samhsa.gov/ViewIntervention.aspx?id=158">http://nrepp.samhsa.gov/ViewIntervention.aspx?id=158</a></li> <li>○ <a href="http://knowledgex.camh.net/amhspecialists/specialized_treatment/trauma_treatment/treating_subuse_ptsd/pages/current_models.aspx">http://knowledgex.camh.net/amhspecialists/specialized_treatment/trauma_treatment/treating_subuse_ptsd/pages/current_models.aspx</a></li> </ul> </li> <li>• Developed by Maxine Harris and Roger Fallot at Community Connections, Washington, DC</li> <li>• Group based clinical intervention implemented in a variety of settings (e.g., residential substance abuse, health clinics, etc.)</li> <li>• Goals: trauma recovery for women who have experienced sexual and physical abuse</li> <li>• Based on cognitive restructuring, psychoeducational, and skills-training techniques</li> <li>• 24-29 group sessions</li> </ul>				

APPENDIX Exhibit D.2: LAUNCH Family Support Program Models: Evidence of Effectiveness <sup>1</sup>		
Name	Focal Outcomes	Findings
<b>Substantial Evidence</b>		
Incredible Years Series (Parent, Child, and Teacher programs)	Education; family/relationships; mental health; social functioning; violence	CEBC: Rating = 1 Child Trends: Mixed findings PPN: Evidence Level = Proven NREPP: Positive results for several outcomes; [Quality of research Quality = 3.6-3.7/4.0] <ul style="list-style-type: none"> <li>• 12 randomized trials of <i>the parenting programs</i> by Webster-Stratton &amp; colleagues and numerous independent replications</li> <li>• 3 randomized trials of the child treatment program with diagnosed children and 2 randomized trials of the prevention program</li> <li>• 1 randomized trial of the teacher classroom management program with diagnosed children by Webster-Stratton &amp; colleagues and 2 randomized trials of the prevention program with high risk populations</li> </ul>
Parent Child Interaction Therapy (PCIT)	Family/relationships; mental health; Social functioning; trauma/injuries; violence	CEBC: Rating = 1 NREPP: Positive results for some outcomes; [Quality of research = 3.2-3.3/4.0]
Strengthening Families Program *Strengthening Families Program: Family Skills	Family/relationships; mental health; social functioning	*Strengthening Families Program – Family Skills: NREPP: Positive results for several outcomes; [Quality of research = 3.1/4.0]
Primary Project	Education; mental health; social functioning; violence	NREPP: Positive results for several outcomes; [Quality of research = 3.6-3.7/4.0]
Nurturing Parenting Program *ABC's for Parents <sup>2</sup>	Nurturing Parent Programs: Parenting skills, abuse and neglect; ABC's: School success	Nurturing Parenting Program: National study by NIMH national study (1983-85): positive results in decrease of parental abuse NREPP: Positive results for several outcomes; [Quality of research = 3.1/4.0] *ABC's: Limited research available

<sup>1</sup> See Appendix Exhibit B.3 for explanation of evidence standards

<sup>2</sup> Nurturing Parenting Program is a 4-tiered model. ABC's for Parents is offered in the primary prevention level.

APPENDIX Exhibit D.2: LAUNCH Family Support Program Models: Evidence of Effectiveness <sup>1</sup>		
Name	Focal Outcomes	Findings
Positive Parenting Program (PPP) <sup>3</sup>	Social, emotional and behavioral problems	Individual studies and syntheses report positive results: RCT <sup>4</sup> with large effects on several outcomes across tiers Meta-analysis <sup>5</sup> with 15 studies implementing tier 4 found positive effects
<b>Emerging Evidence</b>		
Circle of Security	Prevention of insecure attachment and child mental disorders	CEBC: Rating = 3
Parenting Wisely	Family/relationships; social functioning	CEBC: Rating = 3 NREPP: Positive results for some outcomes; [Quality of research = 2.8/4.0]
Trauma Recovery and Empowerment Model Support (TREM)	Alcohol, drugs, mental health, social functioning, trauma/injuries	NREPP: Positive results for several outcomes; [Quality of research = 2.7-2.9/4.0]
<b>Limited/No Evidence</b>		
Centering Health Care Institute Model: * CenteringParenting * CenteringPregnancy	Health, education, parental support	*CenteringPregnancy: results from individual studies show positive effects for knowledge of pregnancy <sup>6</sup> , health care compliance, and rates of preterm births <sup>7</sup> *CenteringParenting: no formal evaluations have been found
Newborn Behavioral Observation	Neurobehavioral development	Ongoing evaluation of effectiveness in 97 communities across Massachusetts. Study is currently funded by the Noonan Foundation
Positive Behavior Support	Reduction of behavioral challenges, increase in independence	PBIS has been adopted in a variety of settings: School-based behavioral interventions, home visiting programs, juvenile justice services, etc. No formal evaluations in context of family support programs have been found

