

IMPLEMENTATION OF  
PROJECT LAUNCH:  
Cross-Site Evaluation  
Findings, Volume I





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CROSS-SITE EVALUATION FINDINGS, VOLUME I

**OPRE Report # 2014-87**

**December 2014**

Margaret K. Gwaltney, Barbara Goodson, Sue Pfefferle, and Deborah Klein Walker, Abt Associates

Submitted to:  
Laura Hoard, Project Officer  
Office of Planning, Research and Evaluation  
Administration for Children and Families  
U.S. Department of Health and Human Services

Contract No. HHSP233200800591G

Project Director: Margaret Gwaltney  
Abt Associates  
55 Wheeler Street  
Cambridge, MA 02138

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## 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) to promote the social-emotional, cognitive, physical, and behavioral health of children from birth to eight years of age (SAMHSA, 2008). Grantees are funded to pursue goals of improving early childhood systems and services in pilot communities selected because of a high need for services for families and children with significant risk factors, insufficient services, and significant health and economic disparities.<sup>1</sup>

This volume of the findings of the Cross-Site Evaluation (CSE) of Project LAUNCH presents results of the process evaluation. The CSE covers findings through 2013 for the first three cohorts of LAUNCH grantees: 6 grantees in Cohort 1 (funded in 2008), 12 grantees in Cohort 2 (funded in 2009), and 6 grantees in Cohort 3 (funded in 2010).

The process evaluation uses descriptive analysis to summarize the extent to which the LAUNCH grantees succeeded in addressing three goals: improvements to the local child services system in the LAUNCH communities, improvements to the state child services system, and enhancements to the child and family services in the communities. Sources of data include annual interviews conducted by the CSE team with grantee staff and state and community partners, data on implementation of services and systems initiatives reported bi-annually by grantees, and grantee end-of-year program and evaluation reports. Key findings include:

- Partnership development and collaboration are common threads that run through the LAUNCH community systems initiatives and are central to the systems work of LAUNCH. This started with the Community Young Child Wellness Councils that all grantees formed of representatives from multiple agencies and sectors that served young children and their families.
- Community systems initiatives implemented by a majority of LAUNCH grantees included public awareness activities about developmental milestones and behavioral health for young children (92% of grantees); systems-wide workforce development around mental and behavioral health (79% of grantees); community-wide systems initiatives around developmental screening for children and maternal depression screening

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<sup>1</sup> In the pilot communities, LAUNCH grantees worked to increase access to screening, assessment, and referral to appropriate services for young children and their families; increase integration of mental and behavioral health in primary care and early childhood education settings, expand use of culturally-relevant, evidence-based prevention and wellness promotion practices; increase workforce knowledge of children's social and emotional development and preparation to deliver high quality care

(58% of grantees); and policy initiatives to improve care coordination and expand behavioral health services for at-risk families (54% of grantees).

- Grantees implemented activities within five core prevention and health promotion strategies. Nearly all grantees implemented enhancements to home visiting in their community, including expanding access, providing training, and funding trained mental health professionals to work with home visitors. The majority of grantees funded mental health consultation to early childhood education and care programs in their community and a majority of grantees undertook activities to bring behavioral health into primary care settings through provider training and by embedding a mental health specialist in the health setting.

After five years, Project LAUNCH has left a legacy in state and community systems and program services. LAUNCH has introduced new programs and enhanced existing programs, all with a focus on integration of behavioral health into the child and family services system. LAUNCH has also undertaken efforts to develop the infrastructure within state and local governments and support evidence-based service delivery that meets the comprehensive needs of at-risk children and their families. LAUNCH grantees are working to sustain the service enhancements and systems initiatives that they have introduced to ensure that the influence of LAUNCH has the potential to live beyond the original grant funding.

## EXECUTIVE SUMMARY

Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health) is a national grant program, administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). The program is grounded in research showing that children’s healthy development early in life is essential to their ability to thrive, learn, and succeed later as an adult. The likelihood of having delays in cognitive, language, or emotional development is high for children with risk factors such as poverty, presence of mental health issues in a parent or caregiver, low birth weight, child abuse and neglect, exposure to traumatic events or violence, and low maternal education (U.S. Department of Health and Human Services, 1999; Karoly, Kilburn, & Cannon, 2005; Barth et al., 2008). Investment in early childhood development services for these and other children has been shown to have substantial benefits, including better academic performance, reduced special education and welfare costs, decreased rates of involvement in the criminal justice system, and lower risk of substance abuse (NIHCM Foundation, 2005; Karoly, Kilburn, & Cannon, 2005).

Project LAUNCH has three guiding principles. First, the program assumes a *holistic perspective* to health that encompasses the physical, social, emotional, cognitive, and behavioral health of all children from birth to age eight. Second, the program employs an *ecological framework*, giving attention to all settings that influence children’s health and wellbeing: the family, home environment, school, pediatric care settings, neighborhood, and community. Third, the program takes a *public health approach*. It focuses on improving all systems that serve young children and their families and incorporates prevention and health promotion activities that encourage intervening early before problems occur.

In the first two years of Project LAUNCH (2008 and 2009), state maternal and child health and tribal agencies were the grant recipients. Most of the grant monies then went to a pilot community to pursue dual goals of improving systems and services for young children and their families. With the third cohort of grants (2010), Project LAUNCH funds were awarded directly to a local community organization, bypassing the state agency. Since then, two additional cohorts (2012, 2013) have received grant awards through their state agency for maternal and child health or mental health or a tribal government. Grantees in all cohorts are expected to use their funds to collaborate across early childhood systems and enhance existing infrastructures and early childhood programs at the state, tribal, and community levels.

In the early months of their grants, grantees conduct an environmental scan and develop a strategic plan for supporting systems changes and addressing service gaps. Grantees' strategic plans outline their plans to meet the following Project LAUNCH objectives:

- Increase the integration of mental and behavioral health into early childhood services, including home visiting, family strengthening and parent education, early childhood education and care, and primary care;
- Expand the use of culturally-relevant, evidence-based prevention and wellness promotion practices (EBPs) in home visiting, family strengthening and parent education, early childhood mental health consultation, and integration of behavioral health in primary care;
- Increase access to screening, assessment, and referral to appropriate services for young children and their families in a range of child-serving settings; and
- Improve coordination and collaboration across local, state, tribal and federal agencies serving young children and their families.

To achieve these objectives, grantees focus on five research-based prevention and promotion strategies:

1. Screening and assessment in a range of child-serving settings;
2. Integration of behavioral health into primary care settings;
3. Mental health consultation in early care and education;
4. Integration of mental and behavioral health into home visiting; and
5. Family strengthening and parent skills training.

As of Fall 2013, SAMHSA has funded 40 grantees in five cohorts: 2008, 2009, 2010, 2012, and 2013.<sup>2,3</sup> The grantees in Cohorts 1 and 2 include 16 states<sup>4</sup>, the

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<sup>2</sup> The six grants in Cohort 1 and twelve in Cohort 2 were awarded either to the state or territorial agency in charge of administering the Title V Maternal and Child Health program or to a tribal agency. The six grants in Cohort 3 were awarded to a local community agency or non-profit organization. The eleven grants in Cohort 4 and five grants in Cohort 5 were awarded either to the Title V or mental health agency within the state or to a tribal agency.

<sup>3</sup> Grantees in Cohorts 4 and 5 were recently funded when this report was written, and, therefore, data from these grantees are not included in this report.

<sup>4</sup> Grantees in Cohort 1 are Arizona, Maine, New Mexico, Red Cliff Band of Lake Superior Chippewas, Rhode Island, and Maine. Grantees in Cohort 2 are California, the District of Columbia, Illinois, Iowa, Kansas, Massachusetts, Michigan, New York,

District of Columbia, and a Native American tribe; grantees in Cohort 3 are 6 local communities; grantees in Cohort 4 include 5 tribes and 6 states<sup>5</sup>; and grantees in Cohort 5 are 4 states and 1 tribe<sup>6</sup>. Each Project LAUNCH grantee identifies a target community in which to implement evidence-based programs and services for young children and their families.

### Context for Project LAUNCH

The first three cohorts of Project LAUNCH grantees received funding at a time when states and communities were undergoing rapid policy and environmental changes. In 2008, the country was entering the worst recession since the Great Depression. States and communities were facing major budget issues and deep cuts in human services. At the same time, there was an emerging consensus that adverse childhood experiences have a significant effect on social and health outcomes. Additionally, a growing number of researchers and practitioners were now advocating for integrated primary and behavioral health services (Agency for Healthcare Research and Quality, 2012), especially in pediatric settings. Recent data also had shown that half of all lifetime cases of mental illness begin by age 18 (Kessler, 2005), and early identification and intervention were deemed imperative to address the potentially negative, long-term effects of mental health problems (National Research Council and Institute of Medicine, 2000; NIHCM Foundation, 2005; NIHCM Foundation, 2009).

Other developments for LAUNCH grantees were passage of the Affordable Care Act (ACA) and establishment of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program in 2010. While implementation of the ACA began after grantees in the first two cohorts received their awards, these grantees and those in later cohorts began to take advantage of the opportunity to invest in expanding models of care delivery encouraged by the ACA, such as patient-centered medical homes, and to link families to behavioral health services that were now more available because of mental health parity laws. The ACA also

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North Carolina, Ohio, Oregon, and Wisconsin. Cohort 3 grantees are Greely, Colorado; Plainville, Connecticut; Columbia, Missouri; New York, New York; Portland, Oregon; and El Paso, Texas.

<sup>5</sup> Grantees in Cohort 4 are Cherokee Nation (OK), Florida, Indiana, Maryland, Missouri, Muscogee Creek Nation (OK), New Hampshire, Nottawaseppi Huron Band of Potawatomi (MI), Pascua Yaqui Tribe (AZ), Pueblo of Laguna (NM), and Vermont.

<sup>6</sup> Cohort 5 grantees are Louisiana, New Jersey, Oklahoma, Standing Rock Sioux Tribe, and Tennessee.

included funding for MIECHV, which is implemented through a partnership between the Health Resources and Services Administration and the Administration for Children and Families. MIECHV provided funding to every state to plan implementation of home visiting programs. In 2011, additional funds were awarded to states by formula, and nine of these states also received competitive awards to expand and/or enhance the development of their home visiting programs.

### **Cross-Site Evaluation of Project LAUNCH**

The cross-site evaluation of Project LAUNCH describes program implementation, including changes in systems and services, and outcomes for children and families in the LAUNCH community. Six questions guide the overall cross-site evaluation. The first three questions, are addressed by this report on program implementation (Volume I), and the last three questions are addressed in a second report on outcomes (Volume II):

1. How has the local child services system changed during the Project LAUNCH grant implementation?
2. How has the state child services system changed during the Project LAUNCH grant implementation?
3. How have child and family services in the community been enhanced?
4. How has health and well-being improved for young children participating in LAUNCH-supported services?
5. How have knowledge and practices changed for providers of LAUNCH-supported services?
6. How have health and well-being improved for parents of children participating in LAUNCH-supported services?

This report (Volume I) presents findings that are cumulative, i.e., encompass data from multiple years of implementation by the Project LAUNCH grantees. It focuses on the first three questions above, using data from several sources: (a) annual interviews with grantee staff and state and community partners, (b) a review and analysis of services and systems data reported by grantees in a Web-based reporting system (Web portal), and (c) abstraction and analysis of data from grantees' annual end-of-year and evaluation reports.

For the first cohort of six grantees, this report represents data from all five years of funding. The report includes four years of data from the 12 grantees in

Cohort 2, and three years of data from the six grantees in Cohort 3. (The 11 grantees in Cohort 4 were completing their first grant year, and the 5 Cohort 5 grants had just been awarded and therefore are not included the report of findings from the cross-site evaluation [Volumes I and II].)

The main focus of this report (Volume I) is on the implementation of Project LAUNCH and on ways that the program has made a potentially lasting change to the early childhood services system. The report discusses Project LAUNCH-supported systems building initiatives within communities and states and describes the services implemented within each of the five prevention and promotion strategies for the first three grantee cohorts.

### **Project LAUNCH-Supported Systems Initiatives Within Communities**

LAUNCH grantees developed *community systems initiatives* to support, expand, and ultimately sustain service strategies implemented as part of their grant programs. Grantees focused on systems initiatives within six categories:

1. Partnership development;
2. Public awareness;
3. Workforce development;
4. Developmental screening;
5. Policy change/infrastructure development; and
6. Data/information system enhancements.

#### ***Partnership Development***

Partnership development and collaboration are common threads that run through all LAUNCH-supported community systems initiatives and are central to the work of Project LAUNCH. Project LAUNCH facilitated partnerships and collaboration by requiring each grantee to form a Community Young Child Wellness Council (CYCWC), comprising representatives from multiple agencies and sectors that serve young children and their families—health (including representatives from the private sector), mental health, child welfare, substance abuse prevention, early childhood education, and local education agencies (Head Start, Early Head Start and Part C). The role of the CYCWCs was to provide oversight for services and systems planning and project implementation.

Planning for systems activities was informed by current and past initiatives in each grantee's state and community—for example, the Early Childhood Comprehensive Systems (ECCS) program, health reform, Children's Cabinets and Commissions, as well as grassroots initiatives. In one Project LAUNCH community, for example, the CYCWC evolved from an existing regional planning network that focused on improving wellness of children and families in the LAUNCH community and surrounding areas. The CYCWC pursued initiatives that build on the network's earlier work.

A primary contribution of Project LAUNCH has been to serve as a catalyst for collaborative community initiatives around the social and emotional development of young children. Through the efforts of the CYCWCs, all LAUNCH communities worked to establish a common vision, language, and tools for use by early childhood providers and to promote attention to behavioral health in young children throughout the community and within policy arenas.

### *Public Awareness Initiatives*

Public awareness activities were implemented by LAUNCH grantees to inform the public about developmental milestones and behavioral health for young children. Most LAUNCH grantees (92%) developed some kind of public awareness or social marketing initiative at the community level. The initiatives included community-wide public awareness campaigns that sought to reach all stakeholders—parents/caregivers, providers, and policy makers—as well as dissemination of products—e.g., informational brochures, resource guides, or websites. Also included were participation in health fairs and Children's Mental Health Awareness Day and creation of social media sites (e.g., Pinterest) to share resources on social-emotional development.

The public awareness activities supported by Project LAUNCH were tailored to the information needs of the specific population served within each LAUNCH community. The main contribution of LAUNCH in public awareness was the use of multiple media strategies for educating parents and others about early childhood development and social-emotional health. Strategies included use of multiple approaches such as public service announcements, radio programs, insertion of information of screening on existing websites, and distribution of print materials.

### ***Workforce Development***

To address the need for a coordinated and trained workforce, many Project LAUNCH grantees (79%) took a systems approach to workforce development, focusing on building the capacity of all types of professionals who can potentially touch a child's life—for example, early care and education providers, teachers, child welfare workers, physicians, and home visitors—and imparting to them the knowledge, skills, and tools to prevent or identify problems early and address a family's needs. LAUNCH-supported workforce development initiatives have contributed to the field by targeting providers in these different child-serving systems, such as education, health, and social services, to create a common vision of child wellness, strengthen collaboration, expand screening for social-emotional health, and improve service quality.

### ***Screening Initiatives***

A majority (58%) of Project LAUNCH grantees developed community-wide systems initiatives around developmental screening for children, and several grantees also implemented maternal depression screening initiatives for mothers. These comprehensive systems approaches included (a) developing and implementing universal screening in multiple settings within communities, (b) implementing systems (e.g., electronic medical records) for tracking screening and referrals across services and reducing duplicate screenings, (c) training providers across service sectors to use standardized screening tools, and (d) exploring ways to maximize reimbursement for screening under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Collaboration and coordination with other screening initiatives, such as Help Me Grow, aided Project LAUNCH communities in increasing the visibility of their screening efforts. Additionally, screening initiatives within some communities informed state initiatives on developmental screening, helping state agencies to work on universal developmental screening programs with the intent of eventually implementing them statewide.

### ***Community Policy Change/System Infrastructure***

Although most LAUNCH-supported policy initiatives occurred at the state rather than the community level, 13 LAUNCH grantees (54%) undertook initiatives to strengthen or change the local system infrastructure or policies within their communities. The overarching goals of these initiatives were to improve care coordination and expand behavioral health services for at-risk families.

LAUNCH's focus on cross-systems work, especially through the CYCWCs, enabled communities to work on developing policies to improve the lives of children in their communities and even beyond. Diversity of perspectives, facilitated by CYCWCs, provided a catalyst for improvements in the infrastructure of child serving systems, including being able to braid and blend funding for services reimbursement outside the bounds of medically-oriented services.

### ***Data/Information System Enhancements***

A third of grantees (33%) worked on data system enhancements with the purpose of improving coordination of care through information systems or sharing data among community providers. Most of these steps toward electronic data systems were incremental yet represented significant strides forward. Funding provided by Project LAUNCH allowed communities to initiate data enhancements to improve coordination of care and facilitate and track screenings and referrals.

## **Project LAUNCH-Supported State Systems Initiatives**

### ***Partnership Development and Collaboration***

Seventeen state grantees in Cohorts 1 and 2 established State Young Child Wellness Councils (SYCWCs).<sup>7</sup> In addition, some state grantees and one community-level grantee in Cohort 3 formed other collaborations with state agencies focused on discreet areas of interest, such as school readiness, or on strengthening the infrastructure of child-serving systems more generally. For example, one grantee in Cohort 3 participated on a state work group focused on mental health consultation approaches in home visiting programs statewide.

The explicit direction from SAMHSA to engage in state infrastructure reform that is in alignment with and furthers community-level activities provided a level of support and engagement from the state that was valued by the target communities and likely propelled them forward. Cross-agency collaboration at the state level, demonstrated through broad cross-sector engagement in the SYCWCs, facilitated knowledge exchange and, in many cases, collaborative planning. Additionally, engagement of diverse stakeholders on the SYCWCs

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<sup>7</sup> The one tribal grantee in Cohort 1 and the District of Columbia grantee in Cohort 2 are excluded from this total number and percentage of grantees.

helped to elevate awareness of and focus efforts on important issues in early childhood development, such as trauma, screening, and behavioral health.

### ***State Public Awareness Initiatives***

Eleven grantees (48%) implemented one or more state-wide public awareness initiatives. These initiatives included production and distribution of CDs and books to encourage healthy social-emotional development, dissemination of information on sudden infant death syndrome and shaken baby syndrome, expansion of parental access to information on healthy child development, promotion of social-emotional health through social marketing, and organization of a public summit on adverse childhood events, among others.

### ***Workforce Development Initiatives***

Fourteen grantees (61%) implemented state-level workforce development initiatives. Some grantees targeted their state workforce development initiatives to distinct segments of the workforce, such as childcare providers, who could benefit from training on early childhood development and mental health. Other grantees focused on training providers across systems on specific models (e.g., Center on the Social and Emotional Foundations for Early Learning (CSEFEL)) or topics (family and child trauma). As with community initiatives, states focused on both pre-service and continuing education efforts to prepare the workforce to address the social-emotional needs of young children.

### ***Screening Initiatives***

State screening initiatives were much less prominent, especially in comparison to other types of systems change activities. Six grantees (26%) implemented state screening initiatives. In one state, Project LAUNCH brought attention to social-emotional screening as surveillance—tracking children’s needs and developmental progress over the long-term—and to the importance of connecting children and families to providers for further assessment and treatment if they received a positive screen.

