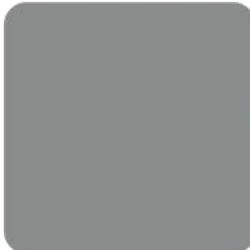


CROSS-SITE EVALUATION OF SAMHSA'S PROJECT LAUNCH INITIATIVE: KEY FINDINGS IN THE FIRST YEAR



OPRE Report # 2013-59
December 2013

CROSS-SITE EVALUATION OF SAMHSA'S PROJECT LAUNCH INITIATIVE

KEY FINDINGS IN THE FIRST YEAR

OPRE Report # 2013-59

December 2013

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

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 Inc.
55 Wheeler Street
Cambridge, MA 02138

This report is in the public domain. Permission to reproduce is not necessary. Suggested citation: Gwaltney, Margaret K., Barbara Goodson, and Deborah Klein Walker. (2013). Cross-Site Evaluation of Project LAUNCH: Key Findings in the First Year. OPRE Report 2013-59. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Disclaimer

The views expressed in this publication do not necessarily reflect the views or policies of the Office of Planning, Research and Evaluation, the Administration for Children and Families, or the U.S. Department of Health and Human Services.

This report and other reports sponsored by the Office of Planning, Research and Evaluation through an Interagency Agreement with the Substance Abuse and Mental Health Services Administration are available at <http://www.acf.hhs.gov/programs/opre>



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). The program’s primary objective is to promote the social, emotional, behavioral, and physical health and cognitive development of young children from birth to 8 years of age. By 2011, SAMHSA had funded 24 grantees in three cohorts to work with a pilot community for five years, pursuing dual goals of improving systems and services.

Through an Intra-Agency Agreement with SAMHSA, oversight of the cross-site evaluation is provided by the Office of Planning, Research and Evaluation (OPRE) within the Administration for Children and Families (ACF) in the U.S. Department of Health and Human Services. Abt Associates Inc. has been contracted to conduct a cross-site evaluation of the Project LAUNCH initiative. The evaluation will describe the implementation of Project LAUNCH, including changes in systems and services and outcomes for children and families in the state and the LAUNCH community. In addition, impact estimates from population studies and local evaluations will be combined to provide an overall picture of the effectiveness of Project LAUNCH in improving developmental outcomes for young children. This report presents key findings from the first year of implementation for grantees in the three cohorts.

Key Findings

- **Project LAUNCH supported enhancements to 25 home visiting programs, serving 580 families.** Sixty-four percent of these programs were evidence-based.
- **Nine hundred sixty three (963) families participated in LAUNCH-supported family strengthening programs.** A total of 704 children were screened on socio-emotional measures, with 4 percent referred for additional mental health-related evaluation or services.
- **Project LAUNCH grantees supported the use of four early childhood, social-emotional curricula in preschool and child care settings, two of which were evidence-based, and provided training to 108 staff in 22 early childhood programs.** Five grantees began to deliver mental health consultation in elementary schools in the first year, using licensed mental health professionals working in eight schools.
- **Sixty percent of grantees implemented integration of behavioral health activities in primary care settings.** In the first year, 5,660 children were screened in primary care settings, and 11 percent were referred for additional evaluation or follow-up services.
- **Grantees screened or assessed 6,799 children in the first year across all core strategies.**
- **Planned systems change activities were outlined in grantees’ strategic plans,** including changes in Medicaid reimbursement policies, implementation of early childhood endorsement programs¹, and enhancements to early childhood data systems. LAUNCH-supported young child wellness councils were taking a leadership role in these activities. Almost all grantees reported strengthened relationships across agencies as an outcome of Project LAUNCH in their first year.

¹ Endorsement programs provide specialized education and training for teachers and childcare providers working with young children and their families. Several LAUNCH grantees have collaborated with local and state agencies to develop and promote mental health endorsement programs that recognize early childhood professionals for having attained core competencies to address the social and emotional development of infants and young children and their families.

Key Findings in the First Year

At the end of the first year, the majority of Project LAUNCH grantees had made moderate progress towards their goals to change the local early childhood service system and to deliver evidence-based services that meet the needs of families in their communities. These changes were accomplished despite the deepening national recession and fiscal pressures on services and funding at all levels. In the midst of budget cuts and service reductions, Project LAUNCH stood out as a catalyst for other community agencies and institutions in their work to build a coordinated and comprehensive service system to promote healthy child development.

Table of Contents

Overview	i
Table of Contents	iii
Executive Summary	vi
Overview of Project LAUNCH.....	vi
Project LAUNCH Grantees.....	vii
The National Cross-Site Evaluation.....	vii
Year One: Planning and Collaboration.....	viii
Year One: Planning and Implementation of Service Strategies.....	ix
Year One: Systems Change.....	x
Next Steps.....	xii
1. Introduction	1
1.1 Research and Policy Background for Project LAUNCH.....	1
1.2 Project LAUNCH Program Initiative.....	3
1.3 Project LAUNCH Grantees.....	5
1.4 Cross-Site Evaluation of Project LAUNCH.....	7
1.4.1 Evaluation Questions.....	7
1.4.2 Data Sources.....	8
1.4.3 Analysis Plan.....	9
2. Context for Project LAUNCH	10
2.1 Community Context.....	10
2.1.1 Population of Focus for Project LAUNCH.....	10
2.1.2 Population Demographics and Economic and Social Characteristics.....	10
2.1.3 Availability of Services in LAUNCH Program Areas at the Start of Project LAUNCH.....	13
2.2 State/Tribal Context.....	15
2.2.1 Challenges and Barriers Identified by State/Tribal Environmental Scans.....	16

3.	Planning and Collaboration Activities in First Year	20
3.1	Planning Activities.....	20
3.1.1	Hiring Project LAUNCH Staff.....	20
3.1.2	Environmental Scans.....	21
3.1.3	Strategic Plans.....	22
3.1.4	Evaluation Plans.....	23
3.2	Collaboration Activities	25
3.2.1	Formation of State Child Wellness Councils	25
3.2.2	Formation of Community Child Wellness Councils	27
4.	Service Delivery in the First Year of Implementation	30
4.1	LAUNCH-Supported Home Visiting Programs: Year One.....	31
4.1.1	Families Served in LAUNCH-Supported Home Visiting Programs.....	33
4.1.2	LAUNCH-Supported Workforce Enhancement for Home Visitors	33
4.2	LAUNCH-Supported Family Strengthening Programs: Year One.....	34
4.2.1	Children and Families Participating in LAUNCH-Supported Family Strengthening Programs in the First Year	35
4.2.2	LAUNCH-Supported Professional Development for Staff of Family Strengthening Programs	36
4.3	Mental Health Consultation Services: Year One	36
4.3.1	Mental Health Consultation in Child Care/Preschool Programs.....	37
4.3.2	Mental Health Consultation in Elementary Schools	38
4.3.3	Integration of Behavioral Health in Primary Care	39
4.3.4	Mental Health Consultation to Home Visitors, Family Strengthening Programs	40
4.4	Developmental Screening and Assessment: Year One	40
4.5	LAUNCH Family Referrals/Coordination: Year One	42
4.6	Cross-Training and Workforce Development: Year One	43
5.	Establishing Priorities for Systems Change	46
5.1	Systems Change Activities Identified in Strategic Plans	46
5.1.1	State/Tribal Priorities for Systems Initiatives	46

5.1.2	Local Priorities for Systems Initiatives	47
5.2	Systems Change in the First Year	49
5.2.1	State/Tribal and Community-Level Systems Change	49
6.	Looking Toward Year 2.....	53
6.1	Year 2 Implementation for Project LAUNCH Programs.....	53
6.2	Next Steps for the Cross-Site Evaluation.....	53
	References.....	57
Appendix A	Logic Model for the Cross-Site Evaluation	60
Appendix B	Sources for Table 3.3	61
Appendix C	Description of Other Early Childhood Initiatives.....	63

Executive Summary

Overview of Project LAUNCH

Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health) is a federal grant program administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). The program’s primary objective is to promote the social, emotional, behavioral, and physical health and cognitive development of young children from birth to 8 years of age. Grantees are funded to work with a pilot community for five years, pursuing dual goals of improving systems and services. Three rounds of funding (2008-2010)² have resulted in 24 Project LAUNCH programs operating in 21 states, the District of Columbia, and 1 tribal nation.

The objectives of Project LAUNCH are to:

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

To achieve these objectives, Project LAUNCH grantees are expected to use a set of five research-based prevention and promotion strategies:

1. **Screening and assessment in a range of child-serving settings.** Screening for social and emotional well-being in young children can help to identify indicators of developmental delays or behavioral concerns and signal that a more extensive assessment is warranted.
2. **Integration of behavioral health into primary care settings.** Integration models seek to bring mental health expertise into the primary care practice both through having mental health consultants on site and through training primary care staff to be able to recognize, assess, and provide appropriate referrals to help their patients who have mental health needs.
3. **Mental health consultation in early care and education.** Mental health professionals work collaboratively with early childhood education programs and staff and families to improve their ability to prevent, identify, treat, and reduce the effect of mental health problems among children from birth through age 8 and to implement classroom and center-based practices that promote healthy social and emotional development.
4. **Home visiting.** Home visitors work directly with families and caregivers in their homes to provide support and guidance on health care, education, and child development. Training is provided for

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

home visitors on program models as well as social and emotional development to improve the effectiveness of home visiting programs at supporting families.

- 5. Family strengthening and parent skills training.** Evidence-based tools and approaches are used to help families create healthy environments that support children’s development (National Center for Mental Health Promotion and Youth Violence Prevention, 2012).

To determine the programs and services they would implement, grantees engaged in a two-step planning process in the early months of the grant. They began by conducting environmental scans at the state/tribal and community levels to identify the systems and existing programs that serve children, birth to 8 years of age, and their families. Grantees then used the results of their environmental scans to develop a strategic plan for supporting systems changes and addressing the gaps in services for families and children that were identified in the environmental scan. The strategic plan identified the evidence-based programs Project LAUNCH grantees would implement (across the five core strategies) within communities.

Project LAUNCH grantees are guided by Young Child Wellness Councils (YCWCs) that engage key leaders in overseeing Project LAUNCH activities. Grantees form YCWCs at both the state/tribal (Cohorts 1 and 2) and community levels (all cohorts). They can establish a new YCWC or integrate the functions of the YCWC into an existing body whose focus is young child wellness. At a minimum, YCWCs are expected to have representatives from health, mental health, child care, Medicaid, substance abuse prevention, early childhood and education, Title V administering agencies (if applicable), and families in the target population (SAMHSA, 2008; 2009; 2010). YCWCs participate in grantees’ efforts to conduct an environmental scan of state/tribal (Cohorts 1 and 2) and community assets (all cohorts), identify unmet needs, and then develop a strategic plan that guides their use of the five prevention and promotion strategies drawn from current research.

Project LAUNCH Grantees

Project LAUNCH grantees work in a designated community over 5 years to implement evidence-based practices, improve collaboration among child-serving organizations, and integrate physical and mental health and substance abuse prevention strategies for children and their families. This report covers activities conducted by the first three cohorts of 24 grantees in their first year of funding.

All LAUNCH communities can be characterized as high need —i.e., children and families have significant risk factors, services are insufficient to meet all needs, and health and economic disparities exist within the community. In addition, when selecting the LAUNCH community, states (in Cohorts 1 and 2) considered criteria, such as population diversity and similarity to other communities in the state, that would make it an appropriate pilot site for an initiative that might later be replicated statewide.