<sup>3</sup> LAUNCH programs implement Tier 2 of Positive Parenting Program

<sup>4</sup> Prinz, R., Sanders, M., Shapiro, C., Whitaker, D., & Lutzker, J. (2009). Population-Based Prevention of Child Maltreatment: The U.S. Triple P System Population Trial. *Prevention Science, 10*(1), 1-12

<sup>5</sup> de Graaf I, Speetjens P, Smit F, de Wolff M, Tavecchio L. (2008). Effectiveness of the Triple P Positive Parenting Program on behavioral problems in children: A meta-analysis. *Behavioral Modification, 32*(5), 714–735.

<sup>6</sup> Baldwin K. (2006). Comparison of selected outcomes of CenteringPregnancy versus traditional prenatal care. *Journal of Midwifery & Women's Health, 51*(4), 266-272.

<sup>7</sup> Grady, M. A. and Bloom, K. C. (2004). Pregnancy Outcomes of Adolescents Enrolled in a CenteringPregnancy Program. *Journal of Midwifery & Women's Health, 49*, 412–420.

APPENDIX Exhibit D.2: LAUNCH Family Support Program Models: Evidence of Effectiveness<sup>1</sup>

Name	Focal Outcomes	Findings
Chicago Parenting Program	Health promotion and prevention	Results from individual studies are available
Effective Black Parenting program	Parental rejection, family relationships, child behavior	1985-1988 NIDA-sponsored evaluation resulted in risk factor reduction and protective factor enhancement <sup>8</sup>
Strengthening Families Program *Parent Cafés	Family/relationships; mental health; social functioning	Limited research available

<sup>8</sup> Myers, H. F., Alvy, K. T., Arlington, A., Richardson, M. A., Marigna, M., Huff, R., Main, M. and Newcomb, M. D. (1992). The impact of a parent training program on inner-city African-American families. *Journal of Community Psychology*, 20, 132-147.

**APPENDIX Exhibit D.3: Rating Criteria for Evidence of Effectiveness of Home Visiting Program Models**

Source of Rating	Description of Rating Criteria
<p><b>SAMHSA</b> National Registry of Evidence-based Programs and Practices (NREPP)</p>	<p>Selected reviewers focus on quality of research and report key findings within an intervention summary.</p> <ul style="list-style-type: none"> <li>• Quality of research: Reviewers use a scale of 0.0 to 4.0 (4.0 = highest rating) and consider reliability of measures, validity of measures, intervention fidelity, missing data and attrition, potential confounding variables, appropriateness of analysis</li> <li>• Report of key findings: Reviewers report a summary of results across individual evaluations per outcome of interest.</li> </ul>
<p>Promising Practices Network (PPN)</p>	<p><b>Proven:</b></p> <ul style="list-style-type: none"> <li>• Program must directly impact PPN identified indicators</li> <li>• At least one outcome is changed by at least 20% or 0.25 standard deviations</li> <li>• At least one outcome with a substantial effect size is statistically significant at the 5% level</li> <li>• Study design uses an experimental or quasi-experimental design</li> <li>• Sample size of evaluation exceeds 30 in treatment and comparison groups</li> <li>• Program evaluation is publicly available</li> </ul> <p><b>Promising:</b></p> <ul style="list-style-type: none"> <li>• Program impacts an intermediary outcome for which there is evidence that it is associated with one of the PPN indicators</li> <li>• Outcome change is significant at the 10% level</li> <li>• Change in outcome is more than 1%</li> <li>• Study has a comparison group, but it may exhibit some weaknesses</li> <li>• Sample size of evaluation exceeds 10 in both the treatment and comparison groups</li> <li>• Program evaluation is publicly available</li> </ul> <p><b>Not Listed on the Site:</b></p> <ul style="list-style-type: none"> <li>• Does not meet qualifications for promising category</li> </ul>
<p>California Evidence-Based Clearinghouse (CEBC)</p>	<p><b>(1) Well-Supported:</b></p> <ul style="list-style-type: none"> <li>• No evidence suggesting program causes harm on recipients compared to its likely benefits</li> <li>• Program has a book, manual, etc. describing specific program components and method for administering</li> <li>• At least two rigorous randomized controlled trials (RCTs) settings demonstrate the practice to be superior to comparisons. RCTs have been reported in published, peer-reviewed literature</li> <li>• Sustained effects for one year post-treatment</li> <li>• Use of valid, reliable outcome measures administered consistently and accurately</li> <li>• If multiple outcome studies have been conducted, the overall weight of the evidence supports the benefit of the practice</li> </ul>