### ***State Policy Development***

Seventy percent of grantees across all three cohorts have implemented state policy change and infrastructure development initiatives. For some states, this has been the primary focus of their work at the state level. New policies and improvements in state infrastructure are important accomplishments of Project LAUNCH, but many have also benefitted from efforts that preceded LAUNCH (e.g.,

ECCS, Help Me Grow) and from collaboration with other state programs (e.g., an existing early childhood advisory group or Children’s Cabinet). In addition, new programs, such as MIECHV and the U.S. Department of Education’s Race to the Top, which for some grantees followed LAUNCH, collaborate with Project LAUNCH on some of these systems change activities. Attribution can be given to LAUNCH for implementing these systems changes, but for many activities, attribution must be shared. Nevertheless, the contribution of LAUNCH to state policy development, and especially to infusing early childhood behavioral health in these policies, is an important outcome of the program.

### ***Data/Information System Enhancements***

Three grantees (13%) established state system initiatives for enhancing data and information systems. The three state grantees that worked in this area sought to improve information tracking for screening and referrals.

### **Implementation of Project LAUNCH-Supported Programs and Services**

Prevention and wellness promotion activities for young children and their families are one of the major pathways for improving child and family outcomes. As noted earlier, Project LAUNCH grantees are expected to implement activities within five core prevention and health promotion strategies: developmental screening and assessments in a range of child-serving settings; integration of behavioral health into primary care settings; mental health consultation in early care and education; enhanced home visiting through increased focus on social and emotional well-being; and family strengthening and parent skills training. What sets Project LAUNCH apart from other early childhood education initiatives is (a) a comprehensive approach that explicitly encompasses key influences on the child’s healthy development: the family, the early childhood care provider, and the health provider; and (b) a focus on the integration of behavioral health across the child and family service system. The particular promotion and prevention strategies encouraged by LAUNCH reflect the “preventive intervention opportunities” for infancy and early childhood—the developmental stages encompassed in the LAUNCH focal age range of birth to 8 years of age. Project LAUNCH grantees have introduced approaches that build and enhance the child and family services system and have also worked to sustain and replicate these approaches through their community and tribe and throughout the state.

### *Home Visiting*

Almost all Project LAUNCH grantees implemented support for home visiting in their communities: 21 of the 24 grantees (88%) supported at least one home visiting program and, collectively, these 21 provided funding to 32 different home visiting programs. Nearly all of these programs (24 of the 32, or 75%) were already operating in the LAUNCH communities when the grants started. Project LAUNCH grantees either expanded the reach of these programs by funding additional staff and/or enhancing staff capacity in the area of maternal and young child mental and behavioral health.

Project LAUNCH expanded the reach of home visiting in the LAUNCH communities in one of three ways: (a) by funding new programs, (b) by hiring additional staff in existing programs, or (c) by funding programs to expand their eligible population, thus enabling programs to increase the number of families served. Project LAUNCH also brought important changes into home visiting. These changes include integrating child mental and behavioral health in the objectives of the programs and placing a special focus within the program on addressing the risks to healthy child development caused by exposure of family members to trauma. Both were manifested through the introduction of new programs whose work with families is informed by these concerns and through programmatic enhancements to existing programs. In addition, a significant contribution was training mental health consultants to work with home visitation staff.

### *Family Support*

Nearly all of the Project LAUNCH grantees (22 grantees, or 92%) provided support for family strengthening programming in their communities, typically by introducing new programs (81% of the LAUNCH programs) but also by enhancing existing programs. Collectively, these 22 LAUNCH grantees provided funding to 63 different family support programs/activities. The primary contribution of LAUNCH was introducing programming into the community that focused on mental health and behavioral health of family members. A small number of LAUNCH grantees provided mental health consultation to family support program staff in models that did not focus on mental health issues, to train staff to be more knowledgeable and aware of issues of mental health, to train staff on how to screen for mental and behavioral health problems, and to provide family-specific consultation when program staff identified concerns.

### ***Early Childhood Mental Health Consultation (ECMHC) in Early Childhood Education and Care***

Twenty of the 24 Project LAUNCH grantees (83%) funded mental health consultation to early childhood education and care programs (including Head Start, child care, and preschool programs). The approaches to ECMHC implemented by the LAUNCH grantees incorporate innovations that move beyond more standard mental health consultation in early childhood that could help inform the early childhood and early care and education fields.

First, the Project LAUNCH grantees used a range of theoretical frameworks to guide their consultation with early childhood education teachers. The different frameworks shared a focus on children's social-emotional development, although they differed in the classroom strategies for supporting and promoting children's development. Second, the mental health consultants in many of the LAUNCH programs provided not only child- or family-specific consultation but also programmatic consultation to directors and teachers (who were also the recipients of child development or curriculum-focused training). This programmatic consultation focused on how to make the classroom environment generally more effective at supporting all children's mental and behavioral health, without focusing on a specific classroom curriculum. Compared to working with individual children or families, consultation about programs offered a greater opportunity to build community capacity and to promote program changes that would remain in place when the LAUNCH funding ended. A third innovation in the approach of the Project LAUNCH grantees to early childhood mental health consultation is embedding the consultants into the early childhood programs. As opposed to providing consultation on an as-needed basis, the consultants essentially function as part of the staff.

### ***Early Childhood Mental Health Consultation in Elementary Schools***

To address the full age range in the implementation of early childhood mental health consultation, Project LAUNCH grantees looked to establish partnerships around issues of child mental health with local schools and school districts. Seven of the LAUNCH grantees (29%) introduced mental health consultation into public elementary schools in their communities. These grantees identified their establishment of positive and productive ECMHC in schools as one of the important LAUNCH achievements in their communities.

LAUNCH grantees undertook mental health consultation activities that represent unique approaches. One provided district-wide training to key school staff on the administration and interpretation of the Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire: Social-Emotional (ASQ-SE), as part of a train-the-trainer model to build this capacity across the school system. Other grantees collaborated with their local schools on developing mental health curricula for kindergarten and first grade classrooms, to help address district or school concerns about supporting the mental and behavioral health of all students in the school.

### ***Integration of Behavioral Health in Primary Care***

Twenty of the 24 Project LAUNCH grantees (83%) undertook activities to bring behavioral health into primary care settings in their communities. For the majority of the grantees, the efforts around integration represented new services in their communities.

Many of the Project LAUNCH grantees funded more intensive forms of consultation for primary care physicians in which the mental health specialist is embedded in the health care setting on a regular basis, but not full time. These allowed for ongoing, direct collaboration between the consultant and the primary care physicians. In 11 LAUNCH sites, the mental health specialist was embedded in the primary care setting, to provide ongoing consultation about children who were being seen by the physicians. The most intensive form of integration is being implemented by six of these projects, which have embedded the consultant in the health care setting on a full-time basis. The LAUNCH approaches to integration of behavioral health tend to be inclusive in terms of evaluation. Typically, entire family systems are screened, including children of all ages and parents for depression and anxiety, and if any family member is identified as having a potential problem, that person is referred for services.

### ***Developmental Screening and Assessment***

Increasing the use of validated developmental screening and assessments is a key goal in Project LAUNCH and grantees addressed this goal with dual strategies: they funded community-wide training of child and family service providers to promote the coordinated use of screening measures and, as part of their work with specific home visiting, family support, early childhood and primary care programs, they trained program staff in the use of screening and

assessment measures, with an emphasis on measures of social and emotional functioning.

Across all of types of settings, LAUNCH made two key contributions to the use of screening and assessment. One contribution was adding measurement of children's socio-emotional development to the repertoire of developmental assessments used by LAUNCH-supported programs. A second contribution of LAUNCH was the inclusion of parent screening along with expanded child screening. Most early childhood programs have traditionally focused only on children, and the broadening of assessment to include all members of the family (parents and children) is an important hallmark of Project LAUNCH.

### **Conclusion**

After its first five years, Project LAUNCH has left a legacy in state and community systems and program services. While the legacies need to be understood in the context of program outcomes (see Volume II of this report), the effects of Project LAUNCH on the service system are clear. The LAUNCH initiative has introduced new programs and enhanced existing programs, all with a focus on integration of behavioral health into the child and family services system. Moreover, the emphasis of Project LAUNCH on behavioral health has enabled grant recipients not only to fill service gaps and enhance existing services with practices that attend to the social-emotional health of young children, but has also led to new efforts that develop the infrastructure within state and local governments and support evidence-based service delivery that meets the comprehensive needs of at-risk children and their families. By building on existing services and enhancing the child and family services system, the influence of LAUNCH has the potential to live beyond the original grant funding. As grantees neared the end of their Project LAUNCH funding period, all were focused on sustaining the enhancements to services as well as ongoing systems initiatives and many had been successful in finding other sources of funding or institutionalizing systems changes.

## 1. Project LAUNCH Initiative

Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health) is a national grant program, administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). The program is grounded in research showing that children’s healthy development early in life is essential to their ability to thrive, learn, and succeed later as an adult. The likelihood of having delays in cognitive, language, or emotional development is high for children with risk factors such as poverty, presence of mental health issues in a parent or caregiver, low birth weight, child abuse and neglect, exposure to traumatic events or violence, and low maternal education (U.S. Department of Health and Human Services, 1999; Karoly, Kilburn, & Cannon, 2005; Barth et al., 2008). Investment in early childhood development services for these and other children has been shown to have substantial benefits, including better academic performance, reduced special education and welfare costs, decreased rates of involvement in the criminal justice system, and lower risk of substance abuse (NIHCM Foundation, 2005; Karoly, Kilburn, & Cannon, 2005).

Project LAUNCH has three guiding principles. First, the program assumes a *holistic perspective* to health that encompasses the physical, social, emotional, cognitive, and behavioral health of all children from birth to age eight. Second, the program employs an *ecological framework*, giving attention to all settings that influence children’s health and wellbeing: the family, home environment, school, pediatric care settings, neighborhood, and community. Third, the program takes a *public health approach*. It focuses on improving all systems that serve young children and their families and incorporates prevention and health promotion activities that encourage intervening early before problems occur.

In the first two years of Project LAUNCH (2008 and 2009), state maternal and child health and tribal agencies were the grant recipients. Most of the grant monies then went to a pilot community to pursue dual goals of improving systems and services for young children and their families. With the third cohort of grants (2010), Project LAUNCH funds were awarded directly to a local community organization, bypassing the state agency. Since then, two additional cohorts (2012, 2013) have received grant awards through their state agency for maternal and child health or mental health or a tribal government. Grantees in all cohorts are expected to use their funds to collaborate across early childhood

systems and enhance existing infrastructures and early childhood programs at the state, tribal, and community levels.

### **Project LAUNCH Goals**

To determine the community's and state's needs, each Project LAUNCH grantee engaged in a two-step planning process in the first six months of their grant. They began by conducting environmental scans at the state/tribal and community levels to identify gaps in the existing services and programs for children, birth to 8 years of age and their families, and perceived community needs. Grantees then used the results of their environmental scans to develop a strategic plan for supporting systems changes and addressing service gaps. Grantees' strategic plans outlined their presented plans to meet the following Project LAUNCH objectives:

- Increase the integration of mental and behavioral health into early childhood services, including home visiting, family strengthening and parent education, early childhood education, and primary care;
- Expand the use of culturally-relevant, evidence-based prevention and wellness promotion practices (EBPs) in home visiting, family strengthening and parent education, early childhood mental health consultation, and integration of behavioral health in primary care;
- Increase access to screening, assessment, and referral to appropriate services for young children and their families in a range of child-serving settings;
- Improve coordination and collaboration across local, state, tribal and federal agencies serving young children and their families; and
- Increase workforce knowledge of children's social and emotional development and preparation to deliver high quality care.

To achieve these objectives, grantees focus on five research-based prevention and promotion strategies:

1. Screening and assessment in a range of child-serving settings;
2. Integration of behavioral health into primary care settings;
3. Mental health consultation in early care and education;
4. Home visiting; and
5. Family strengthening and parent skills training.

Grantees implement evidence-based and promising programs within each of these strategies and, if grantees believed the outcomes of the strategies to be positive, develop plans to sustain, expand, and replicate the strategies after grant funding ends.

As of fall 2013, SAMHSA has funded 40 grantees in five cohorts: 2008, 2009, 2010, 2012, and 2013 (see Exhibit 1.1).<sup>8,9</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; grantees in Cohort 4 include 5 tribes and 6 states; and grantees in Cohort 5 are 4 states and 1 tribe. Each Project LAUNCH grantee identifies a target community in which to implement evidence-based programs and services for young children and their families.

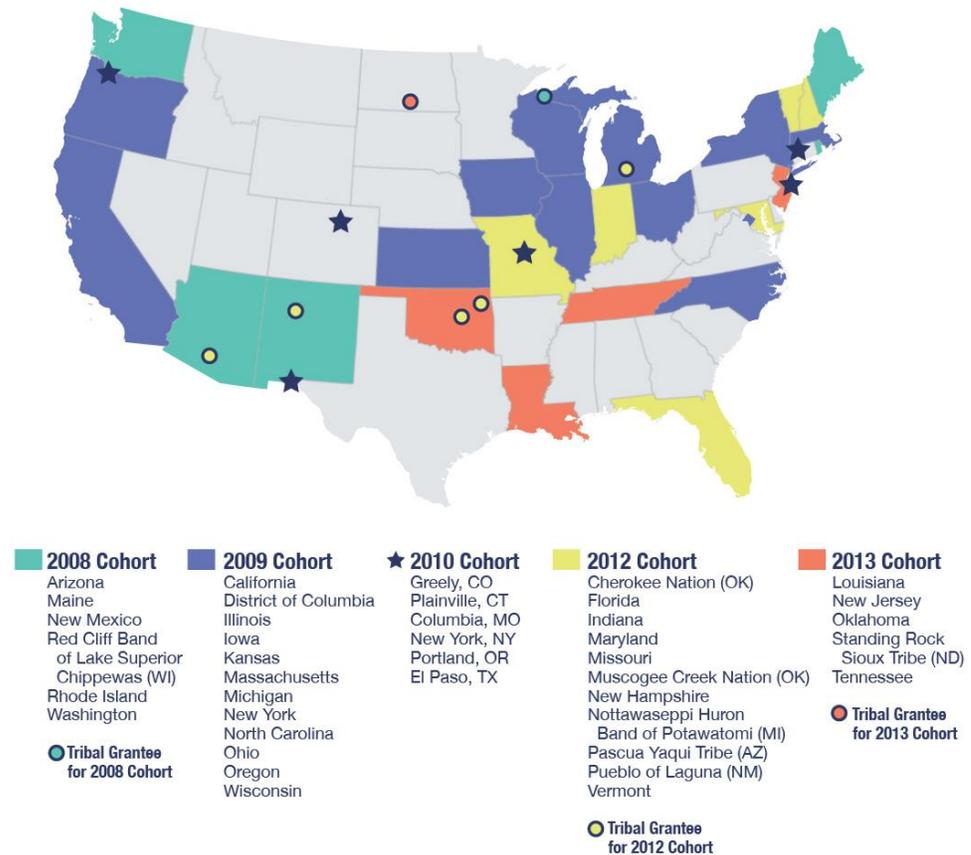
While geographically diverse and varied with respect to their target populations, each LAUNCH community was selected because of its high need for services—e.g., children and families had significant risk factors, services were not sufficient to meet all needs, and the communities had significant health and economic disparities (Gwaltney, Goodson, & Walker, 2013). For example, based on five year estimates (2005-2009) from the American Community Survey, families living below the poverty level were 40 percent higher in LAUNCH communities than in the country overall (14.4 vs. 9.9 percent), 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 LAUNCH communities.<sup>10</sup>

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<sup>8</sup> The six grants in Cohort 1 and twelve in Cohort 2 were awarded either to the state or territorial agency in charge of administering the Title V Maternal and Child Health program or to a tribal agency. The six grants in Cohort 3 were awarded to a local community agency or non-profit organization. The eleven grants in Cohort 4 and five grants in Cohort 5 were awarded either to the Title V or mental health agency within the state or to a tribal agency.

<sup>9</sup> Grantees in Cohorts 4 and 5 were recently funded when this report was written, and, therefore, data from these grantees are not included in this report.

<sup>10</sup> All data are from the American Community Survey five year estimates (2005-2009). The data are averages for Project LAUNCH communities funded in the first three cohorts.

**Exhibit 1.1 Project LAUNCH Grantees**

In states and communities with Project LAUNCH grants, the program represents an investment in the healthy development of young children that is expected to have substantial, long-term benefits not only for participating children and their families but for all young children and families within the funded communities and states.<sup>11</sup> Developing healthy young children who are prepared for school and ready to learn, a primary goal of Project LAUNCH, can have lasting benefits and social and economic value across multiple domains (Karoly, Kilburn, & Cannon, 2005).

<sup>11</sup> While the ultimate goal of Project LAUNCH is to improve outcomes for all children and families in the community and state, achieving this goal will take a long time and is a result of systems change.

## Context for Project LAUNCH

Project LAUNCH grantees implemented their strategic plans at a time when states and communities were undergoing rapid policy and environmental changes. In 2008, the country entered the worst recession since the Great Depression. Over the next several years, states and communities faced major budget issues and deep cuts in health and human services. In every state, children and families were also experiencing deepening poverty and economic insecurity during this time period (Annie E. Casey Foundation, 2012), creating added stressors for families and perhaps increasing the need for behavioral health services.

At the same time, there was an emerging consensus that adverse childhood experiences have a significant impact on social and health outcomes. The Centers for Disease Control and Prevention's (CDC's) Adverse Childhood Experiences Study (ACES) found that early exposure to alcohol and drug use, family violence, and physical and emotional abuse and neglect can lead to health problems, risk-taking behaviors, and even a shortened lifespan (Anda et al, 2009; Chapman et al. 2004; NIHCM Foundation, 2005; Shonkoff, Boyce, & McEwen, 2009). Prevention and early intervention around this type of trauma was an area of focus for LAUNCH grantees, many of which found these conditions prevalent in their communities.

Additionally, a growing number of researchers and practitioners were now advocating for integrated primary and behavioral health services (Agency for Healthcare Research and Quality, 2012), especially in pediatric settings. Recent data had shown that half of all lifetime cases of mental illness begin by age 18 (Kessler, 2005), and early identification and intervention was deemed imperative to address the potentially negative, long-term effects of mental health problems (National Research Council and Institute of Medicine, 2000; NIHCM Foundation, 2005; NIHCM Foundation, 2009). Further, research had demonstrated that screening children and parents in primary care settings, where families are comfortable, makes them more likely to follow through on referrals to services that can help prevent or mitigate later mental health problems (Funk & Ivbijaro, 2008).

Other developments for LAUNCH grantees were passage of the Affordable Care Act (ACA) and establishment of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program in 2010. While implementation of the ACA began

after grantees in the first two cohorts received their awards, these grantees and those in later cohorts began to take advantage of the opportunity to invest in expanding models of care delivery encouraged by the ACA, such as patient-centered medical homes, and to link families to behavioral health services that were now more available because of mental health parity laws. The ACA and other contextual conditions also foreshadowed challenges for states and communities. Expansion of Medicaid as part of the ACA was expected to place greater demands on the health care workforce and the overall health system. In addition, hiring freezes within public agencies at both the state and community levels stretched available resources for early childhood services. The ACA also included funding for MIECHV, which is implemented through a partnership between the Health Resources and Services Administration and the Administration for Children and Families. MIECHV provided funding for evidence-based home visiting programs in many LAUNCH states and communities and expanded the availability of home visiting programs for young children and families. In 2011, additional funds were awarded to states by formula, and nine of these states also received competitive awards to expand and/or enhance the development of their home visiting programs.