The National Cross-Site Evaluation

Through an Intra-Agency Agreement with SAMHSA, oversight of the cross-site evaluation is provided by the Office of Planning, Research and Evaluation (OPRE) within the Administration for Children and Families (ACF) in the Department of Health and Human Services. Abt Associates Inc. has been contracted to conduct a 5-year cross-site evaluation of the Project LAUNCH initiative. The evaluation is intended to describe the implementation of Project LAUNCH, including changes in systems and services and outcomes for children and families in the LAUNCH community. In addition, impact estimates from local evaluations of LAUNCH will be combined to provide an overall picture of the effectiveness of Project LAUNCH at improving developmental outcomes for young children (Goodson, Walker, and Gwaltney, 2012).

The cross-site evaluation is addressing four research questions:

1. What are the system level changes at the state/tribal level?
2. What are the system level changes at the community/local level?
3. How have child and family services in the community been enhanced?
4. What is the effect on the health and well-being of young children in the Project LAUNCH communities?

Future cross-site evaluation reports will expand upon the analysis in this report and further illuminate the findings on the first three research questions. Question four on the effects of LAUNCH on the health and well-being of young children will be addressed in the final year of the cross-site evaluation.

Multiple data sources are used in the cross-site evaluation of Project LAUNCH, including:

- A web-based data system (web portal), in which grantees report information on state/tribal and community systems building activities and services implementation;
- Interviews with the Project LAUNCH coordinator at the community or tribal level and, for grantees in the first two cohorts, with the state project director;³
- Review of grant applications, environmental scans, and strategic plans; and
- Review of end-of-year reports submitted to SAMHSA.

The interviews are conducted as part of site visits during each grant's second year of implementation and by telephone in all other years. During site visits, the CSE interviews key stakeholders such as local service providers, members of the state/tribal or local YCWC, and community members in addition to the LAUNCH project director and coordinator. This report relies on data from each of these sources and presents key findings from the first year of implementation for grantees in the first three cohorts.

Year One: Planning and Collaboration

Project LAUNCH grantees were given time for planning their strategies for improving systems and services rather than having to begin implementation immediately after being funded. Grantees in Cohorts 1 and 2 had 6 months for planning, and grantees in Cohort 3 had 9 months. This time afforded them the advantage of engaging in a multi-step planning process with the following steps: 1) establishing the Project LAUNCH team; 2) conducting environmental scans, both state/tribal and community; 3) developing a comprehensive strategic plan; 4) developing an evaluation plan; and 5) selecting prevention and promotion strategies to implement in the LAUNCH community. Grantees also used their first year to create a collaborative structure to guide program activities at both the state/tribe and community levels. Creating the Young Child Wellness Councils (YCWCs) at the state/tribe and local levels was part of this effort.

At the end of the first year, all grantees had established a YCWC in the state/tribe (Cohorts 1 and 2) and the community (all cohorts).⁴ Across all cohorts, a total of 273 agencies and organizations were

³ For Cohort 3 grants, which do not have state-level components, interviews were conducted with either the state Title V director or the lead for the state Early Childhood Comprehensive Services grant.

⁴ Throughout this report, data from the tribal grantee and District of Columbia are included in the discussion of state/tribal-level findings.

represented on state/tribal YCWCs, an average of 15 agencies per council in the first year. Ten of the state/tribal councils (56 percent) were newly formed for Project LAUNCH. A total of 414 organizations participated on the community YCWCs, averaging 18 organizational members. Twelve grantees (55 percent) formed a new community YCWC for Project LAUNCH. In a relatively short period of time, LAUNCH grantees had formed and convened YCWCs with considerable organizational diversity for the LAUNCH initiative. Even so, YCWCs were in the early phase of their development as oversight bodies for Project LAUNCH. Grantees were continuing to recruit others to join the state/tribal and community YCWCs and reported that membership would grow over the next year.

Year One: Planning and Implementation of Service Strategies

Each grantee developed an individualized plan for how to implement the Project LAUNCH prevention and promotion strategies. Grantees' choices of programs within each LAUNCH strategy were based on the reach of existing services in the communities, identification of the most significant service gaps, and pre-existing relationships with provider systems such as early care and education or primary care.

Maternal screening. In the first year, maternal screening for depression was implemented as part of home visiting programs by 10 grantees: two in Cohort 1, six in Cohort 2, and two in Cohort 3. Four grantees implemented screening as part of their mental health consultation models. In addition, six grantees planned to expand assessment to include mothers in the second year of implementation.

Home visiting and family strengthening. Grantees invested in evidence-based programs or promising practices in home visiting and family strengthening: Seventy-nine percent of LAUNCH-initiated home visiting programs and 81 percent of LAUNCH-initiated family strengthening programs were evidence-based models or promising practices.⁵ The majority of grantees (63 percent) began to implement enhancements of existing home visiting programs and family strengthening programs in the first year. Grantees that did not begin implementing a home visiting or family strengthening program had plans for initiating services in their second year.

Grantees enhanced home visiting and family strengthening services through provider training or new programmatic elements focused on children's mental health and behavior. Some grantees also provided mental health consultation to staff in home visiting programs. Within three grantee communities, this consultation was provided in response to staff stating that they were unprepared to address mental health issues in families and were overwhelmed by the needs of some of the families they serve.

Mental health consultation and integration of behavioral health. Mental health consultation models took longer to implement than direct services: Thirty-eight percent of grantees initiated consultation activities by the end of the first year, with another third of grantees planning to begin implementation in the second year. The remaining third had not initiated plans to implement mental health consultation in primary care settings. Challenges that grantees faced in developing and implementing consultation models included the extended time and effort required to establish collaborative relationships and infrastructure in primary care and early care and education settings, especially where the collaborating organizations had no histories of cross-agency cooperation. All but one of the consultation models adopted by grantees relied on trained mental health clinicians whose primary role was to consult on individual children (and their families) whom providers identified as having mental health concerns.

⁵ The term promising practice, as defined by RAND Promising Practices Network, refers to programs that have shown an impact, but the evaluation design of the program displays some weaknesses such as a poorly matched comparison group.

Some consultants also worked more broadly with providers on environmental changes, such as providing more resources for peer play (e.g., dramatic play areas and materials), changing the organization of activity centers in the classroom, and providing peer-to-peer helping during learning activities, to better support healthy socio-emotional development.

Developmental screening. Grantees screened or assessed 6,799 children participating in LAUNCH services in the first year and expanded the use of standardized developmental screening and assessment in the community. Nearly all grantees went beyond standard assessments of children’s cognitive development to include assessment of children’s socio-emotional development, overwhelmingly using the Ages and Stages Questionnaire-Social-Emotional (ASQ-SE) tool. Grantees actively planned to expand developmental assessments into additional settings in the second year of implementation and work on implementing common screening and assessment measures across programs.

Workforce enhancement. Enhancing the knowledge and practice of the provider workforce is a major objective for all of the LAUNCH grantees. In the first year of implementation, LAUNCH grantees delivered training to 495 staff in primary care settings; 359 staff in early care and education settings; and 265 staff in home visiting and family strengthening programs. The training covered such topics as understanding children’s socio-emotional development and how to evaluate mental and behavioral health. A few of the LAUNCH grantees also provided community-wide training for 472 providers in human service agencies and the broader child care and primary care communities, with additional grantees reporting that they planned to work with provider groups (such as all home visitors in the community) in the second year of implementation.

Year One: Systems Change

Project LAUNCH addresses both service delivery and systems change. While the majority of program funds goes toward service implementation, the LAUNCH initiative also emphasizes systems change across multiple sectors of the child services delivery system. Systems change activities are aimed at ensuring availability and access to quality prevention services for young children and families; sustaining services over time; addressing service gaps in order to improve the health, well-being, and school readiness of young children and families and reduce health disparities; and eliminating fragmentation in systems and funding streams.

State/tribal and community YCWCs are leading systems change activities. In the first year, grantees have brought together agency representatives from across the child-serving system to be on the YCWCs, resulting in YCWCs that have individuals with diverse experience, knowledge, and authority to address needed systems change. Grantees are continuing to increase the representation of parents and other sectors on the YCWCs so that the full range of perspectives and experience is covered. The state/tribal project director and community coordinator for LAUNCH also have a major role in facilitating systems change efforts.

In their strategic plans, most grantees identified state/tribal- and community-level systems building activities they planned to implement. These activities fell within six categories: 1) policy development, 2) funding, 3) workforce development, 4) data systems enhancement, 5) public awareness, and 6) collaboration. While the systems change goals that grantees included in their plans are extensive and require considerable planning and collaboration among key policymakers and program staff, almost all grantees began working on systems change initiatives in their first year. Moreover, grantees reported important systems changes in Year One. Among the outcomes reported are:

- Initial steps toward establishing an endorsement program for all early childhood professionals;⁶
- Changing a Medicaid policy so that primary care offices no longer have a predetermination requirement for developmental screenings of children in primary care offices;
- Providing training on the Ages and Stages Questionnaire Social and Emotional (ASQ-SE) screening tool to all early education teachers in the school district;
- Developing data tracking systems for provider organizations;
- Development of resource guides and other information products and materials; and
- Improving collaboration among senior leaders across multiple early childhood agencies and systems at both the state/tribal and community levels.

Systems change takes time. Many of the systems building activities that Project LAUNCH supports (e.g., changes in policy, securing financing for developmental screens, and mental health consultation in primary care and early childhood settings) may take the full 5-year grant program to achieve. Specific examples from grantees' strategic plans of longer-term system building activities (or plans) include:

- Aligning funding and policies to permit use of Medicaid funds to support developmental screening;
- Creating policies to incentivize non-medical settings to conduct evidence-based screening that leads to early identification and early intervention;
- Implementing educational incentives for school districts to offer transition programs for children entering kindergarten (e.g., summer pre-K programs for children who have had no formal pre-K experiences);
- Establishing a common database system for monitoring the delivery of child and family services;
- Creating awareness of early childhood endorsement systems and having providers complete the endorsement program; and Enhancing workforce competence by implementing skill building or education programs that address infant/early childhood mental health competencies.

Almost all grantees have taken strides in their first year toward meaningful and sustainable change at state/tribal and community levels.

⁶ An early childhood endorsement program provides specialty training and certification to individuals who work with young children. Programs are designed for classroom teachers, child care staff and program directors, and others who care for young children, from birth through grade 3.