**APPENDIX Exhibit D.3: Rating Criteria for Evidence of Effectiveness of Home Visiting Program Models**

Source of Rating	Description of Rating Criteria
	<p><b>(2) Supported:</b></p> <ul style="list-style-type: none"> <li>• No evidence suggesting program causes harm on recipients compared to its likely benefits</li> <li>• Program has a book, manual, etc. describing specific program components and method for administering</li> <li>• At least one rigorous randomized controlled trial (RCTs) demonstrates the practice to be superior to comparisons. RCTs have been reported in published, peer-reviewed literature.</li> <li>• Sustained effects for 6 months post-treatment</li> <li>• Use of valid, reliable outcome measures administered consistently and accurately</li> <li>• If multiple outcome studies have been conducted, the overall weight of the evidence supports the benefit of the practice</li> </ul> <p><b>(3) Promising:</b></p> <ul style="list-style-type: none"> <li>• No evidence suggesting program causes harm on recipients compared to its likely benefits</li> <li>• Program has a book, manual, etc. describing specific program components and method for administering</li> <li>• At least one study utilizing some form of control has shown the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice. The study has been reported in published, peer-reviewed literature</li> <li>• If multiple outcome studies have been conducted, the overall weight of evidence supports the benefit of the practice</li> </ul>
<p><b>Child Trends</b></p>	<p><b>Found to Work:</b></p> <ul style="list-style-type: none"> <li>• Programs in this category have <i>positive and significant</i> impacts on a particular infant, child, or youth outcome</li> </ul> <p><b>Mixed Findings:</b></p> <ul style="list-style-type: none"> <li>• Programs in this category have <i>varied impacts</i> either on particular outcomes or at different times or for varied subgroups</li> <li>• For example, a program that results in significant improvements in behavior problems at post-test but has no impact at a one-year follow-up would be rated as having "mixed findings"</li> <li>• A program that works for one subgroup of participants but not for another subgroup (on a particular outcome) would also receive a "mixed findings" rating</li> </ul> <p><b>Not Proven to Work:</b></p> <ul style="list-style-type: none"> <li>• Programs in this category have <i>non-significant</i> or <i>marginally significant</i> impacts on particular child or youth outcomes</li> </ul>

## Appendix E: Description of the Designs for the LAUNCH Special Studies

**Appendix E.1. Description of the Designs for the LAUNCH Special Studies**

Site/ Study	Research Question	Outcome Measure	Sample/Sample Size	Design	Expected Date for Impact Results
1 Kansas— Finney County (Cohort 2)	What is the impact of the LAUNCH-supported child and family services on children’s school readiness?	State-developed child development checklist (9 domains), administered pre-post during preschool year	At-risk 4-year-olds in state pre-kindergarten program Approximately 100 preschool children/year in programs in LAUNCH communities and 100 in programs in each non-LAUNCH community	Comparison of children in state pre-kindergarten program in LAUNCH counties vs. children in same program in 1-3 comparison counties.  Study combines 4 cohorts of children (2010 – 2014).  5 years of program-level baseline measures (average child readiness scores for programs pre-LAUNCH)	Late fall, 2014
2: Massachusetts - Boston (Cohort 2)	What is the impact of the LAUNCH-supported services for families and children on the rate of reported cases of child maltreatment?	State Child Protective Services database	19 census tracts in LAUNCH community and a sample of matched census tracts outside of LAUNCH community	Comparison of rates of maltreatment over time in LAUNCH census tracts and non-LAUNCH census tracts.  Short interrupted time sample with multiple baseline (pre-LAUNCH years) and multiple years during LAUNCH.	Late fall, 2014
3i California-East Oakland (Cohort 2)	What is the impact of the LAUNCH-supported services for families and children on kindergarten entry readiness scores?	Child assessment completed by kindergarten teachers as part of LAUNCH special study  Parent survey on parent-child relationship, understanding of child development, parent mental health	200 kindergarten children in 9 elementary schools in the school district in the LAUNCH community	Comparison of average kindergarten readiness scores for children entering kindergarten from LAUNCH zip codes and children in same schools from non-LAUNCH zip codes.  Baseline: fall 2011; LAUNCH: fall 2013	Late fall, 2013
3ii California-East Oakland (Cohort 2)	What is the impact of the LAUNCH-supported services for families and children on student achievement in grade 2?	Grade 2 CA Standards Test (CST)  For ELs, CA English Language Development Test (CELDT)  % students with identified special needs, % students suspended, % retained in grade	2 <sup>nd</sup> grade students   9 elementary schools (sample size not known)	Comparison of average achievement scores for children from LAUNCH zip codes and children in same schools from non-LAUNCH zip codes.  Baseline: 2010- 2011; LAUNCH: 2013 - 2014	Late fall, 2014