## 2. Cross-Site Evaluation of Project LAUNCH

### Overview

The cross-site evaluation of Project LAUNCH describes program implementation, including changes in systems and services, and outcomes for children and families in the LAUNCH community. In addition, the evaluation uses impact estimates from grantee-specific local evaluations and population studies to provide an overall picture of the effectiveness of LAUNCH at improving developmental outcomes for young children (Goodson, Walker, & Gwaltney, 2012).

Six questions guide the overall cross-site evaluation. The first three questions, are addressed by this report on program implementation (Volume I), and the last three questions are addressed in a second report on outcomes (Volume II):

1. How has the local child services system changed during the Project LAUNCH grant implementation?
2. How has the state child services system changed during the Project LAUNCH grant implementation?
3. How have child and family services in the community been enhanced?
4. How has health and well-being improved for young children participating in LAUNCH-supported services?
5. How have knowledge and practices changed for providers of LAUNCH-supported services?
6. How have health and well-being improved for parents of children participating in LAUNCH-supported services?

This report (Volume I) presents findings that are cumulative, i.e., encompass data from multiple years of implementation by the Project LAUNCH grantees. For the first cohort of six grantees, the report represents data from all five years of funding. The 12 grantees in Cohort 2 were in their fourth of five years of funding, and the six grantees in Cohort 3 were in their third of five years of funding. (The 11 grantees in Cohort 4 were completing their first grant year and the 5 Cohort 5 grants had just been awarded and therefore are not included in the report of findings from the cross-site evaluation.)

As indicated above, the main focus of this report (Volume I) is on the implementation of Project LAUNCH and on ways that the program has made a potentially lasting change to the early childhood services system. This report

uses data from several sources: (a) annual interviews with grantee staff and state and community partners, (b) data on implementation of services and systems reported by grantees in the Web-based reporting system (Web portal), and (c) grantee annual end-of-year program and evaluation reports. The report presents descriptive statistics on the services and systems activities being implemented by grantees. Data were abstracted from the three sources above, to discern the profile of program implementation by Project LAUNCH grantees, that is, the who, what, when, and where of Project LAUNCH activities and experiences.

The data review process also included content analysis—i.e., coding and categorizing the types of services, programs, and systems activities grantees have implemented and identifying common implementation patterns or themes across all, or subsets (e.g., cohorts) of, grantees. The content analysis involved reviewing the open-ended responses from grantees in the annual interviews. The content analysis was the basis for the development of conclusions about the unique contributions made by Project LAUNCH to early childhood services and systems and of hypotheses about community and state-level factors related to successful implementation as well as those that present roadblocks and challenges. The content analysis involved continual reflection and refinement of the findings to accommodate new insights as additional data were collected. The most important implications of the variation in implementation are discussed in Volume II of this report, which presents findings on outcomes of Project LAUNCH for children, families, and providers and relates these findings to program implementation.

### **Organization of This Report**

The following sections of this report discuss Project LAUNCH-supported systems building initiatives within communities<sup>12</sup> (Chapter 3) and states (Chapter 4). The report goes on to describe the services implemented within each of the five prevention and promotion strategies (Chapter 5). In each of these chapters, we focus on the contributions that Project LAUNCH has made to the early childhood field and discuss how communities and states are working to sustain their efforts over time.

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<sup>12</sup> Data on systems activities implemented by the one tribal community funded in Cohort 1 and the District of Columbia, funded in Cohort 2, are included as part of Chapter 3.

### 3. Project LAUNCH-Supported Systems Initiatives within Communities

*LAUNCH introduced new community systems initiatives ...and accelerated the momentum of existing initiatives through strategic and relatively small investments of time and money.*

All Project LAUNCH grantees developed community systems initiatives to support, expand, and ultimately sustain service strategies implemented as part of their grant programs. In some cases, LAUNCH introduced new community systems initiatives while others accelerated the momentum of ongoing systems initiatives (e.g., those started prior to Project LAUNCH) through strategic and relatively small investments of time and money. Grantees focused on community systems initiatives within six categories: partnership development; policy development; data systems development; developmental screening; workforce development; and public awareness.<sup>13</sup> Grantees took on multiple systems initiatives wanting to achieve meaningful and lasting change within their communities' early childhood systems (Exhibit 3.1). The focus of grantees' initiatives spanned the entire community that received funding from Project LAUNCH and was not limited to the sometimes smaller area (e.g., several ZIP codes, one neighborhood) that was implementing LAUNCH-supported services.

In the sections below, we highlight systems initiatives within LAUNCH communities. These initiatives were identified by local Child Wellness Coordinators during interviews with the cross-site evaluation team and/or reported in grantees' annual end-of-year program and evaluation reports.

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<sup>13</sup> The cross-site evaluation team identified these categories after reviewing the data on grantees' systems-focused activities at the community level.

### Exhibit 3.1 Number of Grantees Implementing Community Systems Initiatives, by Cohort

Initiative	Number (%) of Grantees			
	Cohort 1 (n=6)	Cohort 2 (n=12)	Cohort 3 (n=6)	All Cohorts (N=24)
Partnership Development	6 (100)	12 (100)	6 (100)	24 (100)
Public Awareness	6 (100)	11 (91.7)	5 (83.3)	22 (91.7)
Workforce Development	3 (50.0)	11 (91.7)	5 (83.3)	19 (79.2)
Developmental Screening	4 (66.7)	5 (41.7)	5 (83.3)	14 (58.3)
Policy Development	4 (66.7)	4 (33.3)	5 (83.3)	13 (54.2)
Data Systems Development	2 (33.3)	5 (41.7)	1 (16.7)	8 (33.3)

Source: Abstraction and coding of data in Annual End-of-Year Local Evaluation Reports 2009 – 2013, and Annual Grantee Program Reports 2009 – 2013.

## Partnership Development and Collaboration

### Implementation Summary

Partnership development and collaboration are common threads that run through all LAUNCH-supported community systems initiatives and are central to the work of Project LAUNCH. All grantees across all three cohorts engaged in partnership development as part of their LAUNCH grant. The Project LAUNCH program facilitated partnerships and collaboration by requiring each grantee to form a Community Young Child Wellness Council (CYCWC), comprising representatives from multiple agencies and sectors that serve young children and their families—health (including representatives from the private sector), mental health, child welfare, substance abuse prevention, early childhood education and local education agencies (Head Start, Early Head Start, and Part C). CYCWCs were a voice for young children; they helped to strengthen connections between providers and systems, identify system gaps, and create a dialogue between the state and community/tribal service systems.

*Community Young Child Wellness Councils were a voice for young children and helped to strengthen connections between providers and systems, identify system gaps, and create a dialogue between the state and community/tribal service systems.*

*“The real impact of LAUNCH is seen in the ways that agencies interact currently. The increased collaboration and cooperative practice has changed how business [in the county] is done and has led to other innovations accomplished by agencies planning and working together.”*

*-- Cohort 1 grantee*

Each Project LAUNCH grantee established a CYCWC in the first year of the grant. Most grantees (67%) reported that their CYCWCs were newly formed for Project LAUNCH. A third of the grantees expanded an existing advisory group or created a subcommittee of an existing group focused on young child wellness. Each CYCWC engaged a wide range of stakeholders from across the community’s early childhood system, and 91 percent of grantees (across all cohorts) also engaged representatives from state agencies (Gwaltney, Goodson, & Walker, 2014).

The role of the CYCWCs was to provide oversight for service and systems planning and project implementation. The first products of this effort were environmental scans at the state/tribal and community levels to identify gaps in the existing services and systems for children, birth to 8 years of age and their families. Grantees then developed strategic plans for services implementation and systems change. Planning for systems activities was informed by current and past initiatives in each grantee’s state and community—for example, the Early Childhood Comprehensive Systems (ECCS) program, health reform, Children’s Cabinets and Commissions, as well as grassroots initiatives. In one Project LAUNCH community, for example, the CYCWC evolved from an existing regional planning network that focused on improving wellness of children and families in the LAUNCH community and surrounding areas. The network incorporated as a nonprofit organization several years before receiving the Project LAUNCH grant, and some members of this organization’s board, along with other stakeholder representatives, functioned as the CYCWC for LAUNCH. The CYCWC pursued initiatives that built on the organization’s and network’s earlier work. One of these initiatives was implementation of a PATHWAYS model to improve preventive care for high risk mothers and young children. The organization’s earlier work to improve the health delivery system for young children and their families provided a foundation for this initiative undertaken by Project LAUNCH.

*LAUNCH was seen as an opportunity to develop innovative systems and services initiatives that could then be spread to other communities and potentially scaled up statewide.*

Even in communities where the CYCWCs were newly formed, the initiatives supported by Project LAUNCH were often an outgrowth of preexisting efforts. For example, when SAMHSA published its Request for Applications (RFA), an organization in one community approached the state urging it to apply for the grant, because they saw Project LAUNCH as a way to further their community's already ongoing early childhood system reform efforts. In this example and others like it, LAUNCH was seen as an opportunity to develop innovative services and systems initiatives that could build on other ongoing work.

### ***Contributions to the Field***

A primary contribution of Project LAUNCH has been to serve as a catalyst for collaborative community initiatives around the social and emotional development of young children. Through the efforts of the CYCWCs, LAUNCH communities worked to establish a common vision, language, and tools for use by early childhood providers and to promote attention to behavioral health in young children throughout the community and within policy arenas. Building on the momentum from other initiatives, LAUNCH's emphasis on collaboration and systems development enabled communities to engage in collective action toward improving young child wellness in all developmental domains.

## **Community Public Awareness Initiatives**

### ***Implementation Summary***

Social marketing/public awareness activities were implemented by LAUNCH grantees to inform the public about developmental milestones and behavioral health for young children. Most LAUNCH grantees (92%) developed some kind of public awareness or social marketing initiative at the community level (see earlier Exhibit 3.1). Activities implemented as part of these initiatives ranged from (a) participation in health fairs and Children's Mental Health Awareness Day, to (b) the creation of social media sites (e.g., Pinterest) to share resources on social-emotional development, to (c) the development and implementation of social marketing campaigns.

### ***Developing a Common Language across the Workforce Helps Align Strategies for Social-Emotional Development***

*“We learned that the ... School District was planning to train their preschool teachers in CSEFEL [Center on the Social and Emotional Foundations for Early Learning], and we were able to partner with them to expand the training to all of the Early Childhood Mental Health Consultants and the Quality Coaches serving the ... Child Development Centers. We hope that this will lead to a common language among the professionals and more alignment of strategies and approaches to promote the social emotional development of children enrolled in the preschools.”*

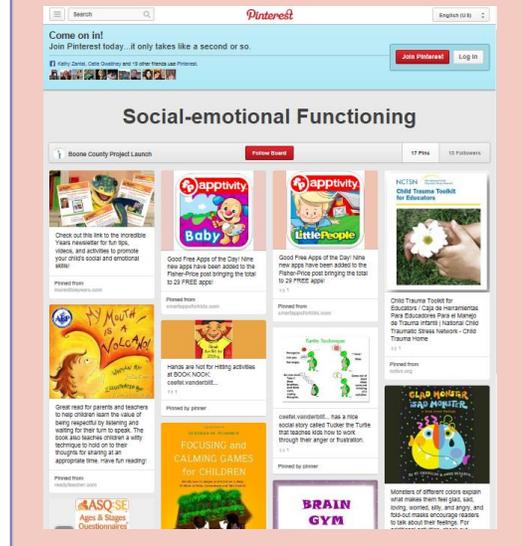
-- Cohort 2 grantee

While all public awareness activities are categorized as systems initiatives for the purpose of this report, there were considerable differences in the reach of these initiatives across grantees. Some grantees implemented comprehensive initiatives (e.g., community-wide campaigns, websites) that sought to reach all stakeholders—parents/caregivers, providers, and policy makers. Other grantees developed specific products—e.g., informational brochures, resource guides—targeted to a more narrow audience; these products were intended to inform community members about direct services and encourage families’ participation in early childhood programs and social-emotional health.

### ***Contributions to the Field***

The public awareness approaches taken by grantees were often new within their local communities. The main contribution of LAUNCH was the use of multiple media strategies for educating parents and others about early childhood development: community-wide social marketing campaigns on child social and emotional health, health fairs to increase awareness of community resources, development and use of websites and social media (e.g., Facebook, Pinterest) to disseminate information about child wellness and promote programs and services, interviews on television and radio talk shows, promotion of mobile applications (e.g., Text4Baby), and print products (resource directories, articles in local newsletters). One of the more innovative public awareness activities was construction of a Born Learning Trail in a city park within one LAUNCH community. The Born Learning Trail, which is part of the United Way’s Born Learning campaign (United Way, 2008), is a public engagement project that enables caregivers and families to take part in various learning activities to build their child’s pre-literacy skills and increase school

### ***A Project LAUNCH Grantee’s Pinterest Site Provides Resources on Social-Emotional Functioning and Other Child Development Topics***



readiness. The [tools](#) and [lessons learned](#) about building trails are now being disseminated to other localities across the state.

## Workforce Development

### *Implementation Summary*

To address the need for a coordinated and trained workforce, many Project LAUNCH grantees (79%) took a systems approach to workforce development (see earlier Exhibit 3.1), focusing on building the capacity of all types of professionals who can potentially touch a child's life and imparting to them the knowledge, skills, and tools to prevent or identify behavioral health problems early and address a family's needs. The professions that LAUNCH grantees worked with included social workers, educators, child care workers, psychologists, mental health consultants, licensed counselors, pediatricians, family practitioners, psychiatrists, nurses, child welfare staff, and others. For many children and families, especially those with risk factors that could lead to negative health or education outcomes, coordination among these various professions is often necessary to meet a family's needs.

Most LAUNCH grantees (79%) implemented community-wide workforce development initiatives (see earlier Exhibit 3.1). These initiatives involved training for providers throughout the community, not just those working in programs funded by Project LAUNCH, and focused on cross-cutting issues such as child trauma, maternal depression, developmental screening, and a common language for young child mental health. Systems-level workforce initiatives also included efforts to strengthen pre-service and/or continuing education programs by infusing them with a public health approach to child development and providing cross-training on mental health. Several grantees also established communities of practice around home visiting and mental health consultation. Participants in the communities of practice engage in discussions and learn from one another about best practices. For example, in a home visitation community of practice, home visitors support one another to translate difficult concepts, such as a model's implementation requirements, into practice, which in turn increases the likelihood of implementing evidence-based models with high fidelity. Another grantee developed a training curriculum on infant mental health that was later brought to the state level and resulted in the institutionalization of an early childhood credential. A state Association for Infant and Early Childhood Mental Health was formed with support from Project

LAUNCH and involvement of professionals in a variety of settings (mental health, education, private practice, state government, and advocacy groups). The Association now serves as a hub to bring parents, practitioners, educators, and policymakers together to improve children's health and wellbeing.

LAUNCH communities maximized use of resources for workforce development by collaborating with other initiatives, such as the MIECHV program, the ECCS program, and Help Me Grow. They also made use of existing technology (e.g., webinars and video recordings of trainings) to expand the reach of workforce development efforts.

*The ultimate aim of all workforce development initiatives has been to enhance provider skills and practices and to improve service quality in the education, health, mental health, and family support domains.*

### **Contributions to the Field**

Children's healthy development involves multiple agencies and systems working together to respond to developmental issues and opportunities. LAUNCH-supported workforce development initiatives have contributed to the communities in which they were implemented by targeting providers in different systems to create a systemic vision of child wellness, strengthen collaboration, and improve service quality. Moreover, they have contributed to the field by demonstrating an approach to enhancing knowledge and practice related to children's mental health. LAUNCH grantees have provided training to promote adoption of screening in early childhood programs and services community-wide. Another grantee convened child care workers, social workers, substance abuse prevention staff, Head Start administrators, school district personnel, and other community providers for a three-day skill-building conference covering a variety of topics: adult and child resiliency, depression in children, aggressive behavior in children, play therapy, the effects of substance abuse on young children, and strength-based services. Other grantees have offered training on early trauma and its consequences. The ultimate aim of all LAUNCH-supported workforce development initiatives has been to enhance provider skills and practice and to improve service quality in the education, health, mental health, child welfare, and family support domains.

## Screening Initiatives

### *Implementation Summary*

LAUNCH grantees provided screening within specific services such as home visitation and family strengthening programs (see Chapter 5). In addition, a majority (58%) developed community-wide systems initiatives around developmental screening for children. With these initiatives, grantees took a comprehensive systems approach by (a) developing and implementing universal screening in multiple settings within their communities, (b) implementing systems (e.g., electronic medical records) for tracking screening and referrals and reducing duplicate screenings across services and enabling primary care providers to access community services, (c) training providers across service sectors—e.g., primary care, education, home visitation, and other programs—to use standardized screening tools (e.g., ASQ, ASQ-SE), and (d) exploring ways to maximize reimbursement for screening under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

In each of these initiatives, the goal was to introduce or expand developmental and social-emotional screening for young children and mothers. As an example, one grantee developed a county-wide maternal mental health initiative focused on depression screening and referral for services. The grantee formed a work group focused on perinatal depression and used the SAMHSA Maternal Depression Community Action Planning Guide (2008) to establish a system for screening, referral, and treatment. This initiative also included a marketing campaign to increase public awareness of maternal depression and the availability of screening services and training for providers on how to screen for maternal depression.

Several other communities collaborated with community-wide Help Me Grow programs to provide developmental and social-emotional screening. Others targeted parents through social marketing activities to increase their awareness of screening services for young children and the benefits of early identification of developmental and behavioral health needs. To explain the benefits of screening, one community produced a video and placed it on their website documenting the experience of one mother whose child was identified with autism after a routine screening and assessment. The mother described her gratitude and relief at having her child's disorder identified and appropriate services and supports put in place.

### ***Pilot Program within the LAUNCH Community Informs the State's Universal Developmental Screening Efforts***

*A pilot program to introduce universal developmental screening in one LAUNCH community informed and helped to advance a statewide universal screening initiative. The pilot began with formation of a community developmental screening workgroup and was jointly supported with funding from Project LAUNCH, the state health department, a grant from the American Academy of Pediatrics, and other sources.*

*The community undertook a needs assessment to determine provider beliefs and assumptions around screening that they would need to address through education and social marketing. A social marketing campaign was then developed to promote online developmental screening. Early care and education providers and medical providers were trained to implement screening. In addition, the community conducted outreach and education to inform the public about the availability of screening and its importance. Finally, a part-time developmental screening coordinator was hired, and a well-respected pediatrician acted as an implementation champion for the screening pilot.*

### ***Contributions to the Field***

Although most grantees initiated their own screening initiatives in the community, some grantees implemented them through collaboration and coordination with existing screening initiatives, such as Help Me Grow. LAUNCH communities shared successes, challenges, and lessons learned to benefit other communities wanting to implement developmental screening programs, especially related to social-emotional health. Additionally, screening initiatives within some communities informed state initiatives on developmental screening, helping state agencies to work on universal developmental screening programs with the intent of eventually implementing them statewide.

### **Community Policy Change/System Infrastructure**

#### ***Implementation Summary***

While most LAUNCH-supported policy initiatives occurred at the state rather than the community level, 13 LAUNCH grantees (54%) undertook initiatives to strengthen or change the local system infrastructure or policies within their

communities. Although the focus of these initiatives was unique to each community, the overarching goals were to improve care coordination and expand behavioral health services for at-risk families. By their very nature, policy and infrastructure initiatives undertaken by communities took the long view. One example is the Memorandum of Understanding (MOU) between LAUNCH and a local medical school to ensure that students receive training on the ASQ and ASQ-SE as well as learn about other behavioral health resources. Under the MOU, medical residents also “shadow” LAUNCH staff as they conduct screenings, thereby learning from Project LAUNCH as it is implemented “on the ground.” Institutionalizing such training for physicians in the workforce pipeline ensures that they will have the skills to screen young children at the start of their careers.