Findings and Lessons Learned

- Across all cohorts, a total of 273 agencies and organizations at the state/tribal level and 414 at the community level participated on **Young Child Wellness Councils**, averaging 15 agency members on state/tribal YCWCs and 18 on community YCWCs. At the end of the first year, grantees continued to recruit members to fill gaps in representation.
- Grantees began to implement services for children and families in the second half of the first year of their grant. Across all LAUNCH service strategies, grantees **screened or assessed** 6,799 children in the first year for cognitive and socio-emotional development. Ten grantees screened mothers for maternal depression as part of home visiting programs or mental health consultation in primary care.
- Project LAUNCH supported new **home visiting and family strengthening programs** and enhancements in these programs. Seventy-nine percent of newly-initiated home visiting programs and 82 percent of family strengthening programs were evidence-based models or promising practices. Enhancements to home visiting and family strengthening programs included provider training or adoption of new program elements that focused on children’s mental health and behavior.
- **Mental health consultation** in early care and education and in primary care settings took longer to implement than other direct services due to several factors: mental health consultation was less likely to exist in communities at the time of LAUNCH funding; evidence-based models for mental health consultation did not exist; and consultation required coordination across two or more settings, and it took time to form these new relationships.
- Some grantees are providing **mental health consultation** to staff in home visiting programs. Consultation was provided in response to home visitors indicating that they were unprepared to deal with mental health issues in families and sometimes overwhelmed by the needs of the families they serve.
- LAUNCH grantees provided **training** to more than 1,600 program staff in the first year, covering a range of topics, including children’s socio-emotional development, developmental screening, and evidence-based practices.
- **Systems change activities** were started, although they received less emphasis in the first year than services delivery. Grantees reported improved coordination across agencies as a result of participation in YCWCs.
- **Contextual factors** such as the economic downturn and freezes in state budgets, as well as competing priorities, posed challenges to LAUNCH grantees. Budget freezes extended the time for some grantees to hire Project LAUNCH staff and to put contracts in place and were thought to limit participation at YCWC meetings. Other priorities—e.g., response to the H1N1 epidemic—also diverted attention from LAUNCH start-up activities in some states.

Next Steps

For Project LAUNCH. Project LAUNCH programs began implementing services and systems change in the first year of implementation despite the sharp national recession and the resulting fiscal pressures on services and funding at all levels. In the midst of budget cuts and service reductions, Project LAUNCH often stood out as a catalyst for other community agencies and institutions in their work to build a coordinated and comprehensive service system to promote healthy child development. Project LAUNCH grantees also recognized the ways in which the recession negatively impacted the overall

health of their communities. These circumstances increased the risk factors faced by families of young children and by the children themselves and threatened the existence of many of the protective services that had been established for children and families at risk.

The fiscal constraints tightened for Cohort 1 in its second year of implementation (i.e., 2009-2010) and will likely continue in the second year for Cohort 2 and 3 communities as well (2010-2011 and 2011-2012, respectively). The 2009-2010 year also coincided with political changes at the state level, with governors elected on platforms that included reducing funding for educational and social services. Grantees acknowledged in their strategic plans that collaboration across programs and agencies would be essential to withstand the program cutbacks, fiscal controls, and staff shortages.

At the federal level, three programs in particular complemented the work of Project LAUNCH grantees: the Supporting Evidence-Based Home Visiting Program to Prevent Child Maltreatment (EBHV), now part of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program; the MIECHV program, created by the Affordable Care Act (ACA); and Race to the Top, funded by the American Recovery and Reinvestment Act (ARRA).⁷ The EBHV program provided funding in 2008 to two states that also had a Project LAUNCH grant. In 2010, MIECHV awarded grants by formula to every state to begin to plan for implementation of home visiting programs; in 2011, additional funds were awarded to LAUNCH states by formula and nine of these states also received competitive awards to expand and/or enhance the development of their home visiting programs. Six Project LAUNCH states received Race to the Top funding in 2010 and another 3 states with LAUNCH grants received Race to the Top awards in 2011. Project LAUNCH grantees that had these other sources of funds began to integrate their LAUNCH activities with these other federal initiatives.

For the cross-site evaluation. The next cross-site evaluation report will continue to use data reported by grantees on service delivery (which is updated every 6 months) and systems development (which is updated annually), evaluation reports submitted to SAMHSA, and information from interviews with Project LAUNCH staff in each site. Telephone or site visit interviews are conducted annually with the state/tribal project director for LAUNCH (Cohorts 1 and 2) and the LAUNCH community coordinator (all cohorts). During site visits, CSE team members will also conduct additional interviews with key stakeholders such as members of the state/tribal or local YCWs.

In addition, in Year 2, the CSE provided funding to four Cohort 1 and 2 evaluators to conduct special studies that evaluate child outcomes. Another four studies were awarded in May 2012. The special studies, which employ quasi-experimental designs, are expected to provide data on the effectiveness of Project LAUNCH in improving child outcomes. As findings from these studies become available, the cross-site evaluation will report on the outcomes of Project LAUNCH in order to address the evaluation question about the effect of LAUNCH on the health and well-being of young children in Project LAUNCH communities.

⁷ The ACA (P.L. 111-148), signed in March 2010, amended Title V of the Social Security Act to create the MIECHV program which allows collaboration and partnership at the federal, state, tribal, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs (see <http://www.acf.hhs.gov/programs/ecd/programs/home-visiting>). The ARRA (P.L. 111-5) was intended to provide temporary relief to those most affected by the recession and to support infrastructure, education, and health programs in states and communities.

1. Introduction

Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health) is a federal grant program administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). The program’s goal is to promote the social, emotional, behavioral, and physical health and cognitive development of young children from birth to 8 years of age. Grantees are funded to work with a target community for 5 years, pursuing dual goals of improving systems and services. The goals of Project LAUNCH for systems are to (1) improve coordination and collaboration across community, tribal, and state agencies responsible for serving young children and their families; and to (2) integrate physical and behavioral health services for children and families. Grantees are also expected to increase the quality and quantity of evidence-based home visiting and family strengthening programs for children and families; to introduce mental health consultation into child care and early education settings; to integrate behavioral health programs and practices into primary care settings; and to extend the use of developmental assessments across child-serving settings. Three rounds of funding (2008–2010) have resulted in 24 Project LAUNCH programs operating in 21 states, the District of Columbia, and a tribal nation.

Each Project LAUNCH program is required to conduct a local evaluation of the implementation and outcomes of the project at the state level (Cohorts 1 and 2 only) and in the targeted community. In addition, a national cross-site evaluation of Project LAUNCH is being conducted that summarizes the implementation and outcomes of Project LAUNCH over the five years of implementation. This report covers activities in the *first year of implementation* and addresses three primary evaluation questions:

- What strategies for changing services and systems were implemented by LAUNCH grantees?
- What are the system changes at the state/tribal level?
- What are the system changes at the community/local level?

This report provides:

- Background and context for the Project LAUNCH program (Chapter 2);
- A description of planning and coordination activities in the first year (Chapter 3);
- A discussion of the services or practices that grantees supported in their first year (Chapter 4) and systems change activities at the state/tribe and community levels (Chapter 5); and
- A forward look at LAUNCH activities in the second year of program implementation and next steps for the cross-site evaluation (Chapter 6).

This chapter describes the research and policy background for Project LAUNCH, the components of the Project LAUNCH program initiative, the Project LAUNCH grantees, and the design and data sources for the cross-site evaluation and this report.

1.1 Research and Policy Background for Project LAUNCH

There are many theoretical underpinnings of Project LAUNCH. They include theories about child development across cognitive and socio-emotional domains; behavioral theories based on risk and protective factors and our understanding of types and level of risk facing children today; and theories about how to build effective systems of care for infants and young children and their families.

Bronfenbrenner’s ecological theory of child development (Bronfenbrenner, 1979) has long established the importance to the child of the multiple layers of relationships—with family, with outside providers, and

with institutions (e.g., schools). More recently, however, research in several fields has found that adverse experiences during a child's early development can affect later adult health status (National Research Council and Institute of Medicine, 2000; Shonkoff, Boyce & McEwen, 2009). The 2000 Institute of Medicine Report, *From Neurons to Neighborhoods*, reviews research evidence that shows children with multiple risk factors are of particular concern for poor developmental outcomes and discusses evidence-based interventions that support healthy child development. The research presented in this and other reports links children's readiness for school to their socio-emotional development and skills (Thompson, 2002; Boyd et al., 2005; Purington, 2009).

Since the release of the Surgeon General's Report on Mental Health (1999), many reports have focused on the importance of addressing the increasing concerns about mental health for infants and young children (Center for Mental Health in Schools, 2005; Duran et al., 2009; Finello & Poulsen, 2011; Gilliam, 2005; National Institute for Healthcare Management, 2005; O'Connell et al., 2009; Purington, 2009; Zeanah et al., 2004). It is estimated that the prevalence of clinically significant behavior and emotional disabilities is between 4 and 10 percent in young children, with higher estimates for children in low income households (Center for Mental Health in Schools, 2005). In the last decade, research has documented increasing rates of suspension and expulsion of children from early care and education programs (Gilliam, 2005; 2008). These disciplinary actions have been in response to a range of severe behavior problems, such as physical aggression and self-destructive behavior. The 2009 Institute of Medicine report, *Preventing Mental, Emotional and Behavioral Disorders among Young People: Progress and Possibilities*, documented the cost of mental illness in terms of dollars, morbidity and mortality, and quality of life to individuals, families, and society. The IOM report also calls for a prevention approach through the use of proven strategies such as strengthening families, screening followed by preventive interventions for specific disorders, and promoting mental health in school, healthcare, and community program settings. Project LAUNCH is designed to support the development of a more coordinated, comprehensive community child and family mental health system to address these risks to children and families.

Several recent reports argue for the development of systems of early childhood care to promote healthy child development and positive mental health status by providing culturally-competent early childhood prevention strategies (Finello & Poulsen, 2011, Zeanah et al., 2004). Duran and her colleagues (2009) present findings from a national study on promising practices of mental health consultation in early childhood settings across the United States. Purington (2009) reviews practices across all states that promote care coordination, case management, and linkages among state Medicaid, Title V, and Part C (of IDEA) agencies and finds that states are implementing many strategies to promote better coordination of systems serving young children and their families. States are using resources found through Medicaid, Title V, and Part C programs to promote program linkages.

Despite the strides being made on a number of fronts, states still face many barriers in their efforts to improve service systems for young children, and efforts are ongoing to improve community linkages. Zeanah and her colleagues (2004) recommend that infant mental health be included in all pediatric, early care and education, and community family support systems. Several reports (e.g., Finello & Poulsen, 2011; Zeanah et al., 2004) also highlight the need for increasing the capacity of the workforce to address early childhood mental health issues, as well as the need for community awareness programs to focus on reducing the stigma associated with mental health. Raghavan et al. (2008) argue that it will take sustained commitment to implementation of evidence-based strategies within a "broader ecology of service delivery," rather than clinical offices alone, to meet the challenges in improving early childhood mental health.

1.2 Project LAUNCH Program Initiative

Project LAUNCH is a national initiative that incorporates the most recent research about risks and protective factors that are thought to impact early childhood development and well-being. The program initiative builds on the recommendations of several national reports concerning the characteristics needed in an early childhood system of care that focuses on evidence-based prevention and health promotion strategies and aims to “create a shared vision for the wellness of young children that drives the development of federal, state, territorial, tribal, and locally-based networks for the coordination of key child-serving systems and the integration of behavioral and physical health services” (SAMHSA, 2008).

The program focuses on change within services and systems. The emphasis on systems is important, because children and families receive services from multiple agencies and service systems. Research indicates that implementing effective interventions supporting the wellness of young children and their families and bringing these programs to scale at the community and state/tribal levels require a supportive infrastructure that includes adequate financing; a well-trained, highly skilled workforce; and a coordinated and effective delivery system (National Research Council and Institute of Medicine, 2009).