## Appendix E.1. Description of the Designs for the LAUNCH Special Studies

Site/ Study	Research Question	Outcome Measure	Sample/Sample Size	Design	Expected Date for Impact Results
4i Wisconsin-Milwaukee (Cohort 2)	What is the impact of the LAUNCH-supported services for families and children on readiness at kindergarten entry?	District administered kindergarten assessment: Measures of Academic Progress (MAP) (literacy & numeracy)	TBD	Comparison of trend lines for children from LAUNCH zip codes and children from non-LAUNCH zip codes in the same elementary schools across pre-LAUNCH and LAUNCH years.  Baseline: 2011; LAUNCH: 2012-2014	Spring, 2015
4ii Wisconsin-Milwaukee (Cohort 2)	What is the impact of the LAUNCH-supported services for families and children on children's academic outcomes in grade 1?	District administered kindergarten assessment: Measures of Academic Progress (MAP) (literacy & numeracy), attendance, suspensions	TBD	Comparison of outcomes for children from LAUNCH zip codes and children from non-LAUNCH zip codes in the same elementary schools across pre-LAUNCH and LAUNCH years.  Baseline: 2011; LAUNCH: 2012-2014	Spring, 2015
5i Red Cliff (Cohort 1)	What is the impact of the LAUNCH-supported services for families and children on the developmental status and school readiness of children at ages 1 - 5?	Assessments administered by early childhood program:  Preschool: PPVT, Social Skills Rating System, Boehm-3 Preschool  I/T: Bayley Scales	Between 32 and 50 children assessed in annual cohort. (Sample represents > 90% of children in this age group in the tribal community at each time point.)	Time lag design comparing children's developmental status pre-LAUNCH and during LAUNCH.  Baseline: 2005-06; LAUNCH: 2006 – 2013  Developmental data for 4 & 5 year olds will be augmented with data from 1-3 year olds beginning in 2009/2010.	Spring, 2014
5ii Red Cliff (Cohort 1)	What is the impact of the LAUNCH-supported services for families, children and schools on student academic outcomes in grades K – 3 (ages 6 – 8 years)?	District data on grades, state proficiency test (grade 3), attendance, special needs	Sample size TBD. Sample will represent > 90% of children in this age group in the tribal community	Time lag design comparing children's academic outcomes pre-LAUNCH and during LAUNCH  Baseline: 2005-06; LAUNCH: 2006 – 2013	Spring, 2014

**Appendix E.1. Description of the Designs for the LAUNCH Special Studies**

Site/ Study	Research Question	Outcome Measure	Sample/Sample Size	Design	Expected Date for Impact Results
6i Maine- Washington County (Cohort 1)	What is the impact of the LAUNCH-supported early intervention services for families and children on the birth outcomes of newborns and their mothers?	Birth weight (low and very low birth weight babies) and other birth outcomes from state databases	LAUNCH county and matched comparison county	Short interrupted time sample following trends over 3 years pre-LAUNCH and 4 years of LAUNCH  Baseline: 2006 – 2008; LAUNCH: 2009 - 2013	Late fall, 2013
6iii Maine- Washington County (Cohort 1)	What is the impact of LAUNCH-supported early intervention services on the health outcomes of babies born to opiate dependent, on the well-being and perceptions of the mothers, and on use and costs of acute health care?	Primary data collection involving interviews with mothers multiple times pre- and postnatally	Opiate-dependent mothers who receive LAUNCH support services pre- and postnatally and similar mother who experience the current standard of care	Comparison of outcomes for two groups of mothers during 2012-13	Spring, 2014