Several efforts to change policy and strengthen the services infrastructure involved altering how agencies collaborate to fund and sustain program initiatives. For example, five communities developed braided or blended funding models to support early childhood services. Another grantee worked to build and strengthen the community service infrastructure (see text box below for one example). In another community, the LAUNCH coordinator and other staff participated in a work group to redesign and coordinate home visiting services throughout the county and add mental health consultation to these

#### **Unmet Need for Autism Services Is Addressed through Efforts of Project LAUNCH**

LAUNCH provided seed money to fund a Medicaid-certified, licensed psychologist to screen children for autism, to link them to autism services through the county agency where autism services are administered, and to provide in-service training to providers on the availability of these services. This seed money enabled intensive autism services to be provided until policy changes could be made at the state level to access Medicaid Autism Waiver funding.

The Medicaid Autism Waiver program in the LAUNCH community took the first step toward sustainability in August 2010 with the hiring of a half-time Family Resource Coordinator/Autism Waiver Coordinator. Children up to age eight became eligible for three years of intensive services through Medicaid. Starting in September 2012, funding for this position moved from LAUNCH to the Independent School District.

programs. The LAUNCH staff person shared lessons learned from implementing mental health consultation for home visitors in LAUNCH-supported programs and proposed ways to integrate consultation into home visitation teams throughout the community as part of the redesign process. Another grantee initiated and expanded a 211 Family Information line in collaboration with the United Way and other funders and has engaged the state in discussions about expanding the family information line statewide.

### *Contributions to the Field*

As evident in the examples above, collaboration has been key to successful policy change and infrastructure development. LAUNCH's focus on cross-systems work, especially through the CYCWCs, enabled communities to work on developing policies to improve the lives of children in their communities and beyond. Diversity of perspectives, facilitated by CYCWCs, provided a catalyst for improvements in the infrastructure of child serving systems, including being able to braid and blend funding for services reimbursement outside the bounds of medically-oriented services.

## **Data/Information System Enhancements**

### *Implementation Summary*

A third of grantees (33%) worked on data system enhancements. Of these eight communities, most focused their efforts on improving coordination of care through information, or data, sharing among community providers. One grantee, for example, purchased an off-the-shelf electronic health information system, called OnPulse, for use by multiple service providers (e.g., medical homes, home visiting, and family support programs). OnPulse organizes a child's health information and makes it accessible to any provider who is given access by the family. The system facilitates coordination of information, referrals, and services between providers and gives parents access to their child's health plan. Purchase of the software facilitated collaboration and referral from pediatric clinics (family-centered medical homes) to home visiting and other programs, helping to create a seamless handoff between services.

To increase coordination of information across providers, other grantees created a central database so that common data elements could be tracked for quality improvement, and gaps in the service system could be addressed. A second grantee developed a data sharing system between two main providers

of early childhood services. Other LAUNCH grantees have developed information systems enhancements within one or more key provider agencies or for the purpose of offering developmental screening online and tracking results in a data repository.

### *Contributions to the Field*

Most of these steps toward electronic data systems were incremental but significant strides forward. In some communities, mental health and other early childhood services have not had the resources to fully join in the “digital revolution.” Funding provided by Project LAUNCH allowed communities to initiate data enhancements to improve coordination of care and facilitate and track screenings and referrals. Often these innovations involved a small number of provider organizations and were not implemented community-wide, but they are serving as models for others and may spread to other parts of the community, and even the state, in years ahead.

#### **Enhancements to Data System Have the Potential to Improve Child Wellbeing**

In one community, Project LAUNCH enabled collection of common data elements for all children enrolled in early childhood services. These data form the foundation of a future data infrastructure that will monitor child health and wellness across the community, and eventually the state.

The Project LAUNCH project developed a common intake form and a HIPAA, FERPA and IDEA-compliant data sharing authorization form to use when enrolling families in home visiting, parent education, and family support services. Data from this form will be entered into the state’s primary and secondary education data management system. The long-term goal is to integrate the database in both health and human services and other child data systems, thus enabling the state to have a “holistic, 360 degree data portrait for every child.”

### **Cross-Cutting Challenges when Implementing and Sustaining Community Systems Initiatives**

Community coordinators for Project LAUNCH reported several challenges in implementing systems initiatives within their communities:

- For some grantees, attendance at CYCWC meetings was erratic, especially when members had competing demands (n=3).<sup>14</sup>
- Obtaining parent involvement on CYCWCs was difficult for many grantees (n=4).
- Turnover in the Child Wellness Coordinator position occurred in some LAUNCH communities, which affected functioning of the CYCWCs due to absent or inconsistent leadership (n=2).
- Lack of reimbursement for screening, especially in settings without Medicaid-eligible providers such as in early care and education and family support programs, influenced grantees' decisions to work on community-wide developmental screening initiatives (n=3).
- Even in settings with Medicaid-eligible providers, such as primary care and some home visiting programs, screening was not always a reimbursable service, or was not reimbursed at a level that made ongoing universal developmental screening a viable activity (n=3).
- For grantees implementing electronic screening, there were challenges related to interfacing with electronic records; provider discomfort with technology was also an issue in some sites (n=5).
- Grantees working on policy reforms understood that change can take a long time and may require executive-level, or even legislative, approval. They understood that some types of policy and infrastructure changes were not possible during their five-year grant period (n=4).
- Grantees found that state support was also necessary for some types of policy change and realized it takes considerable planning and effort to engage state officials and secure their support (n=2).
- Knowledge of technology is required to affect changes in data systems; the small number of communities that undertook this type of systems initiative may indicate that challenges were anticipated or that time and resources were insufficient to realize changes during the LAUNCH grant period (n=3).

Despite these challenges, grantees devoted resources to work on systems change initiatives in their communities and are working now to sustain many of these initiatives beyond the period of their grant.

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<sup>14</sup> The number at the end of each statement indicates the number of grantees identifying the challenge. Grantees were asked during interviews to name up to three challenges they faced; challenges were also identified in grantees' annual programmatic reports.

## 4. Project LAUNCH-Supported State Systems Initiatives

*“Because we have a ‘state supervised, county administered’ governance structure, we have emphasized collaboration building with many other state-level entities. The state’s Early Childhood Advisory Council has responsibility for creating a holistic, comprehensive, coordinated system of services for children from pre-birth to age 8. Project LAUNCH has contributed to this by building and solidifying relationships with new and existing partners.”*

— Cohort 2 grantee

In the first two years of Project LAUNCH (2008, 2009), SAMHSA awarded grants to the state agency responsible for administering the Title V maternal and child health program or to a tribal government. Each grantee in Cohorts 1 and 2 (with the exception of the District of Columbia, which is not located within a state) worked on at least one state systems initiative. The one tribal grant in Cohort 1 was in a state that had also received a grant in Cohort 2, and worked with the state on systems initiatives affecting the tribe. Although state agencies were not the recipient of Cohort 3 grants (grants went to nonprofit agencies/organizations within the communities), four grantees in this cohort (67%) collaborated with their Maternal and Child Health program or another state agency (e.g., agency responsible for child welfare) to work on state systems change.

No pattern emerged regarding which Cohort 3 grantees participated in state systems initiatives and which did not. To determine if there were patterns, the cross-site evaluation examined the following factors: whether the Cohort 3 grantee was in a state that had received a LAUNCH grant in an earlier cohort; whether staff from one or more state agencies participated on the CYCWC; and whether the Cohort 3 community had been involved in other state initiatives prior to LAUNCH (e.g., ECCS, Children’s Cabinet). None of these factors stood out as making a difference in Cohort 3 grantees’ participation in state systems initiatives. For this third cohort, state systems initiatives were extensions of their systems work at the community level and are often referred to in the literature as “bottom up” initiatives (Mazmanian & Sabatier, 1983). These grantees approached the state agency or were contacted (usually by the maternal and child health agency) about ongoing initiatives at the state level that would help to further their work within the Project LAUNCH community and then got involved.

Many LAUNCH-supported state systems initiatives were a continuation of early childhood initiatives already underway when states received their Project LAUNCH grants. While changes in political leadership and state priorities posed challenges to implementing systems initiatives prioritized by grantees, grantees were nevertheless able to make progress during their grant period largely due to strong collaboration among stakeholders across child-serving systems.

Through collaborative efforts and funding support from LAUNCH, grantees made exceptional headway with policy and infrastructure initiatives, improving financing and access to evidence-based promotion and prevention programs.

To meet goals of improving the quality of early childhood systems and services, grantees (excluding the District of Columbia) focused on state systems initiatives within six categories: partnership development; public awareness; workforce development; developmental screening; policy development; and data system enhancements. All grantees in Cohorts 1 and 2 and four grantees in Cohort 3 undertook state systems initiatives (Exhibit 4.1).

#### Exhibit 4.1 State Systems Initiatives, by Cohort

State Systems Initiative	Number (%) of Grantees			
	Cohort 1 (n=6)*	Cohort 2 (n=11)**	Cohort 3 (n=6)	All Cohorts (N=23)
Partnership Development	6 (100)	11 (100)	1 (16.7)	18 (78.3)
Public Awareness	3 (50.0)	6 (54.5)	2 (33.3)	11 (47.8)
Workforce Development	3 (50.0)	8 (72.7)	3 (50.0)	14 (60.9)
Developmental Screening	3 (50.0)	3 (27.3)	0 (0.0)	6 (26.1)
Policy Development	5 (83.3)	10 (90.9)	1 (16.7)	16 (69.6)
Data Systems Development	2 (33.3)	1 (9.1)	0 (0.0)	3 (13.0)

\*Includes Red Cliff, because the tribe conducted systems activities with the state of Wisconsin.

\*\*Excludes District of Columbia, because it does not have a state with which to collaborate on systems initiatives.

## State Partnership Development

### *Implementation Summary*

Sixteen state grantees (100%) established state Young Child Wellness Councils (SYCWCs).<sup>15</sup> The majority (56%) of these councils were in place prior to Project LAUNCH. SYCWCs played key roles in the state systems initiatives discussed later in this section, through work groups established for specific initiatives and the efforts of individual members. In addition, some grantees established other partnerships or collaborations in addition to their SYCWCs. Some of these collaborations were focused on discreet areas of interest, such as school readiness, while others focused on strengthening the infrastructure of child-serving systems more generally. For example, the cross-agency collaboration demonstrated by a grantee in Cohort 1 became a model for a state early learning work group. The work group coordinates early childhood education efforts between state public health and education agencies with a goal of developing an integrated approach to early childhood education. The grantee's SYCWC participated in formation of the work group and supported the state's application for a Race to the Top Early Learning Challenge grant. As another example, a grantee in Cohort 2 developed a memorandum of understanding (MOU) between the state mental health and public health authorities to formalize collaboration on development of the early childhood mental health workforce in the state.

### *Contributions to the Field*

Although Project LAUNCH focuses most of its grant resources on programs and services in a target community, SAMHSA's RFA required that the state agency receiving the grant address "infrastructure reform efforts aimed at creating an integrated [state] system for promoting the wellness of young children and workforce development activities" (SAMHSA, 2008, 2009). The RFA also required the state to create a planning and oversight council. The purpose of the SYCWC was to provide oversight for the grant and to ensure that planning and policy reforms at the state level are consistent with and supportive of work at the local level (SAMHSA, 2008, 2009).

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<sup>15</sup> The one tribal grantee in Cohort 1 and the District of Columbia grantee in Cohort 2 are excluded from this total number and percentage of grantees.

*Grantee advisory councils are not unique to Project LAUNCH. However, the explicit direction to engage in infrastructure reform at the state level that is in alignment with and furthers local Project LAUNCH activities provided a level of support and engagement from the state that was valued by the target communities and likely propelled them forward.*

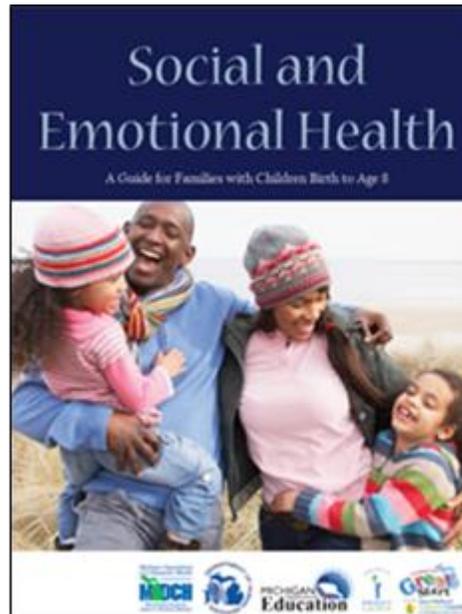
Grantee advisory councils are not unique to Project LAUNCH. However, the explicit direction to engage in state infrastructure reform that is in alignment with and furthers community-level activities provided a level of support and engagement from the state that was valued by the target communities and likely propelled them forward. Moreover, in some states, synchronicity of state and local efforts, particularly when it involved policy development, strengthened early childhood services delivery at the local level (e.g., related to developmental screening); it also helped with the sustainability of community systems change efforts. Finally, cross-agency collaboration at the state level, demonstrated through broad cross-sector engagement in the SYCWs, facilitated knowledge exchange and, in many cases, collaborative planning. Engagement of diverse stakeholders on the SYCWs helped to elevate awareness of and focus efforts on important issues in early childhood development, such as trauma, screening, and behavioral health.

## **State Public Awareness Initiatives**

### ***Implementation Summary***

Eleven grantees (48%), 9 in Cohorts 1 and 2 and two in Cohort 3 (neither of which have a state grant in Cohort 2), implemented a state public awareness initiatives. These included production and distribution of CDs and books to encourage healthy social-emotional development, disseminating information on sudden infant death syndrome and shaken baby syndrome, expanding parental access to information on healthy child development, promoting social-emotional health through social marketing, and organizing a public summit on adverse childhood events, among others. Initiatives were classified as statewide when they were identified as such by the grantee and the initiative focused on social marketing or public education across the state—e.g., a statewide work group to identify common language for messaging on social and emotional health. In this example,

the work group's efforts led to creation of a Social Emotional Messaging Toolkit (see text box below, left).



### ***Contributions to the Field***

Statewide public awareness activities supported by Project LAUNCH increased public access to information on a variety of topics related to healthy child development, child social and emotional health, and approaches communities and parents can take to mitigate toxic stress. Grantees in Cohorts 1 and 2 made use of the Internet and innovative approaches such as Text4Baby and the Born Learning Trail to spread awareness of healthy child development. Other grantees improved access to information on child development and developmental screening, as well as parent perspectives by adding parent education materials to an existing resource (see text box, above right), and contributed expertise to the design of a state event on mitigating toxic stress.

## **State Workforce Development Initiatives**

### ***Implementation Summary***

Fourteen grantees (61%) implemented state workforce development initiatives. Workforce development initiatives included development and promotion of professional credentialing programs that provide early childhood providers with a base set of knowledge, skills, and experience to work effectively with young

children and their families. The purpose of the programs is to support the professional development of providers and enhance the quality of early childhood services. At least three LAUNCH states encouraged early childhood providers throughout the state and in the LAUNCH community to apply for the credentialing programs. One program focused on parent education and two focused on infant mental health. Each program included specialized in-service trainings and guidance from a mentor to promote high quality, culturally-sensitive services delivery.

Grantees also focused on continuing education opportunities for distinct segments of the workforce, such as childcare providers, who could benefit from training on early childhood development and mental health:

- Child/early care providers;
- Parent educators;
- Home visitors;
- Law enforcement and juvenile justice; and
- Primary care providers.

Other grantees focused on training providers across systems on specific models or topics, such as:

- Center on the Social and Emotional Foundations for Early Learning (CSEFEL);
- Developmental screening;
- Family and child trauma;
- Reflective practice;
- Early childhood mental health; and
- Positive Parenting Program (Triple P).

### ***Contributions to the Field***

Innovations in workforce development fall into two categories. Some supported other initiatives (e.g., training providers to conduct developmental screening). Others were targeted to sectors of the workforce that were not thought to have information on the importance of social and emotional health to child development. These included early care and education providers or others that could benefit from increased knowledge of risk factors that can potentially impede healthy social and emotional development. As with community initiatives, states focused on both pre-service and continuing education efforts

to prepare the workforce to address the social-emotional needs of young children.

## State Screening Initiatives

### *Implementation Summary*

Developmental screening and assessment is one of the five LAUNCH strategies that grantees are required to implement within their target communities. As discussed later in this report (Chapter 5), at the community level, grantees introduced the use of new screening measures in home visiting and family support programs and in early care and education and clinical pediatric settings. Within communities, grantees also provided training to program staff on how to administer and use the results of screening measures.

#### ***Preparing the Early Care and Education and Medical Workforces for Statewide Developmental Screening***

With assistance from Project LAUNCH, a state prepared to train early care and education providers in the state on social and emotional health and developmental screening. Lessons learned from the LAUNCH community's universal developmental screening pilot were used to inform the state's training for childcare providers. The new training is being rolled out statewide over the next year and has been included in the state's Early Learning Plan.

Training for early care and education providers will be delivered over time, beginning with identified "early adopters" of innovations and then moving to include all providers. In collaboration with the state health authority, LAUNCH staff also helped develop training modules for physicians to assist them in implementing routine developmental screening. Training for physicians is also being implemented statewide.

At the state level, however, screening initiatives were much less prominent, especially in comparison to other types of systems initiatives. Only six grantees (26%) implemented state screening initiatives. These initiatives mainly focused on primary care and early care and education settings, although one grantee focused on improving access to screening across settings and adding screening

for maternal depression. The only Cohort 3 grantee with a workforce initiative<sup>16</sup> engaged in work on screening in collaboration with their state child welfare agency and worked toward implementing screening in this setting in concert with a state legislator.

***One Grantee's Efforts to Build Upon State Momentum for Developmental Screening***

Project LAUNCH helped to further plans for statewide developmental screening by facilitating the establishment of incentive metrics for screening in 15 Medicaid Coordinated Care Organizations (CCOs) and also facilitated the inclusion of screening in the state's Early Learning Transformation metrics. Starting in 2012, the Project LAUNCH SYCWC and collaborators belonging to the state's Early Learning Council Screening Tools Workgroup developed recommendations for developmental screening. Recommended measures included the ASQ-3 and the PEDS. With input from LAUNCH, metrics for developmental screening through CCOs in the first 36 months of life were implemented in 2013 as part of health system transformation using a Medicaid Demonstration Waiver (1115). Building on the efforts of LAUNCH and other partners, the state is now working to create developmental screening metrics to be used in other early childhood systems.

Six states focused explicitly on implementation of developmental screening—e.g., selection of a common tool to be used across providers and systems statewide. Other grantees implemented related initiatives in the policy development and workforce development domains. For example, one grantee implemented an initiative to expand universal developmental screening by making it a Title V Maternal and Child Health (MCH) block grant performance measure within the state. In January 2013, local health jurisdictions (county or multi-county health departments) could choose universal developmental screening as a performance measure. Another grantee mandated screening across a variety of settings and recommended the addition of developmental and behavioral health screening along with subsequent referral and treatment as part of mental health system redesign. Finally, LAUNCH staff at the state level provided consultation to improve maternal depression screening in home visitation programs.

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<sup>16</sup> This grantee was not one of the two grantees with a state Project LAUNCH grant funded in Cohort 2.