The goals of Project LAUNCH are to:

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

Project LAUNCH Core Strategies

- Developmental assessment
- Integration of behavioral health programs and practices into primary care
- Home visiting
- Mental health consultation in child care and early education settings
- Family strengthening and parent skills training

To achieve these goals, Project LAUNCH grantees are expected to use a set of five research-based prevention and promotion practices (known as the Project LAUNCH “core strategies”):

1. **Screening and assessment in a range of child-serving settings.** Screening for social and emotional well-being in young children can help to identify indicators of developmental delays or behavioral concerns and signal that a more extensive assessment is warranted.
2. **Integration of behavioral health into primary care settings.** Integration models seek to bring mental health expertise into the primary care practice both through having mental health consultants on site and by training primary care staff to be able to recognize, assess, and provide appropriate referrals to help their patients who have mental health needs.
3. **Mental health consultation in early care and education.** Mental health professionals work collaboratively with early childhood education programs and staff and families to improve their

ability to prevent, identify, treat, and reduce the effect of mental health problems among children from birth through age 8 and to implement classroom and center-based practices that promote healthy social and emotional development.

4. **Home visiting.** Home visitors work directly with families and caregivers in their homes to provide support and guidance on health care, education, and child development. Training is provided for home visitors on program models as well as social and emotional development to improve the effectiveness of home visiting programs at supporting families.
5. **Family strengthening and parent skills training.** Evidence-based tools and approaches help families create healthy environments that support children’s development (National Center for Mental Health Promotion and Youth Violence Prevention, 2012).

For the home visiting and family strengthening strategies, LAUNCH grantees are strongly encouraged to select evidence-based practice models when initiating new programs or enhancing existing programs.

Project LAUNCH grantees are guided by Young Child Wellness Councils (YCWCs) that engage key leaders in developing a common strategy and plan for improving outcomes for young children and their families. Grantees form a YCWC at the state/tribal (Cohorts 1 and 2) and community levels (all cohorts). They can establish a new YCWC or integrate the functions of the YCWC into an existing body whose focus is young child wellness. At a minimum, YCWCs are expected to have representatives from the health, mental health, child welfare, Medicaid, substance abuse prevention, early childhood, and state education fields; Title V administering agencies (if applicable); and families from the target population (SAMHSA, 2008; 2009; 2010). These YCWCs join with public and private partners to conduct an environmental scan and identify unmet service needs, then develop strategic plans that guide their use of the five prevention and promotion strategies drawn from current research.

In addition to the five prevention and promotion practices and the YCWC, Project LAUNCH includes additional components:

- Public education campaigns to increase knowledge about healthy child development;
- Alignment of the work of Project LAUNCH with other related initiatives, such as MIECHV⁸ and Early Childhood Comprehensive Systems (ECCS) programs, SAMHSA’s Strategic Prevention Framework State Incentive Grant (SPF SIG) program, and the ACF’s Evidence-Based Home Visitation (EBHV) Program to Prevent Child Maltreatment; and
- Local evaluations of the implementation and outcomes of the project, conducted by an evaluator separate from the program staff.

Other Project LAUNCH Components

- Young child wellness councils at state/tribal and community levels
- Public education campaigns
- Alignment of Project LAUNCH with other initiatives, e.g., MIECHV, ECCS, SPF SIG, and EBHV programs
- Process and outcome evaluation

During the first 6 (Cohort 1 and 2 grantees) or 9 (Cohort 3 grantees) months, grantees carry out a two-step planning process, starting with environmental scans at the state/tribal and community levels to identify the systems and existing programs that serve children, birth to 8 years of age, and

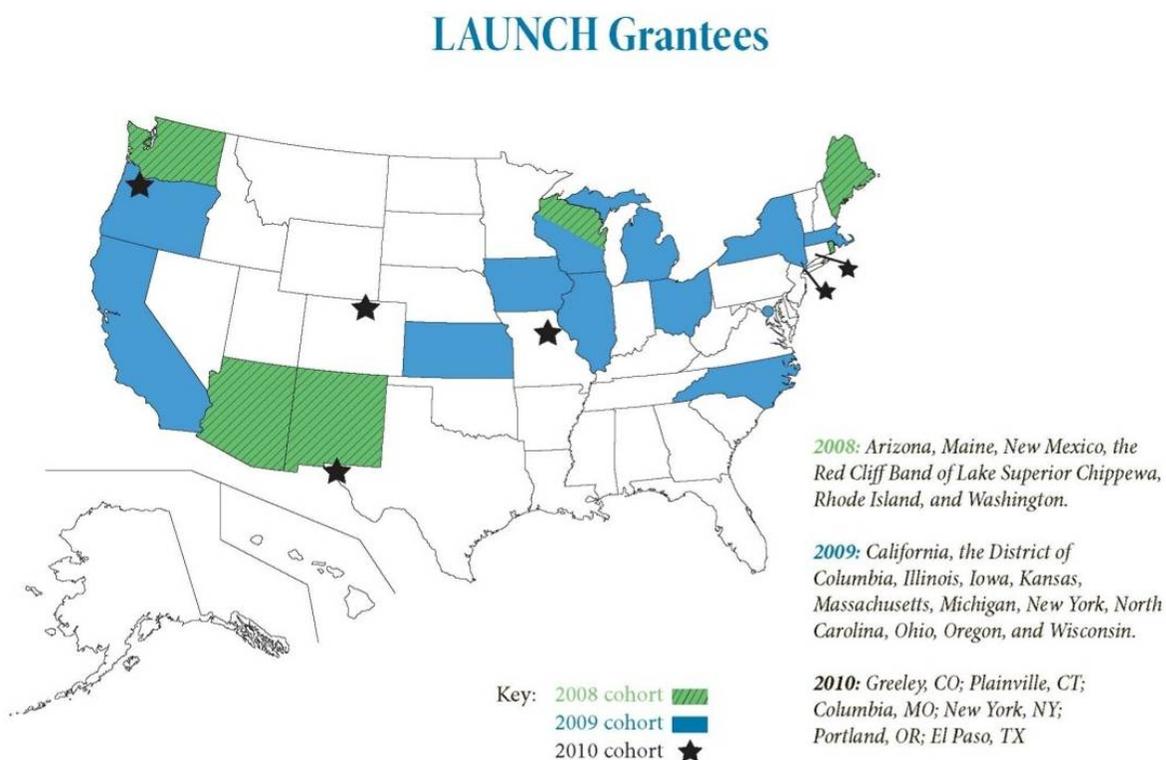
⁸ MIECHV is administered by the Health Resources and Services Administration (HRSA) in collaboration with the Administration for Children and Families (ACF)

their families. Then, using the results of their environmental scan, grantees prepare a strategic plan for supporting systems changes and addressing gaps in services for families and children identified in the community-level environmental scan. The strategic plan identifies the evidence-based prevention and promotion strategies and practices that grantees will implement across the five core Project LAUNCH strategies.

1.3 Project LAUNCH Grantees

Project LAUNCH consists of 24 programs that have been funded across three cohorts: 6 grantees in 2008, 12 in 2009, and 6 in 2010 (see Exhibit 1).⁹ In the first two cohorts, the grants were awarded to the state Title V Maternal and Child Health agency and a target community in the state. In the third cohort, SAMHSA provided awards directly to a community organization (i.e., public and private non-profit

Exhibit 1.1. Map of Project LAUNCH Grantees: Cohorts 1, 2, and 3



⁹ SAMHSA funded 11 grantees in a fourth cohort in September 2012. Grantees in this cohort are not included in this report.

Table 1.1. Three Cohorts of Project LAUNCH Grantees

Grantee State	Grantee Agency	Project LAUNCH Community
Cohort 1		
Arizona	AZ Department of Health Services	Two zip codes in Phoenix
Maine	ME Department of Health and Human Services	Washington County
New Mexico	NM Department of Health	Santa Fe County
Rhode Island	RI Department of Health	City of Providence
Washington	WA State Department of Health	Yakima County
Wisconsin	Red Cliff Band of Lake Superior Chippewas	Red Cliff Reservation
Cohort 2		
California	CA Department of Public Health	East Oakland
District of Columbia	DC Department of Health	Wards 7 and 8
Illinois	IL Department of Human Services	Four communities on Chicago's West side: East and West Garfield Park and North and South Lawndale
Iowa	IA Department of Public Health	Seven zip codes in inner-city Des Moines
Kansas	KS Department of Health and Environment	Finney County
Massachusetts	MA Department of Public Health	Boston
Michigan	MI Department of Community Health	Saginaw County
New York	NY Department of Health	Three communities in Westchester County: Yonkers, Ossining, and Port Chester
North Carolina	NC Division of Public Health	Guilford County
Ohio	OH Department of Health	Four counties of rural Appalachian Ohio: Athens, Hocking, Vinton, and Meigs
Oregon	OR Department of Human Services	Deschutes County
Wisconsin	WI Department of Health Services	Eight zip codes in Milwaukee
Cohort 3¹⁰		
Colorado	North Colorado Health Alliance	Weld County
Connecticut	Wheeler Clinic, Inc.	New Britain
Missouri	Curators of the University of Missouri	Boone County
New York	Fund for Public Health in New York	East Harlem and Hunts Point
Oregon	Multnomah Education Service District	Multnomah County
Texas	Aliviane, Inc.	Three Census tracts within El Paso County and City

¹⁰ LAUNCH grants in Cohort 3 were funded at the community level; the award was not made to the state Title V agency, as for grantees in Cohorts 1 and 2.

organizations, a university), rather than to a state agency. While Cohort 3 grants did not go to a state agency directly, these grantees were encouraged to “work closely with the state early childhood leadership to ensure that planning and policy reforms at the state level are consistent with and aligned with” efforts in the LAUNCH community (SAMHSA, 2010). Each Project LAUNCH project has a designated target community in which to implement evidence-based programs and activities to improve child wellness. The definition of community was left to the grantee, and each has defined the community as one or more counties, cities or towns, Census tracts, or neighborhoods (see Table 1.1).

1.4 Cross-Site Evaluation of Project LAUNCH

Through an Intra-Agency Agreement with SAMHSA, oversight of the cross-site evaluation is provided by the Office of Planning, Research and Evaluation (OPRE) within the Administration for Children and Families (ACF) in the Department of Health and Human Services. Abt Associates Inc. has been contracted to conduct a 5-year cross-site evaluation of Project LAUNCH. The evaluation is intended to describe the implementation of Project LAUNCH over 5 years, changes in systems and services that occur during Project LAUNCH, and outcomes for children and families in the LAUNCH community. In addition, impact estimates from local evaluations of LAUNCH will be combined to provide an overall picture of the effectiveness of Project LAUNCH at improving developmental outcomes for young children (Goodson, Walker, and Gwaltney, 2012).

1.4.1 Evaluation Questions

The cross-site evaluation is guided by a logic model that links the state/tribal/community context to Project LAUNCH system development and service delivery activities, systems changes, and service delivery system outcomes, as well as longer-term community-wide child outcomes (See Appendix A for a copy of Project LAUNCH Cross-Site Evaluation Framework). The cross-site evaluation addresses four evaluation questions:

1. What are the system level changes at the state/tribal level? Are there:
 - Improved coordination and collaboration across agencies serving young children and families;
 - Sustained implementation of a coordinated, family-centered, culturally competent child-serving system;
 - Improved infrastructure, legislation, and other policies;
 - Increased public education outreach and awareness; and
 - Sustained funding and maintenance of child-serving systems?
2. What are the system level changes at the community/local level? Are there:
 - Improved coordination and collaboration across agencies serving young children and families;
 - Sustained implementation of a coordinated, family-centered, culturally competent child-serving system;
 - Improved infrastructure, legislation, and other policies;
 - Increased public education outreach and awareness; and
 - Sustained funding and maintenance of child-serving systems?
3. How have child and family services in the community been enhanced? Have enhancements occurred through:
 - Workforce development;
 - Changes in provider practices; and

- Increased number of children and families receiving high-quality services that meet their needs?
4. What is the effect on the health and well-being of young children in the Project LAUNCH community? Are there:
- Increased number of children reaching physical, social, emotional, behavioral, and cognitive developmental milestones; and
 - Increased number of children entering school ready to learn (including physical, social, emotional, behavioral, and cognitive readiness)?