### *Contributions to the Field*

Project LAUNCH brought attention to social-emotional screening as surveillance—tracking children’s needs and developmental progress over the long-term—and to the importance of connecting children and families to providers for further assessment and treatment if they received a positive screen. One grantee in Cohort 1, for example, focused their efforts almost exclusively on screening and referral, working on uptake of screening in pediatric practices, enhancement of state information systems to track screening and referrals, introduction of assessment as an outcome measure for pediatric medical homes, and technical assistance to front line staff as they implement and interpret screens and assessments of their clients/patients. Another grantee in Cohort 2 worked on an initiative to screen for family risk, such as depression, across child-serving systems.

### **State Policy Development**

#### *Implementation Summary*

Seventy percent of grantees across all three cohorts implemented state policy change and infrastructure development initiatives. For some states, this was the primary focus of their work at the state level. Among the states’ accomplishments were changes in providers being able to bill for child mental health screening, establishing credentialing in early childhood mental health, expanding the infrastructure to enhance home visiting services, accelerating efforts to implement statewide developmental screening, and preparing the early childhood workforce to implement and spread evidence-based services for young children and their families.

SYCWCs played key roles in these initiatives, often because many had members who were senior staff within their agencies and had the ear of influential decision makers and legislators. In other cases, SYCWC members were members of a state chapter of the American Academy of Pediatrics, influential thought leaders, or members of provider groups or professional associations that could facilitate and advocate for policy change. While one might have expected to see few changes in policy prior to upcoming elections and potential leadership changes, this was not the case for the majority of states. Very few cited political considerations as a barrier to policy or infrastructure development.

*“LAUNCH was a catalyst for the public debate to expand codes for reimbursement for tele-psychiatry.”*

*-- Cohort 2 grantee*

*“Because early childhood crosses so many systems and disciplines, trying to connect data systems is an extreme challenge. Many state and federal initiatives...are supporting, encouraging, and/or mandating the changes necessary to interconnect data systems. However this is a large, complex undertaking that requires many partners and significant collaboration, which takes time.”*

-- Cohort 2 grantee

Policy and infrastructure development initiatives varied across grantees. The following are illustrative examples:

- A legislative proposal to garner support for the blending and braiding of funding to support infant and early childhood mental health consultation statewide;
- A bill to fund a child psychiatry consultation line to assist primary care physicians to better address developmental and behavioral problems in young children;
- Establishment of an ad hoc committee to explore Medicaid reimbursement for mental health consultation;
- Development of recommendations for expansion and sustainability of CSEFEL statewide;
- Initiation of an early childhood mental health endorsement in the state;
- Improving Medicaid reimbursement for tele-behavioral health services;
- Addressing transportation issues in rural areas where families have to travel long distances to reach services;
- Garnering state funding for an innovative navigator model that provides care coordination for pregnant mothers and addresses any mental health issues; and
- Facilitating developmental screening statewide, including screening for social-emotional development.

### **Contributions to the Field**

Changing policies and enhancing infrastructures in the early childhood arena require a substantial investment of resources over the long term. The processes involved in policy change more generally are complex, often spanning a period of years and even, in some cases (e.g., civil rights, pollution control, mental health parity), a decade or more (Sabatier, 1988). The RFA for Project LAUNCH encouraged early childhood systems building, including state policy reform. Recognizing that the early childhood system is often fragmented and uncoordinated, SAMHSA required grantees to conduct an environmental scan at the state and community levels to identify key areas of need and then to develop a strategic plan that laid out an intentional way of achieving desired systems change.

The examples of policy and infrastructure development, discussed above, are accomplishments of Project LAUNCH, but many have also benefitted from efforts

that preceded LAUNCH (e.g., ECCS, Help Me Grow) and from collaboration with other state programs (e.g., an existing early childhood advisory group or Children’s Cabinet). In addition, new programs, such as MIECHV and the U.S. Department of Education’s Race to the Top, which for some grantees followed LAUNCH, collaborate with Project LAUNCH on some of these systems change activities. Attribution can be given to LAUNCH for implementing these systems changes, but for many activities, attribution must be shared. Nevertheless, the contribution of LAUNCH to state policy development, and especially to infusing early childhood behavioral health in these policies, is an important outcome of the program.

## Data/Information System Enhancements

### *Implementation Summary*

Three grantees (13%) established state system initiatives for enhancing data and information systems. The grantees that worked in this area (two in Cohort 1 and one in Cohort 2) sought to improve information tracking for screening and referrals. While data system enhancements at the community level were small and incremental, the two state-level initiatives were wider reaching. In one state, for example, practices whose populations included more than 25 percent of Medicaid participants were offered financial assistance in transitioning from paper to electronic screening systems that could be linked into a state database (see text box below). The second grantee incrementally expanded use of their data system and modified data entry screens to make them more accessible and user friendly for community agency staff. Consent forms were introduced so information could be shared between partners.

#### ***Incentivizing Implementation of Electronic Data Systems for Screening***

Implementation of data systems can be expensive and time consuming. To incentivize use of electronic systems, pediatric practices are being offered financial support for the transition from paper records when more than 25 percent of their patient population receives Medicaid. Once electronic systems are implemented, screening results will be transmitted to a state database. To address the issue of limited physician time, practices with high numbers of positive developmental screens will be provided with mental health consultation and Incredible Years parenting groups. The ultimate goal is to connect the electronic screening data system to the state’s educational system.

### *Cross-Cutting Challenges when Implementing and Sustaining State Systems Initiatives*

When asked about the challenges they encountered in their work on state systems change initiatives, Project LAUNCH staff identified the following:<sup>17</sup>

- Longstanding silos between state agencies and between service systems limited some stakeholders' willingness to engage in systems change efforts (n=2)<sup>18</sup>;
- The slow pace of policy and systems change was an impediment for some grantees in engaging in some forms of systems change (n=3);
- The difficulty of engaging primary care providers due to competing demands or attitudes limited interest in implementing developmental screening initiatives in healthcare settings (n=2);
- Changes in staff in leadership positions at the state level, sometimes including Project LAUNCH staff, interrupted or slowed progress toward state systems change (n=5);
- Other state and federal policy initiatives have an impact on and at times delayed LAUNCH-supported state systems initiatives (n=2); and
- In a few states, budget cuts and anticipated changes in the governor and within state legislatures made some stakeholders hesitant to begin work in policy change; they indicated that changing priorities of these key policymakers could disrupt policy development work initiated by Project LAUNCH (n=4).

*Grantees have either sustained or are working toward sustaining the great majority of their systems initiatives.*

While these were challenges to reaching the goals of some state systems initiatives, states that prioritized systems initiatives were not deterred from working toward their goals and trying to sustain their initiatives beyond the

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<sup>17</sup> Each was identified by two or more grantees.

<sup>18</sup> The number at the end of each statement indicates the number of grantees identifying the challenge. Grantees were asked during interviews to name up to three challenges they faced; challenges were also identified in grantees' annual programmatic reports.

grant period. Identified challenges to sustaining state systems initiatives included:

- Competing demands for limited state funding;
- Funding sources to sustain activities are time-limited grants;
- Economic climate; and
- Turnover within state agencies.

Even with these challenges, grantees have either sustained or are working toward sustaining the great majority of their systems initiatives. Understandably, grantees in the earlier cohorts are farther along in securing resources for sustainability than grantees in later cohorts.

## 5. Implementation of Project LAUNCH-Supported Programs and Services

### Introduction

Prevention and wellness promotion activities for young children and their families are one of the major pathways for improving child and family outcomes. Project LAUNCH grantees are expected to implement activities within five core prevention and health promotion strategies: developmental screening and assessments in a range of child-serving settings; integration of behavioral health into primary care settings; mental health consultation in early care and education; enhanced home visiting through increased focus on social and emotional well-being; and family strengthening and parent skills training. What sets Project LAUNCH apart from other early childhood education initiatives is (a) a comprehensive approach that explicitly encompasses key influences on the child’s healthy development: the family, the early childhood care provider, and the health provider; and (b) a focus on the integration of behavioral health across the child and family service system. The particular promotion and prevention strategies encouraged by LAUNCH reflect the “preventive intervention opportunities” for infancy and early childhood—the developmental stages encompassed in the LAUNCH focal age range of birth to 8 years of age.

*What sets Project LAUNCH apart from other early childhood education initiatives is (a) a comprehensive approach that explicitly encompasses key influences on the child’s healthy development: the family, the early childhood care provider, and the health provider; and (b) a focus on the integration of behavioral health across the child and family service system.*

Project LAUNCH grantees have introduced approaches that build and enhance the child and family services system and have also worked to sustain and replicate these approaches through their community and tribe and throughout the state. As one grantee stated, “Our community has been burned before by initiatives that have ended as soon as the funding ends. We were committed to

undertaking initiatives only if we had, from the very start, a plan for sustaining them beyond the initial funding.”

## Home Visiting

### *Implementation Summary*

Almost all Project LAUNCH grantees implemented support for home visiting in their communities: 21 of the 24 grantees (88%) supported at least one home visiting program and, collectively, these 21 provided funding to 32 different home visiting programs.<sup>19</sup> Nearly all of these programs (24 of the 32, or 75%) were already operating in the LAUNCH communities when the grants started.

#### ***Home Visiting Focused on Mental/Behavioral Health: Child First***

One LAUNCH grantee selected Child First as a new evidence-based home visiting model for its community. The model was selected to fill the gap in services needed for families with multiple and complex needs and in services focused on preventing social-emotional problems for young children in these families. The model is designed to decrease the incidence of emotional and behavioral disturbance, developmental and learning problems, and abuse and neglect. It focuses on helping parents and children develop a nurturing, consistent, and contingent relationship that can act as a buffer and protect the child’s developing brain from the damage of an environment with a toxic level of stress. One of the challenges of implementing the Child First model is that because it targets families presenting with multiple and complex needs, staff require a significant amount of reflective supervision and support. The grantee reports that the program has been very successful at family engagement, consistently maintaining a less than 10% no-show rate with participating families, and demand outweighs capacity even after one year of the program.

Project LAUNCH grantees either expanded the reach of these programs by funding additional staff and/or enhanced staff capacity in the area of maternal and young child mental and behavioral health. In line with the guidance from SAMHSA, the majority of the 32 home visiting programs that received LAUNCH

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<sup>19</sup> Six grantees supported multiple home visiting programs.

funding (75%) were evidence-based programs or national models in the process of conducting studies to demonstrate their evidence base.<sup>20</sup>

### ***Effects of Project LAUNCH on Home Visiting and on the Field***

By their nature, most home visiting programs serve a small number of families at any given time. Project LAUNCH expanded the reach of home visiting in the LAUNCH communities in one of three ways: (a) by funding new programs, (b) by hiring additional staff in existing programs, or (c) by funding programs to expand their eligible population, thus enabling programs to increase the number of families served. Project LAUNCH also brought important changes into home visiting. These changes include integrating child mental and behavioral health in the objectives of the programs and placing a special focus within the program on addressing the risks to healthy child development caused by exposure of family members to trauma. Both were manifested through the introduction of new programs whose work with families is informed by these concerns and through programmatic enhancements to existing programs. These enhancements not only altered the home visiting landscape in the LAUNCH communities, but also represent new approaches that have the potential to change the field of home visiting nationally (Goodson et al., 2013).

The heightened profile of child mental and behavioral health in home visiting programs has been achieved via three main approaches (Exhibit 5.1):

1. Funding home visiting program models with child mental and behavioral health as an explicit objective (16% of LAUNCH-supported programs);
2. Providing training for staff in home visiting programs on issues related to maternal and young child mental and behavioral health (97% of LAUNCH-supported programs); and
3. Funding trained mental health consultants to work with the staff of home visiting programs that do not explicitly include child mental health in their content (56%).

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<sup>20</sup> For this report, the definition of an “evidence-based home visiting model” is whether or not it is one of the 13 home visiting models that meet the HHS criteria for evidence-based models for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program (from the HRSA MIECHV webpage, April 2014: <http://mchb.hrsa.gov/programs/homevisiting/models.html>)

### Exhibit 5.1 LAUNCH-Supported Integration of Mental/Behavioral Health in Home Visiting Programs

Home Visiting Program Models Supported by LAUNCH	# of Grantees	LAUNCH Funds Mental Health Consultation	LAUNCH Funds Model with Focus on Child Mental/Behavioral Health	LAUNCH Provides Training on Topics Related to Child Socio-Emotional Development
<b>Evidence-based models<sup>a</sup></b>				
Parents as Teachers	9	5	0	9
Nurse Family Partnership	4	3	0	4
Healthy Families	4	0		
Child First	1	0	1	1
Early Head Start	1	1	0	1
HIPPY	1	1	0	1
<b>Models based on national frameworks/models not yet evidence-based</b>				
Problem Based Intervention System (PBIS)	2	1	2	2
Promoting Maternal Mental Health During Pregnancy (based on NCAST (Nursing Child Assessment Satellite Training center))	1	1	1	1
Partners in Parenting Education (PIPE)	1	0	1	0
<b>Local Models/Models Not Yet Designated as Evidence-Based</b>				
First Born	1	1	0	1
Public health home visiting	4	4	0	4
Dad's home visiting program	1	0	0	1
Massachusetts home visiting program	1	1	0	1
Local program using community health workers	1	1	0	1

<sup>a</sup> Designation of "evidence-related" home visiting models based on ratings developed as part of the MIECHV program (from the HRSA MIECHV webpage, April 2014: <http://mchb.hrsa.gov/programs/homevisiting/models.html>)

As shown in Exhibit 5.1, across all of these approaches to integrating mental and behavioral health into home visiting, all of the LAUNCH support led to increased importance of child mental and behavioral health in the home visiting programs in their communities.

### ***LAUNCH-Initiated Home Visiting Models Focused on Child Mental/Behavioral Health***

Five home visiting programs that LAUNCH grantees initiated in their communities focused more explicitly on maternal and child mental health and wellness. Only the Child First model has been assessed as evidence-based; the other programs used national models not yet evidence-based, including two programs that used Positive Behavioral Interventions and Supports (PBIS) as a framework, a program using Partners in Parenting Education Program (PIPE), a program that used the Nurse Child Assessment Satellite Training, and a program using a locally-developed model in a health center where trained clinicians assessed and referred mothers with familial concerns or with a child with developmental concerns to receive home visits. Three of these models, Child First, the PBIS programs, and the local model in the health care center, are more clinically-oriented and targets families with a child who has been identified as having emotional, behavioral or developmental concerns, and all team a mental health clinician with a non-clinical family worker. This team approach allows the programs to provide secondary evaluation of mental health and short-term mental health services as well as address broader family support and parenting goals and child developmental needs. For two other programs, the social and emotional focus derives from the use of the PBIS framework as the foundation. PBIS is a prevention-oriented approach for staff to use to (a) organize evidence-based practices in positive behavior support, (b) improve the implementation of those practices, and (c) maximize social behavior outcomes for children.

One of the newly initiated home visiting programs referenced above is Child First, an evidence based program notable for an explicit focus on supporting the development of a healthy parent-child relationship (see text box on page 36). This program not only recognizes the threats to strong, healthy parent-child relationships posed by the toxic levels of stress faced by families in many of the LAUNCH communities, but also conceives a nurturing parent-child relationship

as a possible protective factor buffering the negative consequences of this stress for the child's development.<sup>21</sup> This same focus is represented by the Partners in Parenting Education Program (PIPE), a group parent training experience, which (see text box below) focuses the parent on the child's needs and parent-child emotional communication using supervised, joint activities. The goal of the PIPE instructional model is to provide a framework for parents to become aware of the concepts of emotional development and attachment and to integrate them into their parenting practice.

***Home Visiting Focused on Mental/Behavioral Health: Partners in Parenting Education (PIPE)***

One LAUNCH grantee initiated PIPE training for nurse home visitors as an approach for working with families with parent-child bonding concerns. The model is designed to increase the emotional availability and relationship-building skills of parents/caregivers with young children. PIPE is an interactive and relationship-based curriculum and instructional model whose goal is to provide a framework for parents to become aware of the concepts of emotional development and attachment and to integrate them into their parenting practice.

***Workforce Enhancement for Home Visitors: Training on Maternal and Young Child Mental and Behavioral Health***

After conducting their environmental scans, LAUNCH grantees recognized that most of the existing home visiting programs in their communities used models that did not have an explicit focus on supporting maternal and child mental and behavioral health. Therefore, in line with the overall goals of the Project LAUNCH initiative, grantees elected to provide training to staff in existing home visiting programs on issues related to maternal and young child mental and behavioral health, including understanding how children develop social and emotional competence, how to assess these aspects of children's functioning, and referral options for children with concerns. These trainings operate as

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<sup>21</sup> Recent discoveries in neuroscience, for example, point to the cumulative impact of adverse childhood experiences on the development of a broad range of later conditions (Dube et al., 2003). Children exposed to ongoing adverse experiences can face prolonged stress, often referred to as "toxic stress," which puts them at risk for changes in the architecture and later functioning of their brains and immune systems (National Scientific Council on the Developing Child, 2005).

workforce enhancement and are a mechanism by which LAUNCH hopes to contribute to lasting changes in the knowledge, skills, and practices of home visitors in their work with mothers and their young children.

### *Integration of Mental Health Consultation in Home Visiting*

LAUNCH's work in home visiting also has included a more intensive method of integration of maternal and child mental health, one that holds out even greater chances of changing provider practice and producing benefits for families. This model, mental health consultation for home visitors, was implemented by 10 of the 21 grantees that supported home visiting programs. These grantees funded mental health consultation for 18 home visiting programs—10 programs using evidence-based models, two programs using national frameworks, two local models, and four state public health home visiting programs (Exhibit 5.1, above). Mental health consultation in these communities appears to have grown out of grantees' dual recognition that the families being served are facing increasing risks to the establishment of nurturing parent-child relationships, to child socio-emotional development, and to maternal mental health. Further, the home visitors in traditional programs are unlikely to be equipped to address the substantial mental health, substance abuse, and domestic violence problems in the families they serve.

The fact that the home visitors are not themselves trained MENTAL HEALTH clinicians led to efforts to integrate a mental health provider into the ongoing operations of their programs, thus helping home visiting programs respond to the challenges of the families they serve. Mental health consultation involves a partnership between a professional consultant with early childhood mental health expertise and home visiting programs and staff. Mental health consultation in home visiting uses methods similar to those in models of integration of mental health consultation in early care and education settings, which has yielded promising results over the last decade (Perry et al., 2010). Project LAUNCH's innovative efforts to integrate early childhood mental health consultation into existing home visitation service models hold the promise of promoting parent and child behavioral health by enhancing the capacity of home visitors to identify and appropriately address the unmet mental health needs of children and families.

***Mental Health Consultation in Home Visiting in LAUNCH***

In Project LAUNCH, mental health consultation for home visiting programs is designed to build the capacity of the home visitors to recognize, interpret, and support the individual socio-emotional needs of children and families in their care, especially 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 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. The LAUNCH mental health consultation approaches typically include reflective supervision. Reflective supervision provides 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.

In LAUNCH, all of the mental health consultation models (see Appendix A) used include direct support to the home visiting staff through training, consultation on individual families, and reflective supervision.<sup>22</sup> For example, as reported by Project LAUNCH sites, mental health consultants have provided training to home visitors on strategies for managing their own stress and trauma, strategies for identifying mental health issues in parents and children and referral resources in the community, the developmental importance of early mother-child attachment, and strategies for addressing attachment disorders.