As discussed previously, the first year of Project LAUNCH implementation focused on planning service delivery and systems building activities and creating and enhancing partnerships with state/tribal and community organizations. Therefore, first-year data collected and analyzed by the cross-site evaluation also focuses on the planning and partnership building activities that took place and the initial implementation of services in the latter part of the first year (questions 1 through 3, above). Future cross-site evaluation reports will expand upon the analysis in this report and further illuminate the findings on these evaluation questions.

Question 4 on the effects of LAUNCH on families and children will be addressed primarily in the final year of the cross-site evaluation through a set of special impact studies that were funded by SAMHSA through a competitive process. LAUNCH grantees and local evaluators could apply for additional funding to implement studies of impacts on young children that had a population-wide focus and employed a rigorous, quasi-experimental design. Grantees had to submit proposals in response to stated requirements (Goodson, Walker, and Gwaltney, 2012). In two rounds of applications, seven special studies were funded among Cohort 1 and Cohort 2 sites.¹¹ The final CSE report will summarize the findings on child impacts across the special studies.

1.4.2 Data Sources

The cross-site evaluation of grantees' first year of Project LAUNCH implementation uses multiple sources of data to characterize implementation and early outcomes of Project LAUNCH (see Table 1.2). Data sources for this report include:

- A web-based data system (web portal), where grantees report information on state/tribal and community systems building activities and services implementation;
- Forty-two telephone interviews conducted by the cross-site evaluation team with the Project LAUNCH project director at the community or tribal level and with the state project director (Cohorts 1 and 2). For Cohort 3 grants, which do not have state-level components, interviews were conducted with either the state Title V director or the lead for the state ECCS grant;
- A systematic review of grant applications, environmental scans, and strategic plans; and
- Review of mid-year and end-of-year reports submitted by grantees to SAMHSA.

The interviews are conducted as part of site visits during each grant's second year of implementation and by telephone in all other years. During site visits, the CSE interviews key stakeholders such as local service providers, members of the state/tribal or local YCWC, and community members in addition to the

¹¹ One of the seven special studies was terminated after one year, because of a change in the grantee's evaluation team.

LAUNCH project director and coordinator. This report relies on data from each of these sources and presents key findings from the first year of implementation for grantees in the first three cohorts.

Table 1.2. Data Sources for the First Year of Implementation of Project LAUNCH

Data Source	Cohort 1 Grantees	Cohort 2 Grantees	Cohort 3 Grantees
Web portal	Reporting Period 1 ^a (10/08 – 9/09)	Reporting Period 3 (10/09 – 9/10)	Reporting Period 5 (10/10 – 9/11)
Telephone Interviews	November 2009	November 2010	November 2011
Environmental scans	April 2009	April 2010	April 2011
Strategic plans	June 2009	June 2010	June 2011 ^b
Mid-year reports	March 2009	March 2010	March 2011
End-of-year reports	December 2009	December 2010	December 2011

^a The reporting periods are based on the first cohort’s timeline.

^b Strategic plans were not available for two grantees.

1.4.3 Analysis Plan

The cross-site evaluation will examine implementation and outcomes of Project LAUNCH. Analysis will involve qualitative and quantitative methods. As discussed above, qualitative data will include data collected through annual key informant interviews and grantee reports. These data will inform questions about systems change and contextual factors at the state and local levels that facilitate or hinder implementation of Project LAUNCH. The CSE will conduct descriptive analyses of these data and will report on common themes, or patterns, across Project LAUNCH grantees. The analysis will involve describing systems change activities and outcomes at specific points in time (e.g., in the first grant year) and over time. In addition, the CSE will use simple statistics (frequencies, means, percentages) to describe grantee activities and outcomes in the systems domain.

The CSE will also describe implementation of Project LAUNCH services using qualitative and quantitative data reported in the web portal and collected during key informant interviews. For example, descriptive statistics will provide data on the number of children and families served through Project LAUNCH, the types of evidence-based program models that are supported, and fidelity of program implementation. Changes in provider knowledge, skills, and practices will also be described, using quantitative and qualitative data reported in the web portal and grantee reports.

To understand the outcomes of Project LAUNCH for children and families, the CSE will support special studies of the impact of the program on community-wide indicators of child wellness. The special studies will use quasi-experimental designs to assess child outcomes, using one or more comparisons, including outcomes from a comparison community or a comparison estimate created from state-level datasets. The CSE will summarize the community impact estimates from the special studies and any other quasi-experimental studies that grantees conduct as part of their local evaluations.

2. Context for Project LAUNCH

This chapter discusses the community and state/tribal context for Project LAUNCH. This context includes the risk factors of families in LAUNCH-funded communities and the gaps and challenges of existing services and program initiatives to meet family and community needs. The chapter begins by summarizing selected demographic, socio-economic, and health indicators for LAUNCH communities, each of which can affect the developmental outcomes of young children (Child Trends and Center for Child Health Research, 2004). The chapter also discusses the gaps in services identified in environmental scans, which were conducted by grantees during the initial 6 to 9 months of their grant period. Finally, the chapter concludes with a discussion of the state/tribal context for LAUNCH, which includes several programs that preceded LAUNCH and set the stage for continued development and improvements in the child-serving system.

2.1 Community Context

Project LAUNCH grantees in Cohorts 1 and 2 were required to select a local community in which to implement evidence-based programs (EBPs) and activities to improve child wellness (SAMHSA, 2008; 2009). Title V Maternal and Child Health state agencies, which were the applicants in these two cohorts, applied with a community where they would be implementing services. In some sites, the impetus to apply for funding originated with the community, which solicited state support and involvement. In other sites, state agencies selected the LAUNCH community. In either case, each of the designated communities had a history of implementing similar types of programs in one or more parts of the child service system. For example, several communities were involved in other statewide initiatives for children (e.g., First 5 in California, All Our Kids in Illinois). In Cohort 3, where the LAUNCH community is the grantee, the communities applied for funding to enhance programs and services for families and young children. All LAUNCH communities were characterized as having a high need for services in the community—i.e., children and families had significant risk factors, and health and economic disparities and services were not sufficient to meet all needs. In addition, when selecting the LAUNCH community, states considered criteria, such as population diversity and similarity to other communities in the state, that would make it an appropriate pilot site for an initiative that, if successful, might later be replicated statewide.

2.1.1 Population of Focus for Project LAUNCH

Project LAUNCH serves children from birth to 8 years of age and their families (SAMHSA, 2008; 2009; 2010). Within this age range, some grantees have identified subpopulations within the community, based on their environmental scans, that have particular risk factors (e.g., families with involvement in the criminal justice system; non-English speaking parents; substance using, pregnant mothers; families who have experienced trauma) to whom they are targeting some or all of their direct services. These demographic characteristics and risk factors within the LAUNCH community have guided the selection of evidence-based programs and/or the types of service enhancements LAUNCH communities are implementing.

2.1.2 Population Demographics and Economic and Social Characteristics

The 24 communities participating in Project LAUNCH vary widely in population size. Half (50 percent) of the LAUNCH communities qualify as rural, based on population density. Overall, the rural LAUNCH communities tend to be smaller in population and larger geographically (i.e., in square miles) than the other 12 grantees. Across the grantees, the smallest community includes fewer than 1,000 residents; the

Key Findings in the First Year

largest includes more than four million. Consequently the strategies adopted by grantees to create systemic improvements in their communities are very different for communities this disparate in size.

As indicated earlier, Project LAUNCH communities were selected in part because they had existing initiatives on which to build. At the same time, the communities identified had an overrepresentation of high levels of risks for young children and their families. For example, on average, the communities included more young children living in poverty and families where English was not the primary language, compared to the national average.

The cross-site evaluation team examined the demographics and multiple risk factors for all Project LAUNCH communities that can be found in extant data sets. The following statistics illustrate the multiple risks that children and families are facing in these communities (see Table 2.1):

Table 2.1. Selected Demographic, Social, Economic, and Health Indicators for LAUNCH Communities¹

Indicator	U.S.	Mean	Median	Range	
				Minimum	Maximum
Demographic Characteristics²					
Total population (per '000)	–	555	199	<1	4,023
% under age 5 years	6.9	6.9	6.8	4.1	9.9
% ages 5-9 years	6.6	8.6	6.4	4.0	24.6
% race other than White	23.6	33.5	24.8	2.7	90.6
Social Characteristics					
% without a high school diploma ³	9.1	18.3	15.8	8.1	31.3
% graduation rate, 2006 – 2011	84.0	72.9	75.0	50.0	95.0
% speaking a language other than English at home ³	19.6	25.4	22.7	1.0	74.9
Economic Characteristics²					
% families below the poverty level	9.9	14.4	13.9	3.9	36.7
% families with children under 5 living below the poverty level	21.5	22.4	17.1	5.7	72.0
% unemployed	4.7	8.0	7.6	4.2	13.7
Health Indicators⁴					
% births to women receiving late or no prenatal care, 2007-2009	7.0	18.5	15.2	2.5	52.2
Teen birth rate, 15-19 years (per 1,000 population), 2001 - 2008 (Cohort 1, n=5; Cohort 2, n=12; Cohort 3, n = 6) ⁵	41.5	43.7	43.7	15.5	85.5
% low birth weight babies, 2007-2009	8.2	8.8	8.4	5.8	14.1

¹ Data are for Cohort 1, 2 and 3 communities.

² U.S. Census Bureau, 2005-2009 American Community Survey

³ U.S. Census Bureau, 2006-2008 American Community Survey 3-Year Estimates

⁴ Data collected between 2001-2009.

⁵ Data for the tribal grantee in Cohort 1 are not included.

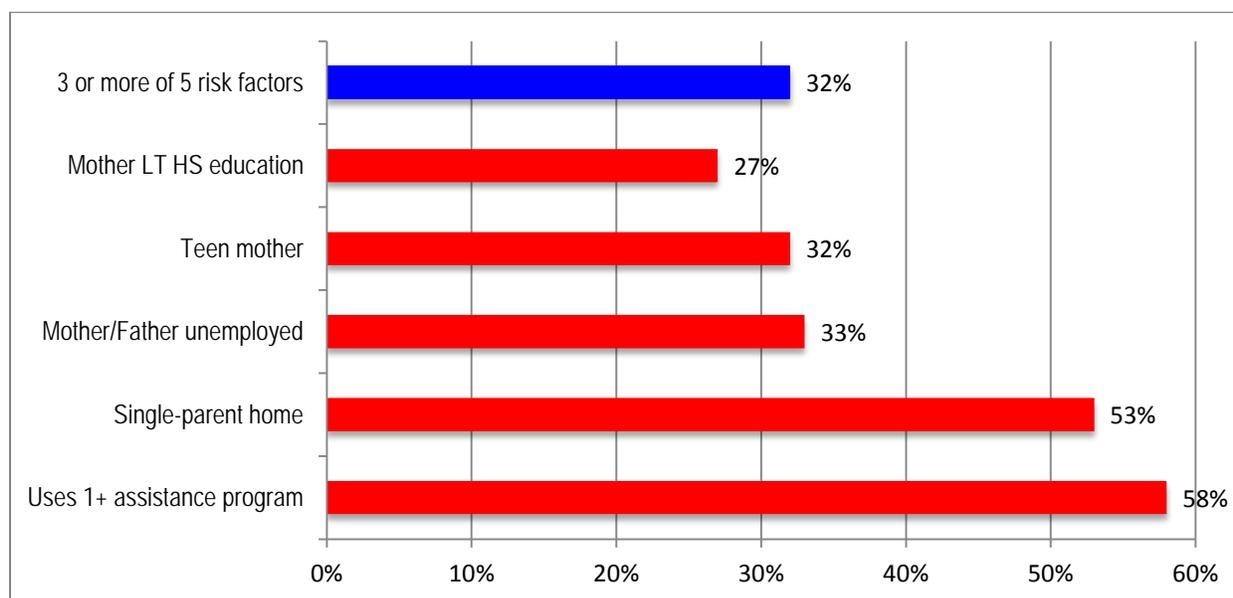
Sources: See Appendix B.

Key Findings in the First Year

- On average, the percentage of families *living below the poverty level* is more than 40 percent higher in LAUNCH communities than the country overall (14.4 vs. 9.9 percent); however, across all LAUNCH communities, the range of families living below the poverty level varies from 3.9 percent to 36.7 percent.
- The average *unemployment rate* in LAUNCH communities was 70 percent higher than the U.S. rate of 4.7 percent (5 year estimate, 2005-2009), and ranged from 4.2 to 13.7 percent.
- Across all LAUNCH communities, 18.5 percent of all births were to women *receiving late or no prenatal care*, compared to 7.0 percent in the U.S.; the range across all LAUNCH communities was 2.5 to 52.2 percent.
- The mean *graduation rate* in LAUNCH communities is lower than in the U.S. as a whole—72.9 percent compared to 84.0 percent, and ranged from 50 to 95 percent in Project LAUNCH-funded communities.
- On average, *children under age 5* make up 6.9 percent of LAUNCH communities and those ages 5 to 9 years are 8.6 percent of the community, compared to 6.9 percent and 6.6 percent, respectively, in the U.S. overall.
- On average, 25.4 percent of individuals in LAUNCH communities *speak 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.

Other risk factors identified in families that participated in LAUNCH in the first year (Exhibit 2.1) include 27 percent of families where the mother does not have a high school diploma or GED; 53 percent of children living in single parent households; 33 percent of LAUNCH families with either the mother, father, or both unemployed; and 58 percent of LAUNCH families receiving public assistance. Thirty-two percent of families participating in LAUNCH services in the first year had three or more of these risk factors.

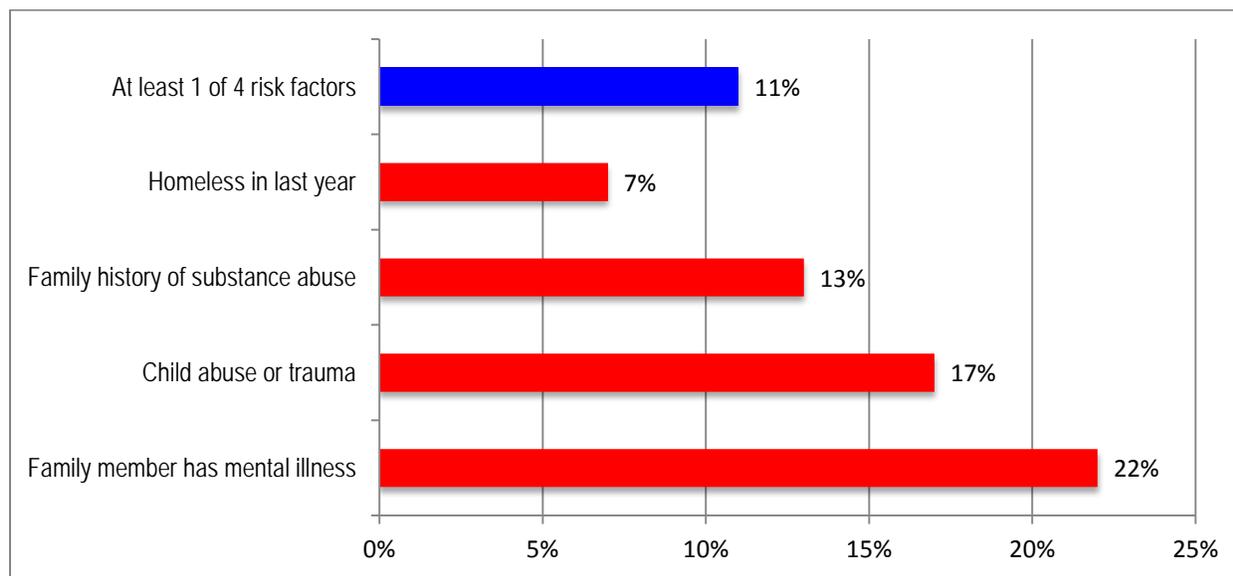
Exhibit 2.1. Risk Factors in Families Served by LAUNCH in Year One



Source: CSE Web Portal – October 2009, October 2010, October 2011.

Exhibit 2.2 displays additional family risk factors of those who participated in the first year of Project LAUNCH. Twenty-two percent of children had a family member with a mental illness, 17 percent had been affected by child abuse or trauma, 13 percent of families had a history of substance abuse, and 7 percent of families had been homeless in the last year. Eleven percent of LAUNCH families had at least one of these four risk factors.¹²

Exhibit 2.2. Additional Risk Factors in LAUNCH Families in Year One



Source: CSE Web Portal – October 2009, October 2010, October 2011.

In addition, grantees noted the following in their environmental scans: 1) children in LAUNCH communities lack insurance or are underinsured and often do not have a medical home; 2) parents are unaware of the early childhood programs and other supports available to them in the community; and 3) especially in rural communities, transportation barriers keep some families from seeking services for their children and make services less accessible.

2.1.3 Availability of Services in LAUNCH Program Areas at the Start of Project LAUNCH

Project LAUNCH grantees were expected to implement five evidence-based program strategies—developmental screening and assessment, home visiting, family strengthening and parent training, mental health consultation in early care and education settings, and integration of behavioral health in primary care. In each of these strategy areas, Project LAUNCH grantees described gaps in the child service system in their communities—i.e., insufficient services for all of the families who might need or want to participate. Even when services did exist, certain groups in a community might not have access because of language or cultural differences. Gaps were also reported in the availability of mental health screening and treatment services and in the knowledge base of existing service providers about how to identify and provide appropriate services to children with mental and behavioral health problems. Finally, grantees reported an overall lack of coordination and collaboration across the different components of the child service system, such as early childhood, health care, public health, schools, and protective services.

¹² Grantees reported risk factor data for a subset of LAUNCH families participating in home visiting and family strengthening services in the first year of their grant implementation.

At baseline, all of the target communities had home visiting programs in place, and more than half (75 percent) of the communities already had in place an evidence-based home visiting model. However, none of the grantees reported that existing home visiting programs met the needs within the community, either because of insufficient slots or because programs had eligibility criteria that cut off services at designated child ages or length of participation, even for families with continuing needs.

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

Very few of the communities had existing mental health consultation activities in early care settings or in schools. One exception was Head Start programs,¹³ which offer an array of family and child mental health assessment and support activities. In a few sites, there was a limited amount of mental health consultation services being provided to selected programs, but none of the grantees reported a widespread mental health consultation system in place across early childhood care settings at the time of LAUNCH. In contrast with the early childhood system, there was some integration of behavioral health in primary care. Four grantees reported that there were health care settings in their communities that had integrated mental health staff into the delivery of care to children.

Most of the grantees reported that developmental assessment of children using standardized measures was already taking place at the time LAUNCH began, as part of existing home visiting programs or parts of

Community Context for Project LAUNCH

- Project LAUNCH communities were selected in part because they had existing initiatives on which to build and families and young children in the communities had high levels of risk.
- Project LAUNCH grantees described gaps and lack of coordination across services in the child service system in their communities. Gaps included insufficient slots in programs, lack of access to services for families with language or cultural differences, and insufficient knowledge of how to identify and provide services to children with behavioral health problems.
- Most grantees reported that developmental assessment of children was taking place when they received their Project LAUNCH grant, but primary care settings were not using a screening measure focused on children's behavioral health. Moreover, a standard set of measures was not used across programs and services.

¹³ Head Start programs have performance standards related to supporting children's mental health. Programs must work collaboratively with parents to obtain information about their child's mental health, help parents understand mental health issues, and support parents' participation in needed mental health interventions. Programs must also obtain the services of mental health professionals to "enable timely and effective identification of and intervention in family and staff concerns about a child's mental health" and provide mental health consultation on "how to design and implement program practices responsive to the identified behavioral and mental health concerns of an individual child or group of children, promote children's mental wellness by providing group and individual staff and parent education on mental health issues, assist in providing special help for children with atypical behavior or development, and utilize other community mental health resources, as needed" (ACF, 2012).

the early childhood education system. Although several communities had ongoing screening in primary care settings, most of them did not use a screening measure specifically focused on children’s behavioral health. Moreover, there was no coordination across programs or systems in terms of a standard set of measures, and grantees reported that providers did not feel knowledgeable about appropriate referrals on the basis of these assessments. As opposed to child screening, no grantees reported systematic screening of parents at baseline for depression or other mental health concerns or for substance abuse.

2.2 State/Tribal Context

Project LAUNCH offered states and communities an opportunity to take on cross-system data access challenges and to build on infrastructure and services improvement efforts that were started under other federal and state initiatives. Several of these other initiatives—Assuring Better Child Health and Development (ABCD), Early Childhood Comprehensive Services (ECCS), and Comprehensive Community Mental Health Services for Children and Their Families (see Appendix C)—were aimed at strengthening the early childhood system. Two other programs—MIECHV, which started in 2010, and the EBHV initiative, first funded in 2008 and subsumed under MIECHV in 2011—provided funding for evidence-based home visiting programs with the goal of improving maternal and child health outcomes and linking families to appropriate services and supports.¹⁴

While these other initiatives, like Project LAUNCH, are concerned with the social, emotional, and behavioral health of young children and collaboration and partnership building, LAUNCH departs from these earlier initiatives in several important ways.

- First, Project LAUNCH has a dual focus on improving services for young children and their families and on infrastructure development and systems improvement.
- Second, as a systems initiative, Project LAUNCH’s efforts to improve the child-serving system are implemented at both the state and community levels (i.e., for grantees in Cohorts 1 and 2). While states were not the recipients of funding in Cohort 3, LAUNCH communities and state agencies collaborate to ensure that planning and policy reforms, as well as early childhood goals and objectives at the state and community levels, are consistent and aligned.
- Third, Project LAUNCH takes a public health approach, using multiple evidence-based interventions to improve outcomes at both the individual and population levels. The program addresses individual risk and protective factors associated with the physical, emotional, social, cognitive, and behavioral aspects of well-being, including substance and alcohol use, within four domains—individual, family, school, and community/society.

State/Tribal Context for Project LAUNCH

- States/tribes had an opportunity with Project LAUNCH to enhance the service system in a target community and to focus on systems development issues and needs.
- States/tribes were expected to coordinate their Project LAUNCH-funded system building activities with other state initiatives such as ECCS, ABCD, and, starting in 2010, with the MIECHV program.
- The economic recession, which started in December 2009, severely affected state revenues and resulted in program cutbacks, staff layoffs, and hiring freezes in some states. These conditions slowed start-up of some Project LAUNCH programs, especially the hiring of program staff.