All of the mental health consultation models also include child/family consultation in which the mental health consultant collaborates with the home visitors to help them develop ways to assist families that do not meet criteria for immediate crisis intervention but whose well-being is of concern. This may include helping the home visitors identify appropriate referrals to additional mental health services. Project LAUNCH sites use different approaches to this collaboration, ranging from consultation with a home visitor by telephone, to individual discussions outside the home setting, to accompanying home visitors on family visits. In about half of the mental health consultation models, the

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<sup>22</sup> For description of the components of the mental health consultation approaches used by Project LAUNCH grantees, see Goodson, Mackrain et al, 2013, Table 2.

mental health consultant also was available to work directly with families, providing some short-term mental health treatment.

### ***Implementation Challenges***

The reported challenges to implementation of enhanced home visiting were focused on offering mental health consultation to existing programs. Challenges included lack of trained staff to provide the mental health consultation and integrating this new component into programs with their own policies and practices that were not always consistent with the mental health consultation model. For example, making time for reflective supervision and increased staff training from the mental health consultant required grantees/agencies to take time out of their own training and supervision schedules. Grantees also reported increasing challenges for home visiting programs in meeting the needs of families with multiple adverse circumstances such as family violence, trauma, substance abuse, and maternal-infant attachment problems. Grantees reported that staff were overwhelmed by the needs of the families they were working with, both in terms of how much time it took to address the problems and the stress on staff of working with multi-risk families. Programs also reported difficulties in making appropriate referrals, for a number of reasons, including absence of mental health services in many of the communities and family difficulties in accessing services that required them to have transportation, lack of culturally-sensitive mental health services and staff, and resistance among families to use counseling or therapeutic services. Even as LAUNCH grantees recognized the need for even more support for home visitors as well as the families themselves, they were challenged to develop long-term funding mechanisms for mental health consultation when the LAUNCH funding ended.

### ***Sustainability of LAUNCH Supports for Home Visiting***

*Funds from the federal MIECHV Program are playing a critical role in sustaining LAUNCH-supported activities with home visiting programs.*

Grantees report that 28 of the 31 home visiting programs (90%) that are receiving funding from Project LAUNCH are expected to continue operating after LAUNCH ends. The question facing grantees is identifying funders to continue both the support that LAUNCH has been providing for program expansion and for the

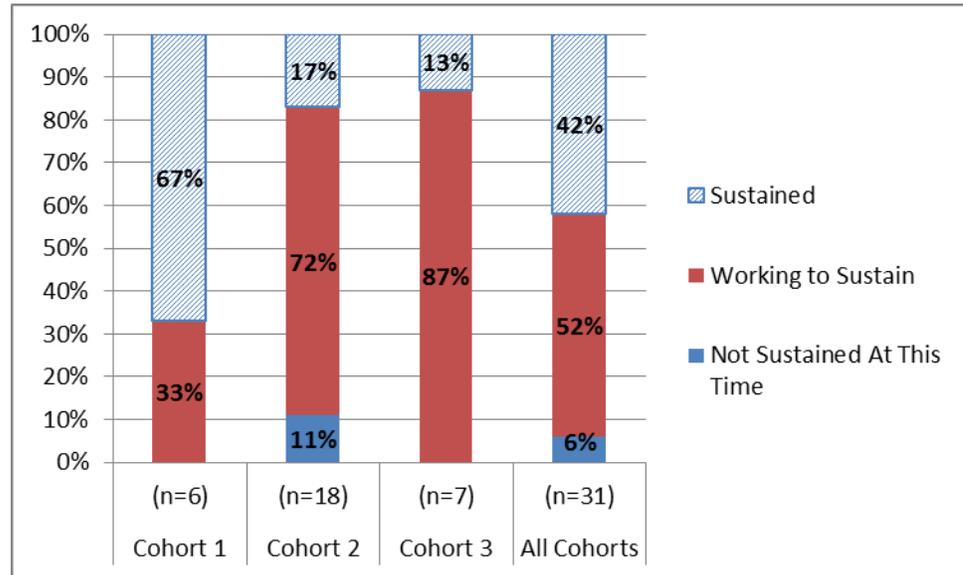
enhancements related to mental health consultation. Overall, grantees had found funding to sustain 42 percent of the LAUNCH-funded home visiting activities (Exhibit 5.2). The sources of funds for sustaining the LAUNCH activities varied. Funds from the federal MIECHV Program are playing a critical role in sustaining LAUNCH-supported activities with home visiting programs.<sup>23</sup> Eight of the grantees reported that they have either confirmed sustained funding of home visiting programs through MIECHV or are in the process of negotiating continued support of their activities from the program. This includes funding for program operation and for mental health consultation-related activities. The continued funding of the LAUNCH-instituted enhancements has been more of a challenge but, again, MIECHV funds are proving to be important in ensuring the sustainability of some of the LAUNCH enhancements.

Grantees in Cohort 1, who were nearing the end of their grants at the time of this report, report more success than the Cohort 2 and 3 grantees at developing strategies to sustain their LAUNCH-supported enhancements in home visiting. One reason cited by Cohort 1 grantees is that they have had more time to develop strategies and access outside funding sources to sustain their LAUNCH enhancements of home visiting programs, compared to grantees in Cohorts 2 and 3. Because the enhancements, such as mental health consultation, have not been “packaged” as part of the home visiting models, grantees have found it more difficult to secure funding for their enhancements activities than to secure funding to continue program operations.

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<sup>23</sup> Starting in 2010, the MIECHV Program began to provide grants to states to deliver critical health, development, early learning and family support services to children and families to strengthen relationships between parents and their infants and young children and to help ensure women have a healthy pregnancy. MIECHV is intended to facilitate collaboration and partnership at the federal, state, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs. Since the MIECHV Program was enacted in 2010, it has been implemented in 544 communities in all 50 states, the District of Columbia, and five territories to serve about 15,000 families. The Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services partners with the Health Resources and Services Administration (HRSA) to implement the MIECHV Program, and leads the Tribal Home Visiting Program.

**Exhibit 5.2 Sustainability Status of LAUNCH-Supported Home Visiting Programs, by Cohort<sup>1, 2, 3</sup>**



Source: Annual CSE interviews with LAUNCH project directors

<sup>1</sup>Period covered for each cohort: Cohort 1 – October 2008-September 2013; Cohort 2 - October 2009-September 2014, and Cohort 3 - October 2010-September 2015.

<sup>2</sup>n's are the number of home visiting programs implemented by each cohort.

<sup>3</sup>The number of grantees with home visiting programs: Cohort 1 –five grantees; Cohort 2– nine grantees; Cohort 3 –six grantees; and All Cohorts –20 grantees.

## Family Support

### *Implementation Summary*

Nearly all of the Project LAUNCH grantees (22 grantees, or 92%) provided support for family strengthening programming in their communities, typically by introducing new programs (81% of the LAUNCH programs) but also by enhancing existing programs. Collectively, these 22 LAUNCH grantees provided funding to 63 different family support programs/activities. In line with the guidance from SAMHSA, two-thirds (42 programs, or 67%) of the family support programs that received LAUNCH funding were evidence-based. Together, the LAUNCH grantees supported 18 different branded family support models (Exhibit 5.3).

**Exhibit 5.3 Family Support Programs Supported by Project LAUNCH Grantees and Focus on Child and Parent Mental Health**

Family Support Program Model	# of Grantees (# of programs, if different)	Focus on Child Socio-Emotional Development	Focus on Parent-Child Attachment	Focus on Parent/Child Trauma, Mental Illness	Focus on Parenting, Parent-Child Relationship	Other
<b>Branded or national models<sup>a</sup></b>						
Incredible Years Basic Parent Training	10	✓			✓	
Strengthening Multiethnic Families and Communities	3				✓	
Parent-Child Interaction Therapy	3		✓		✓	
Parent Cafes	5 <sup>b</sup>				✓	
Circle of Security	2		✓		✓	
Triple P (Positive Parenting Program)	2	✓			✓	
Centering Pregnancy	2				✓	
Centering Parenting	2				✓	
Parenting Wisely	2				✓	
Nurturing Families	2				✓	
Trauma Focused Cognitive Behavioral Therapy	1			✓	✓	
Trauma Recovery Empowerment Model	1			✓	✓	
Positive Solutions Groups	1	✓			✓	
Newborn Behavioral Observation System	1				✓	
Video-feedback Intervention to Promote Positive Parenting (VIPP)	1	✓	✓		✓	
Make Parenting a Pleasure	1		✓		✓	
Play and Learn	1				✓	

Family Support Program Model	# of Grantees (# of programs, if different)	Focus on Child Socio-Emotional Development	Focus on Parent-Child Attachment	Focus on Parent/Child Trauma, Mental Illness	Focus on Parenting, Parent-Child Relationship	Other
<b>Local models</b>						
Mental health treatment	8		✓	✓		
Family Navigation/ Systems Navigators	3					✓ Needs assessment, service referrals
Local program models <sup>c</sup>	11				✓	✓

Source: Annual CSE interviews with LAUNCH project directors

<sup>a</sup> Designation as “branded” or “national” model is based on (i) formal statement of program content/written curriculum, (ii) training materials/system for program leaders, and (iii) program organization or website where program materials can be obtained.

<sup>b</sup> One grantee adapted the Parent Café model as the Community Café; this adapted model was discontinued after one year.

<sup>c</sup> Includes community events for families, native language.

Consistent with the goals of Project LAUNCH, many grantees elected to implement family support programs that focus explicitly on issues related to maternal or young child mental and behavioral health. Half of the family support programs introduced by LAUNCH had an explicit focus on helping parents cope with family violence, trauma, and mental illness, and the risks these pose to the development of nurturing, positive parent-relationships that are necessary for children’s healthy development.

### ***Contributions to the Field***

A primary contribution of LAUNCH in the field of family strengthening was introducing programming that focused on mental and behavioral health of family members. As described, many of the programs adopted by LAUNCH were national models developed for working with mothers experiencing depression or the effects of trauma. A small number of LAUNCH grantees provided mental health consultation to family support program staff in models that did not focus on mental health issues which sought to train staff to be more knowledgeable and aware of issues of mental health, on how to screen for mental and behavioral health problems, and to provide family-specific consultation when program staff identified concerns.

***Family Support Focused on Family Trauma: Trauma-Focused Cognitive Behavioral Therapy***

One LAUNCH grantee is supporting this form of therapy for families with a child with living with significant emotional problems (e.g., symptoms of posttraumatic stress disorder, fear, anxiety, or depression) related to traumatic life events. The model serves families in the community with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement. This is a treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles and techniques. Children and parents learn new skills to help process thoughts and feelings related to traumatic life events; manage and resolve distressing thoughts, feelings, and behaviors related traumatic life events; and enhance safety, growth, parenting skills, and family communication. It is designed to be a relatively short-term treatment, typically consisting of 12-18 sessions of 50-90 minutes each, with individual sessions for child and parents and family therapy, . Because of the intensity and expense of the program (the model uses trained clinicians), the grantee is only able to serve a small number of families per year.

***Implementation Challenges***

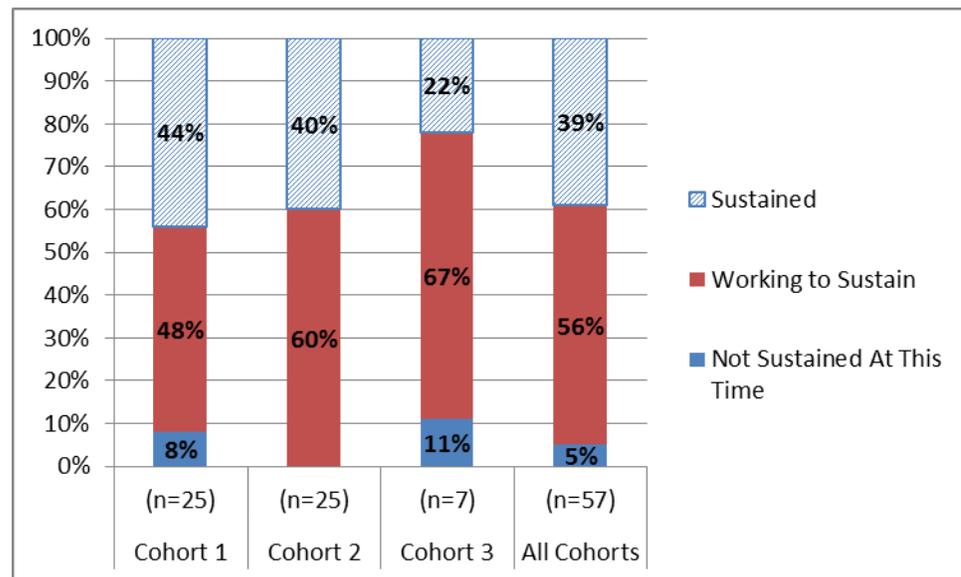
Grantees identified some challenges to their effective implementation of family support programs. One set of challenges related to getting families to commit to participate in multi-session programs. This kind of commitment was recognized as being difficult for families who had inadequate access to transportation, shifting or flexible work hours that are typical of low-wage and part-time employment, and parent issues such as depression that could limit family engagement. As a result, attendance at family support programs was a challenge cited by a number of grantees. Another set of challenges arose on the program side. For family support programs that were more intensive and dealt with more serious family issues, the requirements for well-trained staff increased, and grantees indicated that the training and support for these program staff was often insufficient. Further, these staff were not necessarily prepared to engage as deeply with families as the program model assumed was a key component of effective implementation of the approach. Also, even high-fidelity implementation of the program models was not sufficient for effective intervention with the families in some of the LAUNCH communities who were experiencing multiple risks, including a combination of low income, low education, maternal mental health issues, and maternal-child relationship problems. As one grantee stated, “Family mental health has not been

the historic charge of family resource programs, and existing staff do not have enough knowledge of child development, attachment theory, and topics such as violence- and trauma-related issues in families.”

### ***Sustainability of LAUNCH Supports for Family Support Programs***

The Project LAUNCH grantees also have worked to identify funding sources for the family support programs once LAUNCH funding is ended. As of Fall 2013, which corresponds to the end of years three and four for the grantees in Cohorts 1 and 2, grantees reported having developed sustainability plans for 40 percent of the family support programs they are supporting (Exhibit 5.4). This was in spite of the fact that for family support, there is no parallel to the federal home visiting initiative, MIECHV, which is one of the major sources of continuing funding for the LAUNCH-supported home visiting efforts. The Cohort 1 and Cohort 2 grantees report more success at sustaining their family support programs at this stage of their grants, compared with Cohort 3 grantees that have more years left in their grant period. Grantees report exploring a variety of funding options, including national and local foundations and grants, county public health departments, and Medicaid billing. Some of the family support programs will continue to be funded by the agency that received the LAUNCH grant, where the program aligns with the agency mission.

**Exhibit 5.4 Sustainability Status of LAUNCH-Supported Family Support Programs, by Cohort<sup>5, 6, 7</sup>**



Source: Annual CSE interviews with LAUNCH project directors

<sup>5</sup> Period covered for each cohort: Cohort 1 – October 2008-September 2013; Cohort 2 - October 2009-September 2014, and Cohort 3 - October 2010-September 2015.

<sup>6</sup> n's are the number of family support programs implemented by each cohort.

<sup>7</sup> The number of grantees with family support programs: Cohort 1 –six grantees; Cohort 2 –11 grantees; Cohort 3 –six grantees; and All Cohorts –23 grantees.

## Early Childhood Mental Health Consultation (ECMHC) in Early Childhood Education and Care

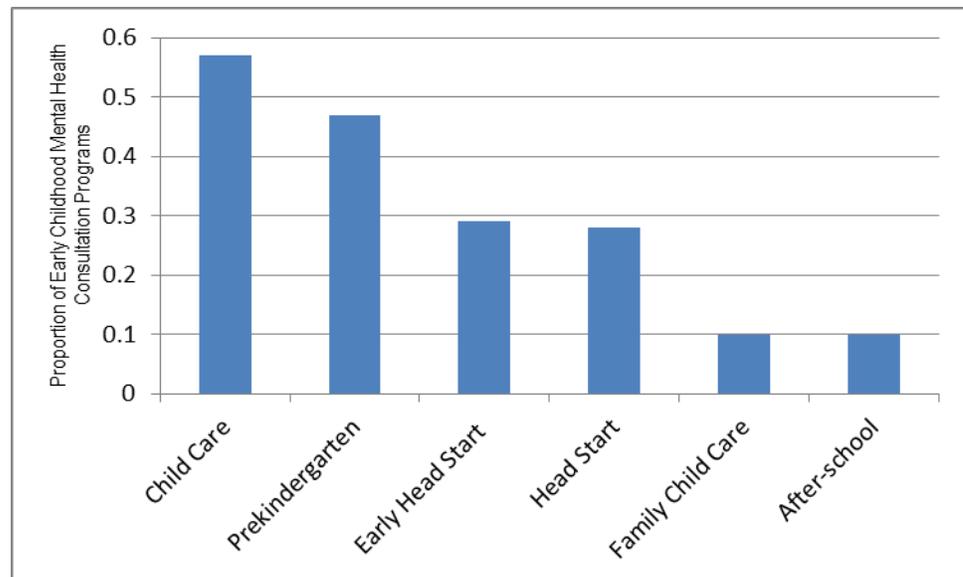
### *Implementation Summary*

One of the strategic priorities in Project LAUNCH was early childhood mental health consultation (ECMHC) as an approach to building the capacity of teachers to prevent, identify, and respond to mental health issues among children in their care. ECMHC offers an indirect approach to reducing problem behaviors in young children and, more broadly, promoting positive social and emotional development. Twenty of the 24 Project LAUNCH grantees (83%) funded mental health consultation to early childhood education and care programs (including Head Start, child care, and preschool programs). The majority of the ECMHC programs (14 programs, or 74%) were new programs initiated under LAUNCH. Together, the LAUNCH grantees funded mental health consultation to programs

*The approaches to ECMHC implemented by the LAUNCH grantees incorporate a number of innovations that could help inform the field.*

across the early childhood spectrum, including Head Start and Early Head Start programs, community child care programs, prekindergarten programs (state, district or school programs), and family child care (Exhibit 5.5) The LAUNCH grantees funded mental health consultation in only a small proportion of the total number of early childhood programs in their community. Numbers of programs served ranged from a single program to 24 programs, with an average of seven programs per grantee.

#### **Exhibit 5.5 Types of Early Childhood Education and Care Programs Receiving LAUNCH Mental Health Consultation**



The relatively modest scale of the efforts to introduce mental health consultation into early childhood education and care programs was, according to grantees, due to a combination of the cost of the salary of a mental health professional to work with program staff and the time required to establish relationships with early childhood education and care agencies in order to break down their reluctance to ask their staff for more staff time for training than was already being asked.