¹⁴ The number of Project LAUNCH grantees with funding from these programs is provided in Appendix B.

- Fourth, Project LAUNCH involves working with an array of providers (primary care providers, mental and behavioral health providers, child welfare providers, child care providers, early care and primary grade educators) to enhance their knowledge and skills related to young child wellness and healthy child development.
- Finally, service delivery is focused on implementing evidence-based programs that prevent mental, emotional, and behavioral disorders and promote healthy development of young children, with a focus on five prevention and promotion strategies that broadly support the healthy development of young children (SAMHSA, 2008; 2009; 2010).

2.2.1 Challenges and Barriers Identified by State/Tribal Environmental Scans

When states first received Project LAUNCH funding, they were experiencing several challenges that potentially limited the effectiveness of their early childhood service delivery systems. Grantees reported that the economic recession, which officially began in December 2007, was adversely affecting many of their states. Due to budget cuts, in Fiscal Year 2009 at least 18 states had made cuts in programs that affected low-income children's and families' eligibility for health insurance or reduced their access to health care services. At least 21 states had cut or were proposing to cut K-12 and early education programs, and several were reducing access to child care and early education (McNichol and Lav, 2009). State budget gaps also led to lay-offs, or furloughs, of program staff. At least 44 states and the District of Columbia had made cuts affecting their state workforce, often leading to reduced access to services; 19 of these states and the District of Columbia were Project LAUNCH grantees (Johnson, Oliff, and Williams, 2011). Moreover, with rising unemployment, lower incomes, and record rates of home foreclosure, many families were finding themselves in poverty. Some families were homeless and unable to meet basic needs.

In addition to these dire economic conditions, grantees' environmental scans,¹⁵ conducted during the first 6 months of their Project LAUNCH grant, revealed other challenges. One theme emerging from the environmental scans was the fragmentation of services across multiple systems, which grantees viewed as a barrier to children's health. State/tribal service systems were reported to be weakly aligned, operating in silos with relatively little coordination, despite common programmatic goals. Environmental scans also revealed service and funding gaps. While the federal government and states had made recent investments in early childhood programs, the budget crises in nearly all states threatened the foundation laid by these programs. LAUNCH grantees noted in their end-of-year reports and in interviews with the cross-site evaluation team that these issues put tremendous stress on families with young children and were increasing risk for parental depression and substance use, as well as child abuse and neglect.

¹⁵ Because the environmental scans did not use a common template, the cross-site evaluation team was not able to obtain baseline data or even systematically categorize gaps in services and service systems from information included in grantees' environmental scans. Each grantee conducted its environmental scan differently, and the final product also varied in detail across grantees. Therefore, the cross-site team instead reviewed the plans for common themes that could be summarized across grantees. Information was abstracted from the scans in the following areas: the availability of evidence-based programs serving young children and their families across LAUNCH strategies in the community, the extent of coordination across agencies and organizations at the state/tribal and community levels, other related state/tribal and community-wide programs and initiatives, and challenges of the early childhood system at the state/tribal and community levels (e.g., related to financing, workforce development, access to information, economic climate). Because the process for conducting the environmental scan and the types of information presented were not standardized across grantees, this report does not provide the number of grantees that reported on specific topics within their scans.

Before their LAUNCH grant began, most states recognized that implementing evidence-based practices, involving families in early childhood programming, and considering cultural competency in the selection of programs and delivery of services were critical to achieving positive child development outcomes (National Research Council and Institute of Medicine, 2000). However, there was considerable variation across states in the implementation of these practices. In some states, delivery of evidence-based, promising, or best practices was the norm when Project LAUNCH was funded, but in other states, evidence-based practices were relatively scarce or were implemented inconsistently within and across service systems. Moreover, as noted in environmental scans, many communities had not systematically examined ways of making services family-focused, child-centered, and culturally competent.

Additional barriers identified by grantees in their scans included the following recurring themes:

- Lack of public understanding of the importance of investing in early childhood services;
- Limited professional development opportunities for early childhood providers and, in many states, absence of a state-wide workforce development plan for those working with young children and their families;
- Inconsistent comprehensive developmental screening in primary care, early care, and education settings;
- Infrequent mental health screening for young children;
- Lack of a uniform screening tool, keeping many states and communities from implementing comprehensive and universal screening programs;
- Parents' lack of knowledge about where to go and when to get developmental screenings for their children;
- Lack of mental health providers for young children, especially those younger than age 3;
- Limited services to address parental depression; and
- Inadequate funding or reimbursement for screening and mental health services.

Furthermore, some states noted in their environmental scans that mental health and providers of mental health services were poorly integrated into the state early childhood system. As an example, one state noted that there was minimal inclusion of mental health in professional development or early childhood pre-service programs. Two states indicated in their environmental scans that they had initiated an infant mental health endorsement system¹⁶ to “promote knowledge of children’s mental health and social emotional development at all levels of the system.” The endorsement provided an opportunity to coordinate and expand workforce development efforts for professionals working with young children and their families, although efforts in this area were in their infancy at the start of Project LAUNCH.

Finally, many LAUNCH states indicated that data collection across state agencies was not coordinated, making it difficult for them to evaluate outcomes for young children over time. Further, states did not have common outcome indicators across programs, and there were no benchmarks or targets for mental

¹⁶ Endorsement programs recognize professionals who have attained a specific level of education; participated in specialized trainings; had specialized experience work experiences with infants, toddlers, young children, and families; and engaged in reflective supervision/consultation.

health and social-emotional development. States acknowledged the need to link data systems across programs and agencies, but also recognized the costs.

Gaps Identified in Environmental Scans

- Fragmentation of services across multiple systems
- Service and funding gaps
- Programs threatened by state budget crises and economic recession
- Variation across states in communities' implementation of evidence-based programs
- Infrequent mental health screening for young children
- Lack of common screening/assessment tool that is used across programs and settings
- Limited services to address parental depression
- Inadequate funding or reimbursement for screening and mental health services
- Lack of public understanding of importance of investing in early childhood services
- Stress on families with young children and increasing risk for parental depression, substance use, and child abuse and neglect as a result of economic downturn and growing unemployment
- Limited professional development opportunities for early childhood providers
- Lack of mental health providers, especially for children birth to 3

Key Findings: Context for Project LAUNCH

Socio-demographic data show Project LAUNCH communities have more needs compared to other communities in the U.S.:

- The percentage of families living below the poverty level in LAUNCH communities is more than 40 percent higher than the country overall.
- The average unemployment rate is 70 percent higher in LAUNCH communities than in the U.S.
- On average, 25.4 percent of individuals in LAUNCH-funded communities speak a language other than English at home, compared to 19.6 percent of U.S. residents.
- Twenty-two percent of children participating in LAUNCH-funded services in the first year had a family member with a mental illness; 17 percent had been affected by child abuse or trauma; 13 percent had a family history of substance abuse; and 7 percent had been homeless in the last year. Eleven percent of families had at least one of these four risk factors.
- The U.S. recession, which began in December 2007, had put stress on families with young children and was thought to increase risk for parental depression, substance use, and child abuse and neglect.

When states and communities were awarded the Project LAUNCH grant, they reported the following conditions in their states and communities:

- Service gaps reported by grantees in their environmental scans included: insufficient slots in programs that families needed, a lack of access to services for parts of the community with language or cultural differences, and service providers with insufficient knowledge of how to identify and provide appropriate services to children with mental and behavioral health problems.
- All LAUNCH communities had home visiting and family strengthening programs in operation.
- With the exception of Head Start, none of the LAUNCH grantees had a widespread mental health consultation system in early care settings and schools.
- Seventeen percent of LAUNCH-funded communities reported some integration of behavioral health in primary care settings.
- All grantees conducted developmental assessment of children using standardized measures as part of home visiting programs or in parts of the early childhood education system when they received LAUNCH funding.
- Systems-building efforts begun under other state-wide initiatives (e.g., ECCS, First 5 in California; All Our Kids in Illinois) provided a foundation for Project LAUNCH-supported systems change initiatives.
- The economic recession adversely affected most states. Some states had made cuts in their early childhood programs due to budget shortages, and some had laid off staff because of budget gaps.

3. Planning and Collaboration Activities in First Year

One important provision of Project LAUNCH was that grantees were given time for planning their strategies for improving systems and services rather than having to begin implementation immediately after their grant award. Grantees in Cohorts 1 and 2 had 6 months for planning, and those in Cohort 3 had 9 months. This time afforded grantees the advantage of engaging in a multi-step planning process that involved:

1. Establishing the LAUNCH project team;
2. Conducting an environmental scan to identify state, tribal, and community needs;
3. Developing a comprehensive strategic plan, including the selection of prevention and promotion strategies; and
4. Developing an evaluation plan to monitor program activities and assess the effectiveness of Project LAUNCH.

In addition, grantees used their first 6 months of implementation¹⁷ to create a collaborative structure to guide program activities at both the state/tribe and community levels. Creating the Young Child Wellness Councils (YCWCs) at the state/tribal and local levels was a critical part of this effort.

This chapter describes how the Project LAUNCH grantees accomplished the planning tasks (above) in the first year and the steps they took towards establishing the collaborations across the service system that are crucial to implementation of the Project LAUNCH program.

3.1 Planning Activities

3.1.1 Hiring Project LAUNCH Staff

Having the right staff to lead Project LAUNCH activities at the state/tribal and community levels was critical. For many grantees, this meant recruiting a project director at the state/tribal level (Cohorts 1 and 2) and a child wellness coordinator in the LAUNCH community (Cohorts 1, 2, and 3) immediately after grant award. However, hiring was slow in some sites because of the state approvals often needed for these positions,¹⁸ hiring freezes implemented during the economic recession, and the challenge of finding individuals with the appropriate educational background and experience.

Recruitment for other positions (e.g., mental health consultants, family navigators¹⁹) also began after award, although with somewhat less urgency. The goal was to have individuals in these positions when

¹⁷ Grantees in Cohorts 1 and 2 were required to begin implementing services no later than 6 months after their grant award; grantees in Cohort 3 were required to begin implementing programs no later than 9 months after receiving funding. Therefore, the services data presented in this report cover this first period of services implementation (at least 6 months for Cohort 1 and 2 grantees and 3 months for Cohort 3). For ease of reference, this period will be referred to as the “first year of implementation” for all grantee cohorts.

¹⁸ In one site, the community coordinator was hired 15 months after grant award because of the more than 10 months it took for the state to finalize the contractual arrangement with the fiscal agent for the community partner organization.

¹⁹ Family navigators are staff who provide individualized support to families, assisting them in “navigating” the child service system in their communities and obtaining access to needed services.

services began, no later than 6 or 9 months after grant award. Grantees experienced occasional challenges in hiring for these service staff positions as well, usually due to the difficulty in finding individuals within the community with the desired qualifications (e.g., Spanish speaking, early childhood experience) and, in a few cases, problems in finding individuals interested in relocating to the LAUNCH community. Hiring challenges at both state/tribal and community levels were largely unexpected and contributed to delays in delivering services and starting to work on systems development activities.

3.1.2 Environmental Scans

Grantees were expected to develop a blueprint for the service system in their state and communities, as the foundation for finalizing their strategic plan (see below). Within the first 6 or 9 months,²⁰ grantees conducted an environmental scan to identify the systems and programs that serve children from birth to 8 years of age and their families at the state/tribal and community levels (SAMHSA, 2008; 2009; 2010). The scan also was to include a “financial map” of the funding streams that supported these programs.