***Project LAUNCH Early Childhood Mental Health Consultation: Multi-modal, Multi-tiered***

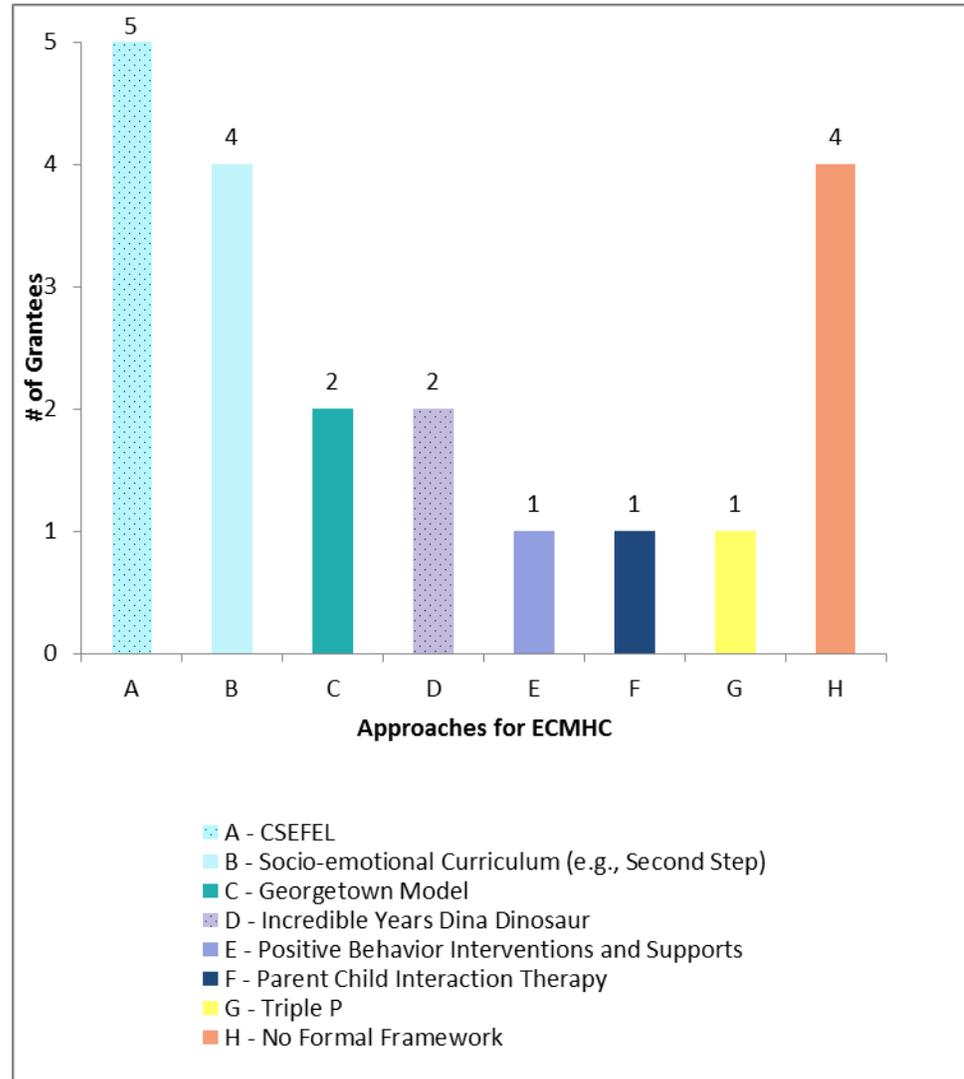
One grantee developed a mental health consultation program based on the widely adopted Georgetown University and Devereux Foundation models. The ECMHC includes three service tiers: universal intervention (consultation program in early education settings), targeted intervention (services to individual children/families), and intensive intervention. Children who are identified as needing intensive intervention services essentially move from the consultation program into mental health services from a provider outside of LAUNCH who is funded through other means. The program's two experienced staff participated in weekly Parent-Child Interaction Therapy (PCIT) consultation calls. During the 2012-2013 school year, the Incredible Years Dina-Dinosaur Classroom-Based Curriculum was incorporated by teachers who were receiving consultation services, weekly into the classroom. The curriculum emphasizes training children in skills such as emotional literacy, empathy or perspective-taking, friendship, anger management, interpersonal problem-solving, school rules, and school success.

***Innovations for the Field***

The approaches to early childhood mental health consultation implemented by the LAUNCH grantees incorporate a number of innovations that move beyond more standard mental health consultation in early childhood that could help inform the field. First, the Project LAUNCH grantees used a range of theoretical frameworks to guide their consultation with early childhood education teachers. The different frameworks shared a focus on children's social-emotional development although they differed in the classroom strategies for supporting and promoting children's development. Sixteen grantees used one of eight different named frameworks or programs as the base for their mental health consultation (Exhibit 5.6). Four of the consultation frameworks involved working with programs to implement new curricula in the classrooms, such as Dina Dinosaur (part of Incredible Years) or Second Step.

Second, the same mental health consultants in many of the LAUNCH programs provided not only child- or family-specific consultation but also programmatic consultation to directors and teachers (who also were the recipients of child development or curriculum-focused training). This programmatic consultation

**Exhibit 5.6 Frameworks Guiding Project LAUNCH Early Childhood Mental Health Consultation**



focused on how to make the classroom environment generally more effective at supporting all children’s mental and behavioral health, without focusing on a specific classroom curriculum. Compared to working with individual children or families, consultation about programs offered a greater opportunity to build community capacity and to promote program changes that would remain in place when the LAUNCH funding ended. Although grantees differed in the conceptual framework underlying their approach to mental health consultation, all of the consultants engaged in training teachers on general principles and practices in child mental health and in conducting assessments of children’s

socio-emotional development. In the LAUNCH projects, the mental health consultants working with the early childhood education and care settings were a mix of clinicians (60% of the programs) and early childhood specialists (40% of the programs).

A third innovation in the approach of the Project LAUNCH grantees to early childhood mental health consultation is embedding the consultants into the early childhood programs. That is, as opposed to providing consultation on an as-needed basis, the consultants essentially function as part of the staff. This allows them to work closely with teachers on adopting new practices to improve classroom climate and supports for child mental and behavioral health. In 12 of the ECHMH programs (63%) supported by LAUNCH, the mental health consultants spent regular time at the programs, usually a day a week or a day every other week.

A fourth innovation in the LAUNCH approach to early childhood mental health consultation is the inclusion of family child care providers in the consultation services. Four of the grantees provided mental health consultation to family child care providers. In each of these sites, the work with these providers started out as small efforts exploring the feasibility of establishing relationships with home care providers. The grantees either worked with a sponsoring agency and invited the participating providers to join the effort, or used general outreach through local Child Care Resource and Referral offices. As a result, the number of family child care providers served was very small. All four of the grantees provided the same training and consultation to family child care providers that were provided to center-based providers. In addition, LAUNCH mental health consultants helped family child care providers conduct systematic screening of children's social-emotional development. One particularly innovative approach was to implement the Parent Café model with family child care providers, with the family child care providers as participants rather than parents. These cafes covered the same Strengthening Families Protective Factors that constitute the framework for the Parent Cafes, but were focused on encouraging providers to talk about strategies they could use to both help the families of the children they cared for build strengths and to support their own strengths and resilience in dealing with the stresses of their jobs.

The concept of mental health consultation in early childhood education and care settings has developed simultaneously with the increased focus on young child mental and emotional health. The work of Project LAUNCH in this area is

grounded in earlier programs. Prior to the early 2000s, for example, there were programs, such as the *Keys to Caregiving* home visiting program (Barnard, Morisset & Spiker, 1993) and the Partners Project (Yosikawa & Knitzer, 1997), a program within Head Start to integrate core mental health principles into the parent involvement component. In the last decade, more widespread policies concerning early childhood mental health consultation have emerged. As an example, the Center for Early Childhood Mental Health Consultation at Georgetown University was funded as an Innovation and Improvement Project by the Office of Head Start in October 2008, to develop strategies to help Head Start programs build a strong mental health foundation for children, families and staff. The Center on the Social and Emotional Foundations for Early Learning (CSEFEL) was funded by the Office of Head Start and the Child Care Bureau as a national resource center for disseminating research and evidence-based practices to early childhood programs across the country. Early childhood mental health consultation implemented in Project LAUNCH goes a step farther by providing ongoing training and assistance that equips early care providers and teachers with the knowledge and skills to identify behavioral issues in young children and by demonstrating approaches for conducting screening and linking providers with other community services to help young children and families with behavioral health needs.

### ***Implementation Challenges***

A number of LAUNCH grantees reported challenges in establishing partnerships with local early childhood education and care agencies and programs. As one grantee put it, “It has taken active, continuous, and untiring outreach” to gain the trust and interest of the early childhood education community. Grantees reported that they needed to educate and convince early childhood programs of the benefits of mental health consultation. There was some resistance to bringing consultants into the program, especially for programs that had been operating for many years. Also, early childhood teachers and family child care providers were not always comfortable talking with parents about mental and behavioral health issues identified by the mental health consultants. The importance of and the time needed for relationship-building was emphasized as critical for effective implementation of mental health consultation.

Other sources of challenges included: high levels of staff turnover in early childhood settings, finding ways programs could cover classrooms so that providers could attend training, and the limited resources programs had to carry

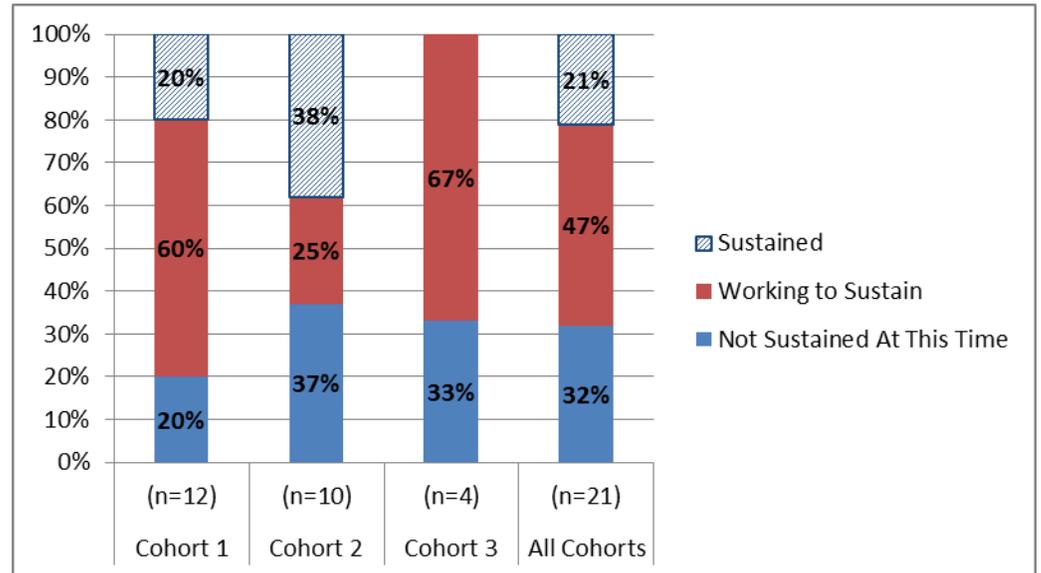
out the recommendations of the mental health consultations regarding working with individual children and families and making program changes. In many sites, the child care community was facing pressure to participate in their state Quality Rating and Improvement Systems (QRIS), especially in states that had Race to the Top Early Learning Grants. As part of participating in the QRIS, programs were facing threats of having to close unless they met standards for staff training and education, program quality, assessment, and family involvement. Grantees reported that while the LAUNCH supports for screening and assessment were a positive factor in meeting QRIS quality standards, integrating mental health consultation activities proved to be an uphill battle for early childhood programs striving to meet even basic quality standards.

A small number of grantees in more rural communities were challenged in finding the appropriately trained individuals to serve as mental health consultants. Finding the right consultants to work with early childhood programs was not always easy. Not only did consultants need to understand early childhood development, they also needed to have a working knowledge of the context in which early childhood education and care programs operate. Further, the consultants needed to understand and, ideally, be embedded in the community in order to work most effectively with community-based early childhood programs. Without this connection to the community, it took longer to build relationships between mental health consultants and program staff.

### ***Sustainability of ECMHC in Early Childhood Education and Care***

Identifying ongoing funding sources to sustain the ECMHC programs is a challenge for the LAUNCH grantees. In 2013, for the programs being implemented in early childhood education and care settings, funding to sustain the programs post-LAUNCH has been identified for only 3 of the 21 programs (Exhibit 5.7). For five programs, grantees reported that the consultation program will not continue after LAUNCH funding ends. For the remaining programs, grantees report that they are still trying to find funding to sustain them.

**Exhibit 5.7 Sustainability Status of LAUNCH-Supported ECMHC in Preschool Programs, by Cohort<sup>8, 9, 10</sup>**



Source: Annual CSE interviews with LAUNCH project directors

<sup>8</sup> Period covered for each cohort: Cohort 1 – October 2008-September 2013; Cohort 2 - October 2009-September 2014, and Cohort 3 - October 2010-September 2015.

<sup>9</sup> N's are the number of mental health consultants in early childhood education and care programs implemented by each cohort.

<sup>10</sup> The number of grantees with mental health consultants in early childhood education and care programs: Cohort 1—five grantees; Cohort 2—three grantees; Cohort 3—three grantees; and All Cohorts—11 grantees.

## Early Childhood Mental Health Consultation (ECMHC) in Elementary Schools (K-3)

### *Implementation Summary*

In Project LAUNCH, grantees were expected to work with children from birth through age 8. To address the full age range in the implementation of early childhood mental health consultation, Project LAUNCH grantees looked to establish partnerships around issues of child mental health with local schools and school districts. Seven of the LAUNCH grantees (29%) introduced mental health consultation into public elementary schools in their communities. These grantees identified their establishment of positive and productive ECMHC in schools as one of the important achievements in their communities. The seven grantees implemented very different approaches to mental health consultation in schools. All of the grantees provided consultation to teachers about social or

behavioral problems of individual students, and grantees identified the consultation as filling a gap related to the lack of systematic screening and assessment of students who were exhibiting emotional or behavioral problems but not yet identified by the school for referral to more comprehensive (and more expensive) evaluation (i.e., to determine eligibility for special education services). Five of the grantees also consulted with teachers more broadly about the social and behavioral functioning of the whole classroom.

### *Innovations for the Field*

Three LAUNCH grantees undertook mental health consultation activities that represent unique approaches. One grantee provided district-wide training to key school staff on the administration and interpretation of the ASQ and ASQ-SE, as part of a train-the-trainer model to build this capacity across the school system. Two other grantees collaborated with their local schools on developing mental health curricula for kindergarten and first grade classrooms, to help address district or school concerns about supporting the mental and behavioral health of all students in the school.

### *Implementation Challenges*

LAUNCH grantees noted the challenges of bringing mental health consultation into schools and negotiating collaborative relationships not only with teachers but also with the district special education and counseling staff. Schools were part of well-defined systems, with well-defined roles and responsibilities, and school systems were historically siloed from the early childhood community and public health agencies. Further, grantees recognized that schools were overwhelmed with competing demands, making it difficult for mental health consultants to gain access to classrooms. One grantee noted that one strategy for helping get into schools was making the argument about the importance of young children's social, emotional, and behavioral development needs, especially when districts are dealing with other mandates such as obesity prevention and chronic absenteeism. The LAUNCH grantees who were successful at establishing relationships were those that had advocates in the school system or were partners with organizations who were already in the schools and could facilitate the introduction of LAUNCH. However, for all of these reasons cited, grantees reported slow progress in implementation of mental health consultation in schools.

***Early Childhood Mental Health Consultation in Schools: Whole School Intervention***

Through Project LAUNCH funding, the mental health consultants in one grantee site expanded their clinical work with schools beyond the traditional role of therapy. This partnership has inspired new and innovative approaches to serving larger numbers of students in the public schools, focusing on early identification/intervention, improving adaptation to school life, and increasing students' capacities for focusing on learning. The consultants engage in school-wide community building and wellness activities and conduct whole-group presentations within K-3 classroom on mental health topics. These consultants have identified an important role in helping teachers create classroom environments that promote the socio-emotional development of students. The consultants began to collaborate with school staff to develop a curriculum about self-regulation and empathy, including written materials and videotapes of implementation. The consultants deliver the curriculum to students directly and work with teachers after they deliver the content to integrate the curriculum into the classroom. Upon beginning work in the K-3 classrooms, clinicians found that students had enormous issues with self-regulation and containment. Thus, the empathy curriculum was put on hold and the consultants began adapting the curriculum to focus on the more pressing need to help students with containment and sensory regulation. The consultants also brought in an Occupational Therapist to help integrate sensory regulation/integration/self-soothing activities into the curriculum and help teachers incorporate these strategies into their daily classroom work. The effects of these activities might show up in reduced suspension rates and absenteeism, and, ultimately, in improved academic performance; providing evidence of effects in these aspects of student behavior could help open the door for mental health consultation in schools.

***Sustainability of ECMHC in Schools***

The story is the same for the school-based ECHMC programs as it is for ECMHC programs in early care programs: identifying funding to sustain the programs beyond LAUNCH has been difficult. When mental health consultation involves work with individual children, the opportunity at some point to bill for the services makes grantees optimistic. However, when the consultation is with teachers or on classroom- and school-wide programming, the prospect for sustainability is diminished. Although grantees are looking for ways to continue to support the mental health consultation after LAUNCH, they have not been successful to date.

## Integration of Behavioral Health in Primary Care

### *Implementation Summary*

Twenty of the 24 Project LAUNCH grantees (83%) undertook activities to bring behavioral health into primary care settings in their communities. For the majority of the grantees, the efforts around integration represented new services in their communities; only five of the grantees chose (or had the opportunity) to expand on existing efforts to integrate mental or behavioral health in the medical community. Typically, grantees worked with a small number of health care settings. However, the settings differed widely in the number of physicians employed, ranging from 5 to over 100 (median = 25).

### *Approaches to Integration of Behavioral Health in Project LAUNCH*

Unlike home visiting, family support, and early childhood mental health consultation, where there are evidence-based models and national frameworks, in the field of integration of behavioral health in pediatric primary care, there are not a set of well-recognized or tested approaches that grantees could draw on. As a result, most of the integration approaches were locally-developed and specific to the community. Eighteen of the 20 LAUNCH grantees (90%) implemented activities with primary care providers to help integrate behavioral health into their practices. The majority of the grantees (75%) provided training for primary care physicians/staff as the core of their approach to integration of behavioral health. The training covered a range of topics about child development, especially socio-emotional development, about the effects of trauma on children's development, and on identifying and referring children with mental health or behavioral concerns. Nearly all of the approaches included use of systematic screening and assessment of children's mental and behavioral health. Grantees differed on whether physicians or their staff were trained to administer the measures (35% of the grantees) or whether LAUNCH-funded staff (early childhood specialists, clinicians, parent educators) embedded in the medical sites administered the measures in the primary care settings (65% of the approaches).

### *Innovations for the Field*

Many of the Project LAUNCH grantees funded more intensive forms of consultation for primary care physicians in which the mental health specialist is embedded in the health care setting on a regular basis, but not full-time. These allowed for ongoing, direct collaboration between the consultant and the

primary care physicians. In these programs, the specialist and the physician collaborated on identifying children with concerns and establishing a service plan for those children. In 11 LAUNCH sites, the mental health specialist was embedded in the primary care setting, to provide ongoing consultation about children who were being seen by the physicians. In addition to collaborating with the medical staff, these embedded consultants also were available to provide short-term consultation or services to individual families of children with concerns.

The most intensive form of integration is being implemented by six of these projects, which have embedded the consultant in the health care setting on a full-time basis. Five projects that are implementing the medical home model are incorporating the mental health specialist full-time into a medical setting :

- In one LAUNCH project, a family partner and an early childhood mental health specialist are embedded into a pediatric practice that is organized to provide a full spectrum of screening, assessment and follow-up services to children and families for physical concerns. The addition of the mental health staff allows the team to expand its coverage of mental and behavioral health. These mental health staff work together to assess, support, and follow families with children who are identified by primary care providers as showing early signs of social-emotional difficulties or are experiencing risk factors known to lead to poor social-emotional development outcomes. The program provides integrated service delivery: Services and supports are offered to the at-risk children and their families, including home visiting and family support programs for the families, and following the children into educational settings (early childhood programs and schools) to work with staff there to support the children's needs.
- In a second project, two therapists and a licensed supervisor are added to the medical team. These specialists consult with the pediatricians on children's mental and behavioral health concerns and the team collaborates to create holistic treatment plans that take into account the medical, mental, and social health needs of the children and families together rather than separately and collaborating continuously across the team members to reinforce the developed plan of care.
- A third LAUNCH project is fully integrating behavioral health, early intervention screening and primary care services within a community

health care center. When families come to the health center, they are interviewed by mental health educators who have been trained to identify critical primary care, early intervention and behavioral health concerns. The family members are screened, and the results are communicated immediately to the primary care and behavioral health staff. For families identified as being at-risk, the integrated staff conduct immediate consultation with the goal of developing a coordinated care plan. Family members are referred to services at the health center or from other providers.

- Another LAUNCH project that is serving a rural population is embedding early childhood specialists in rural health centers. The community has very limited access to clinical specialists; to address this gap, LAUNCH is providing training to early childhood specialists in wraparound case management, cultural competency, attachment, trauma, substance abuse, and the impact of poverty on children and families. The early childhood specialists work with the families who are seen in the health center, conducting assessments and evaluations, consulting with the medical staff to develop appropriate service plans, and building the knowledge and awareness of the medical staff about child and parent mental and behavioral health. As part of LAUNCH, the early childhood specialists receive individual and group supervision from a trained clinician.
- The fifth LAUNCH grantee uses a different approach to collaboration with a medical home. In this project, when the home visiting program identifies a child with a mental or behavioral health concern or a concern about the family's health and wellbeing, they link the family to a responsive pediatric medical home at the community health clinic. The medical home can then meet the psychological and physical needs of the families in a holistic manner. The home visiting program also shares the results from their child screening with the medical home providers.

The LAUNCH approaches to integration of behavioral health tend to be inclusive in terms of clinical evaluation. Typically, entire family systems are screened, including all children and their parents for depression and anxiety, and if any family member is identified as having a potential problem, that person is referred for services. Grantees noted that in these medical settings, follow-up to document whether parents or children actually received the referred services and the results of these services was uneven at best.

### **Implementation Challenges**

*Establishing collaborative relationships with primary care providers and settings was recognized by grantees as a challenge.*

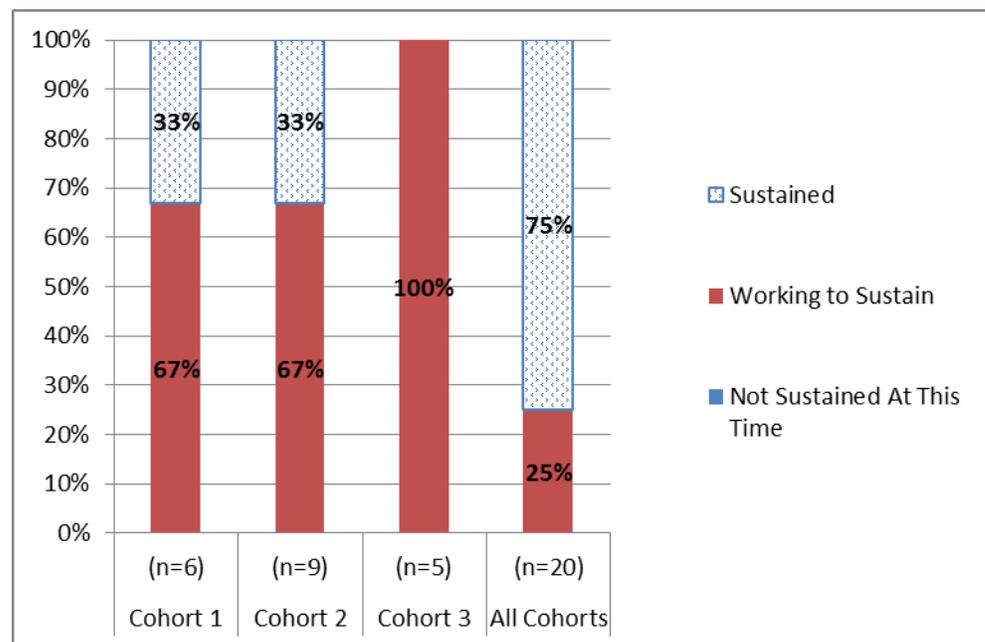
The challenges in working with physicians that were cited by grantees emphasized the difficulty for physicians of making extra time for integrating children's mental and behavioral health more completely into their practices, by participating in training on socio-emotional development, administering developmental screens, or discussing individual children and assessment results with consultants. Physicians were described as being over-burdened and reluctant to engage in additional activities. Time was not the only barrier to implementation of effective integration of behavioral health. Payment for physicians' time attending training or consulting about patients' mental or behavioral health issues was another major obstacle that grantees faced. Physicians had difficulty billing for preventive mental health services, which then limited their involvement in the training and consultation. One grantee described establishing relationships with primary care providers as a "very deliberate process that requires developing the types of interactions that are perceived as valuable, meaningful, and relevant to the provider. This is a lengthy process demanding a number of interactions, reinforcing the *new* knowledge around integration of behavioral health and primary care. Building the relationship requires *continually* building the relationship, and this takes time." The programs that described themselves as successful at establishing strong relationships were those implementing the medical home model, where these relationships were integral to addressing the whole child.

### **Sustainability of LAUNCH-Supported Integration of Behavioral Health in Primary Care Programs**

Most of the Project LAUNCH grantees who are implementing mental health consultation in primary care are in the process of trying to identify funding for their programs once LAUNCH funding ends. Five grantees report having found funding to sustain their programs, while the other 17 grantees are continuing to try to find funding to sustain their activities (Exhibit 5.8). For four of these programs, the primary care settings have committed to funding the mental health consultation. While the reasons for being able to sustain funding

differed across sites, a common characteristic is that Project LAUNCH enhanced mental health consultation in these primary care settings, and a structure for mental health consultation was already in place. The other two programs will be sustained through blended funding including Medicaid, third party billing, and state funding through grants such as Race to the Top.

**Exhibit 5.8 Sustainability Status of LAUNCH-Supported Integration of Behavioral Health in Primary Care Programs, by Cohort<sup>11, 12, 13</sup>**



Source: Annual CSE interviews with LAUNCH project directors

<sup>11</sup> Period covered for each cohort: Cohort 1 – October 2008-September 2013; Cohort 2 - October 2009-September 2014, and Cohort 3 - October 2010-September 2015.

<sup>12</sup> n's are the number of Behavioral Health in Primary Care programs implemented by each cohort.

<sup>13</sup> The number of grantees with Behavioral Health in Primary Care programs: Cohort 1 –six grantees; Cohort 2 –9 grantees; Cohort 3 –5 grantees; and All Cohorts –20 grantees.

## Developmental Screening and Assessment

### *Implementation Summary*

Increasing the use of validated developmental screening and assessments is a key goal in Project LAUNCH and grantees addressed this goal with dual strategies: (1) they funded community-wide training of child and family service providers to promote the coordinated use of screening measures (described

above) and, (2) as part of their work with specific home visiting, family support, early childhood and primary care programs, they trained program staff in the use of screening and assessment measures, with an emphasis on measures of social and emotional functioning. Training the providers (e.g., the home visitors, family strengthening staff, child care teachers) in LAUNCH-supported programs enhances providers' access to systematic information on families and children to help assess risk and target services and potentially improves program outcomes. The training also builds staff capacity and supports the possibility of sustained changes in screening practices in these programs when LAUNCH funding ends.

Project LAUNCH grantees introduced the use of new screening measures in about half of the home visiting programs and about a third of the family strengthening programs that they supported. The most commonly-used child measure was the Ages and Stages Socio-Emotional Questionnaire; for parents, it was the Edinburgh Postnatal Depression Scale. In these programs, grantees provided training to program staff on how to administer and use the results of screening measures. The introduction of systematic developmental screening also was an element in nearly all of the LAUNCH early childhood mental health consultation programs and the programs to integrate behavioral health in primary care. In about half of these programs, the mental health consultants administered the assessments, while in the other half of the programs, the consultants trained the primary care providers to administer assessments.

### *Contributions to the Field*

*Broadening of assessment to include the family is an important hallmark of Project LAUNCH.*

In many of the home visiting and early childhood education programs that LAUNCH worked with, systematic developmental assessment was already in place prior to LAUNCH. The two exceptions were family support programs and primary care settings. Screening was not typically conducted in family support programs. Reasons given by grantees included that the family strengthening programs tended to be short and staff did not have time to develop the kind of relationships with parents that would have made the offer of screening seem appropriate; also, most of these programs were universal as opposed to focusing on families with identified child or family concerns, which also made the concept of screening seem less appropriate to these program staff.

In primary care, most providers did not conduct formal screening and assessment with their patients prior to LAUNCH. Therefore, in these settings, LAUNCH support and provider training was the impetus to the establishment of systematic screening as part of the program practices. Across all types of settings, LAUNCH made two key contributions to the use of screening and assessment. One contribution was adding measurement of children's socio-emotional development to the repertoire of developmental assessments used by programs. For example, most of the the measures recommended or required for home visiting program models, such as Parents As Teachers or Nurse Family Partnership, focus on general cognitive development. LAUNCH provided training and support to programs to incorporate validated measures of social-emotional development. The measure that was most often supported by LAUNCH grantees was the ASQ-SE. The ASQ-SE was especially popular because it was short and could be reliably administered by non-clinicians. Some of the LAUNCH programs, where clinically trained staff were available, went further and introduced clinical measures that could produce more in-depth information on children's social-emotional functioning, such as the Brief Infant-Toddler Socio-Emotional Assessment (BITSEA), the Pediatric Symptom Checklist (PSC), and the Modified Checklist of Autism in Toddlers (MCHAT).

*Across all settings, LAUNCH made two key contributions to the use of screening and assessment: 1) adding measurement of children's social-emotional development to the repertoire of developmental assessments used by programs, and 2) including parent screening along with expanded screening of children.*

A second contribution of LAUNCH was the inclusion of parent screening along with expanded child screening. Most early childhood programs have traditionally focused only on children, and the broadening of assessment to include the family is an important hallmark of Project LAUNCH. Half of the grantees expanded screening activities to include screening for maternal depression. The most commonly-used measure is the Edinburgh Postnatal Depression Scale, which is intended for use during the first few months postpartum, although several grantees chose to use depression scales that are appropriate for a wider population, such as the Patient Health Questionnaire

(PHQ-9). In addition, about a third of the grantees extended their parent screening to include screening for trauma, family violence, and substance abuse. Most of these measures focused on the mother, rather than also being used with other adults in the families, including fathers.

### ***Implementation Challenges***

LAUNCH grantees have provided training to a variety of programs on child and parent screening and assessments. The challenges reported by grantees focus less on issues of program interest and participation in training and more on how to provide support to providers on interpreting and using the results from assessments. This includes challenges in appropriately supporting providers to be competent and comfortable in discussing children's social-emotional functioning with parents, as well as discussing parents' own mental health issues. Most grantees recognize that it is not enough to train providers on how to administer screening measures; additional training and support is needed to help providers know when children or parents should be referred on the basis of results and what appropriate referrals would be. This knowledge requires a deeper understanding of developmental risk and appropriate interventions, which the staff of many community programs do not have. These issues are exacerbated by the increasing number of multi-risk families being served, who present more complicated needs and therefore require more comprehensive service plans.

### ***Sustainability of Developmental Assessments in LAUNCH-Supported Programs***

For Project LAUNCH grantees, the training they provide to program staff on child and parent screening measures has the possibility of being sustained, as long as the staff remain relatively stable and/or programs undertake ongoing training of new staff as they are hired.

## 6. Conclusion

This process evaluation component of the cross-site evaluation of Project LAUNCH addressed three questions focusing on implementation:

1. How has the local child services system changed during the Project LAUNCH grant implementation?
2. How has the state child services system changed during the Project LAUNCH grant implementation?
3. How have child and family services in the community been enhanced?

The cross-site evaluation provided evidence to support a positive answer to the first research question. As summarized in Chapter 5, Project LAUNCH grantees have introduced new child and family programs and enhanced existing programs, all with a focus on the integration of mental and behavioral health into these services. Grantees took seriously the LAUNCH guidance on working simultaneously across service providers in the community, including home visiting, parent education, early childhood education and care, and health care. In all of these areas, Project LAUNCH worked to bring an awareness of, understanding of, and supports for child mental and behavioral health into services. Existing programs were enhanced by provider training and collaboration with mental health professionals; new programs were selected to encompass child mental health in content and approach.

The evaluation also provided evidence that addressed the second research question related to changes in the state child services system. Project LAUNCH grantees undertook to improve the services system by implementing a variety of policy initiatives and instituting inter-agency collaborations, as summarized in Chapter 4. New policy initiatives implemented by LAUNCH grantees raised the profile of child mental and behavioral health in the state child service system.

Finally, the evaluation provided evidence on efforts by Project LAUNCH grantees to improve the child services systems in their communities. Chapter 3 describes how LAUNCH grantees have developed infrastructure in the community to support evidence-based service delivery that meets the comprehensive needs of at-risk children and their families. In addition, grantees worked to integrate awareness of child mental and behavioral health into the services system. Grantees also encouraged collaboration across sectors of the child service system.

The implementation findings presented in this report provide evidence that, after its first five years, Project LAUNCH has left a legacy in states and communities of changes to the state and local systems and services. These include:

- Enhanced and improved child and family services in the community services system (increasing the the integration of child mental and behavioral health into early childhood services, expanding the use of culturally-relevant, evidence-based prevention and wellness promotion practices (EBPs); and increasing access to screening, and referral to appropriate services for young children and their families); and
- Enhancements and improvements to the local and the state child services systems through increased coordination among services providers and increased integration of child mental and behavioral health into local early childhood policies and initiatives.

The influence of Project LAUNCH has the potential to be sustained beyond the original grant funding. LAUNCH did not simply implement new services that might not continue when the original LAUNCH funding ends. Instead, they implemented more permanent changes by building on existing services and enhancing the capacities of providers in the child and family services system. The early childhood services system is complex with many layers (systems, agencies, policies, programs, and practices) and participants (policymakers, program directors, early childhood providers, clinicians, families, and children). The broad goals of Project LAUNCH have provided an opportunity for states and communities to integrate mental health content, practice and policies into all parts of the early childhood system. If these changes in practices in services and upgraded systems are sustained over the long term, there is the likelihood of improving health outcomes for children in the LAUNCH communities.

This report has described the process of Project LAUNCH program implementation and documented the program's potentially lasting effects in local communities, as well as implementation challenges. Volume II of this report presents the outcomes of the program for young children and families. Whereas this report addresses the main contributions of Project LAUNCH to the early childhood service system, they need to be understood in the context of program outcomes. That is, changes in services and systems are meaningful to the extent that they result in changes in service providers and in parents that lead to better mental and behavioral health for the children in their care. How we view the legacy of Project LAUNCH ultimately depends on our understanding of both implementation and outcomes.

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## **Appendix A: LAUNCH-Supported Home Visiting Models**

**APPENDIX Exhibit A.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 A.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> </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 A.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.marinusvanijendoorn.com/video-feedback-intervention-vipp">http://www.marinusvanijendoorn.com/video-feedback-intervention-vipp</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 A.2: LAUNCH Home Visiting Program Models: Evidence of Effectiveness**

Home Visiting Program Model	Focal Outcomes	Evidence of Effectiveness <sup>a</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>24</sup> and caregiver sensitivity and knowledge. <sup>b</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 (HIPPY)	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

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

Home Visiting Program Model	Focal Outcomes	Evidence of Effectiveness <sup>a</sup>
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 <sup>®</sup> 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>c</sup> and in Lithuania. <sup>d</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 A.4 for explanation of evidence standards

<sup>b</sup> Community based RCT (Susan Spieker, PI) from 2006-2012 found modest effect sizes in several outcomes

<sup>c</sup> Klein Velderman, M., Bakermans-Kranenburg, M. J., Juffer, F., & Van IJzendoorn, M.H. (2006). Effects of attachment-based interventions on maternal sensitivity and infant attachment: differential susceptibility of highly reactive infants. *Journal of Family Psychology*, 20(2), 266-274.

<sup>d</sup> Kalinauskienė, L., Cekuoliene, D., Van IJzendoorn, M. H., Bakermans-Kranenburg, M.J., Juffer, F., & Kusakovskaja, I. (2009). Supporting insensitive mothers: the Vilnius randomized control trial of video-feedback intervention to promote maternal sensitivity and infant attachment security. *Child: Care, Health and Development*, 35(5), 613-623.

**Appendix Exhibit A.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.
<b>Center on the Social and Emotional Foundations for Early Learning (CSEFEL)</b>	Social, emotional, and behavioral development	No evaluations of studies were reported on CSEFEL website

**APPENDIX Exhibit A.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 A.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>
Coalition for Evidence-Based Policy (CEBP)	<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>
California Evidence-Based Clearinghouse (CEBC)	<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 A.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 B: LAUNCH-Supported Family Support Models**

**APPENDIX Exhibit B.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>		
	<table border="1"> <tr> <td data-bbox="506 444 772 857">Centering Parenting</td> <td data-bbox="779 444 1923 857"> <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> </td> </tr> </table>	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 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

- Source of information:
  - <http://www.chicagoparentprogram.org/>
- Developed by Rush University
- Based on Webster-Stratton model (Incredible Years)
- Goals: health promotion and prevention program
- 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

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

Family Support Model	Goals and Source of Information on Model
	<p>distract strategies, time-out, stress management, and problem-solving skills with adults</p> <ul style="list-style-type: none"> <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> <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>

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

Family Support Model	Goals and Source of Information on Model
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>
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> <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>

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

Family Support Model	Goals and Source of Information on Model
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>• Online or CD-ROM course delivery format for parents (to purchase by parents directly or to access through an agency with course subscriptions)</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="https://www.childrensinstitute.net/programs/primary-project">https://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>
Strengthening Families Program	<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</li> </ul>

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

Family Support Model	Goals and Source of Information on Model				
	<p style="text-align: center;">school performance</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 5px;">Parent Cafés</td> <td style="padding: 5px;"> <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 style="width: 30%; padding: 5px;">Strengthening Families Program: Family Skills</td> <td style="padding: 5px;"> <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>	Parent Cafés	<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>	Strengthening Families Program: Family Skills	<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>
Parent Cafés	<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>				
Strengthening Families Program: Family Skills	<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>				
Trauma Recovery and Empowerment Model Support (TREM)	<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 B.2: LAUNCH Family Support Program Models: Evidence of Effectiveness<sup>a</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>b</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
Positive Parenting Program (PPP) <sup>c</sup>	Social, emotional and behavioral problems	Individual studies and syntheses report positive results: RCT <sup>d</sup> with large effects on several outcomes across tiers Meta-analysis <sup>e</sup> with 15 studies implementing tier 4 found positive effects

**APPENDIX Exhibit B.2: LAUNCH Family Support Program Models: Evidence of Effectiveness<sup>a</sup>**

Name	Focal Outcomes	Findings
<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>f</sup> , health care compliance, and rates of preterm births <sup>g</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
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>h</sup>
Strengthening Families Program *Parent Cafés	Family/relationships; mental health; social functioning	Limited research available

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

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

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

<sup>d</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>e</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>f</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>g</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.

<sup>h</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 B.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 (<b>NREPP</b>)</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 (<b>PPN</b>)</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 (<b>CEBC</b>)</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> </ul>

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

Source of Rating	Description of Rating Criteria
	<ul style="list-style-type: none"> <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>