Environmental scans for both the state/tribe and community relied on input from several sources. Almost all LAUNCH grantees (92 percent) had conducted a similar state-level (e.g., ECCS) or community (e.g., a community-level grant program) scan recently for other initiatives and updated this scan with current information for Project LAUNCH. All grantees also convened focus groups and/or conducted key informant interviews (e.g., of state agency representatives, service providers, parents) to learn about existing programs, service gaps, and opportunities and challenges in the target community. In addition, members of the state/tribe and community YCWCs provided information about the programs within their agencies and organizations that served young children and the funding for these programs. State/tribal and community YCWC members identified program and policy areas needing improvement. The financial maps were developed by LAUNCH staff in collaboration with agency and organizational partners.

Through their environmental scans, grantees found that much was already happening in the early childhood arena in their states and communities, but programs were fragmented and those focusing on the behavioral health of families and young children were absent in some settings (e.g., child care, education, and primary care). The environmental scans also made it obvious to grantees that LAUNCH needed to partner closely with other, ongoing early childhood initiatives that already had momentum and the commitment of key policymakers in their states and communities as well as other organizational partners in both the public and private sectors. Potential partners were identified through the environmental scan process—for example, other community and state/tribal programs or community sectors (e.g., business) not yet

Environmental Scans

- Project LAUNCH grantees conducted environmental scans at the state/tribal and community levels within 6 (Cohorts 1 and 2) or 9 (Cohort 3) months of grant award.
- Grantees relied on a variety of sources in conducting their scans: recent needs assessments completed for other initiatives, focus groups, key informant interviews, and program information from state/tribal and community agencies and provider organizations.
- Grantees identified many existing programs that served young children and their families, but they found that these programs were often fragmented and some settings lacked behavioral health services for young children and their families.
- Grantees identified the need to partner with other early childhood initiatives that had momentum and the commitment of policymakers.

²⁰ Grantees in Cohorts 1 and 2 were required to complete an environmental scan in the first 6 months; the requirement for Cohort 3 grantees was to complete the scan within 9 months.

represented on the YCWCs. A key finding from the environmental scans was the need to expand membership of YCWCs in order to broaden the councils' knowledge and perspective, enable a stronger outreach to families, coordinate policies and programs, and offer opportunities for networking among program leaders and providers.

In some cases, the scan also identified needs within the LAUNCH community that were not adequately addressed in the initial service delivery plans that had been outlined in their grant applications—for example, hiring additional service providers (e.g., mental health consultants) to support families in specific programs, providing training to enhance provider knowledge and skills to address the needs of participating families.

3.1.3 Strategic Plans

After completing the environmental scan, grantees developed a comprehensive strategic plan. The plan addressed the Project LAUNCH programmatic elements that grantees would focus on, including the infrastructure building activities and evidence-based programs they would implement and a plan for sustaining LAUNCH-funded services and infrastructure improvements. The plan identified goals and objectives for Project LAUNCH and set priorities for services and systems change.

Many grantees began with an existing plan at the state level—for example, the ECCS plan or an early childhood plan that had been developed by the governor's office. The state/tribal and community YCWCs reviewed these existing plans or, if no plan existed, initiated a new strategic planning process. Planning occurred during state/tribal and community YCWC meetings or work sessions that were held during the early months of the grant. Grantees reported that YCWCs' involvement in strategic planning increased agency partners' buy-in and ownership of Project LAUNCH, although several grantees also noted that the short timeframe given for completing both the environmental scan and strategic plan may have limited full stakeholder engagement at the outset. Nevertheless, many grantees reported that the planning process helped raise awareness of issues related to the behavioral health and wellness of young children and helped build a common vision for the types of systems changes that would be needed at both the state/tribal and community levels.

When completed, the strategic plan served as a general roadmap for LAUNCH activities. Prioritizing the many goals and objectives (e.g., one grantee noted that they included more than 300 strategies in their strategic plan) and developing action plans for accomplishing them was one of the first steps that Project LAUNCH staff and the YCWCs had to take on. Grantees are also encouraged to update their strategic plans annually as part of their end-of-year reports to SAMHSA. This gives staff and YCWC members the

Strategic Plans

- In developing their strategic plans, many Project LAUNCH grantees started with an existing plan at the state level (e.g., the ECCS plan or early childhood plan).
- Most grantees engaged their YCWCs at the state/tribal and community levels in the strategic planning process.
- Grantees reported that YCWCs' involvement in the planning process increased agencies' buy-in to Project LAUNCH, but they also stated that the short amount of time given to complete the strategic plan may have limited full stakeholder engagement.
- The planning process was reported to raise awareness of behavioral health issues for young children and the services that were needed to meet behavioral health needs.
- Grantees planned to implement new services as well as enhancements of existing services to make them more prevention-focused, family-focused, and culturally competent.
- Sustainability of programs was an important consideration during the planning process.

opportunity to review what has been accomplished, redefine priorities for the year ahead, and address any new and emerging issues.

Using their strategic plans as an implementation framework, all of the grantees began implementing some services by the end of the first year, but grantees spent much of the first year engaged in intensive planning, outreach, and relationship building in preparation for the eventual full implementation of services in the five core strategies. As part of their strategic plan, the grantees developed a prioritization among the services to guide the schedule of implementation over the first 2 years of the grants.

A key factor in grantees' service strategy was the status of existing services in the community in the five LAUNCH strategies. Grantees built their own plans based on understanding of not only what services already existed but also the level of quality of the services (whether the services were evidence-based, whether the services were being delivered with high-fidelity), whether the services could enroll all eligible children and families, and whether there were significant service gaps (families in the community who could or did not access services for which they were eligible). Even where there were existing services, grantees understood that the focus on prevention, a foundation of LAUNCH, was often missing in existing service systems, especially in the field of young child mental health. Therefore, LAUNCH grantees planned enhancements of existing services to make them more prevention-focused, family-centered, and culturally competent.

For some of the grantees, an impetus for systems change as part of the first year planning has been the federal MIECHV program, especially in the six states where the LAUNCH and MIECHV communities overlap. Grantees understood that the federal MIECHV funding offers the potential for building a community of home visitors who can share approaches to serving families, benefit from the same mental health consultation activities, and participate in common training and professional development. Another example of changes in the field that are reflected in LAUNCH planning and activities in later cohorts is the increased profile of mental health endorsement systems, particular the Michigan Association for Infant Mental Health (IMH-E[®]) Endorsement (a system of culturally sensitive, relationship-based, infant mental health learning and work experiences), which has become a model for other states. At least two grantees are promoting this endorsement as a community-level initiative for providers working with young children and their families.

Sustainability also was part of planning from the earliest stages. Some grantees noted in their strategic plans that they wanted to avoid creating new services or programs for which communities would have to find alternative funding when LAUNCH ended. At the same time, grantees who worked in communities with families experiencing extremely high levels of stress and risk understood that existing program models might not be appropriate for these families and children. In these communities, grantees felt the need to initiate new services in home visiting and family strengthening that were more trauma-focused and concerned with the mental health of both the mother and the child, as opposed to offering the more traditional parent education and support.

3.1.4 Evaluation Plans

Project LAUNCH grantees were required to conduct an evaluation of their project at the state/tribal and local levels.²¹ The RFA required an assessment of:

²¹ This evaluation of the state/tribal and/or community level hence forth will be called the "local evaluation" in comparison to the cross-site evaluation where each grantee provides similar data.

- The effectiveness of grant-funded interventions;
- The costs of implementing the program across the various populations served;
- The quality and fidelity of implementation of evidence-based programs and practices; and
- The strength of local and state/tribal partnerships.

In addition, all grantees were required to participate in the cross-site evaluation.

A local evaluation plan was required 6 months after award of the grant. Evaluation plans were expected to address two different needs: 1) state/tribal and community stakeholders' needs for data on program implementation (service enhancements, service participation, training delivery, screening and referrals, parent satisfaction), state/tribal and community partnerships (collaborative activities, increased coordination and collaboration), changes in provider knowledge and practices as a result of LAUNCH, and the effectiveness of LAUNCH interventions on young children and their families, which would support program improvement; and 2) data collection to meet the requirements of the cross-site evaluation and SAMHSA's performance monitoring system. To meet both needs, evaluators met with providers to determine if their existing data systems were adequate to meet the overall evaluation requirements of Project LAUNCH, or if their data systems had to be modified or supplemented with other data collection tools to enable them to report information on children and families participating in LAUNCH services. In the first year, data systems consisted of electronic spreadsheets or other basic tools to capture information needed for reporting purposes. Evaluators were required to report aggregated services data to the cross-site evaluation and planned to use either individual-level or aggregate data for their own analyses and reporting purposes.

Evaluation Plans

- Project LAUNCH grantees developed an evaluation plan within the first 6 months outlining how they planned to assess program implementation and outcomes.
- Evaluation plans were intended to meet stakeholder needs for data on program implementation and outcomes that could be used for program improvement as well as for data that could meet the requirements of the cross-site evaluation and SAMHSA's performance monitoring system.
- Five grantees described plans to conduct a population-level, quasi-experimental design study of child outcomes. Five other grantees proposed to track child outcomes longitudinally but without a comparison group. Others focused mainly on collecting program implementation data.

To measure the outcomes of Project LAUNCH, five grantees proposed a population-level, quasi-experimental design study of child outcomes in their evaluation plan.²² Child outcomes included socio-emotional development, readiness for school, academic success, child abuse and neglect, immunization rates, and birth outcomes. Five additional grantees proposed to track child outcomes longitudinally within the LAUNCH community, but without a comparison group. Most grantees hired external evaluators, working at university-based or private research organizations, to conduct their local evaluations.

²² These studies were proposed in initial local evaluation plans and were not funded as special studies.

3.2 Collaboration Activities

One of the distinctive aspects of Project LAUNCH was the focus on collaborative structures to guide program activities at both the state/tribe and community levels. In many ways, this collaboration mirrored what Project LAUNCH intended to nurture across all parts of the child-serving system: a comprehensive, culturally competent, coordinated, and linked system of programs and services for young children and families.

In the early months of their grants, grantees created a planning and oversight council on young child wellness (YCWC) at both the state/tribal level and in the LAUNCH community. The YCWCs are intended to be planning and oversight bodies with representation from the different sectors serving young children and families: health, including representatives from the private sector; mental health; child welfare; Medicaid; substance abuse prevention; early childhood and state education (e.g., Early Head Start, Head Start, Part C); child care; Title V agencies; the Indian Health Service (for tribal grantees); and the office of the governor or chief executive of the state or tribe (SAMHSA, 2008; 2009; 2010). Families in the target population are to be represented on the YCWCs as well.

3.2.1 Formation of State Child Wellness Councils

All LAUNCH grantees in Cohorts 1 and 2 established state/tribal YCWCs in the first year of their grant. In forming the YCWCs, grantees' first decision was whether to form a new council or build on an advisory group that already existed in the state/tribe. According to data reported by grantees in the cross-site evaluation web portal, more than half (56 percent, 10 of 18 grantees) established a new advisory state/tribal YCWC. Eight grantees used an existing group for their state YCWC, deciding to combine the LAUNCH YCWC with an advisory group working on a related initiative. In most of these states, the ECCS coordinating council or a committee of this council became the YCWC for Project LAUNCH, while also retaining their other advisory functions. Grantees reported that expanding the role of an existing group helped to ensure that early childhood systems building activities were coordinated and that resources were used most effectively.

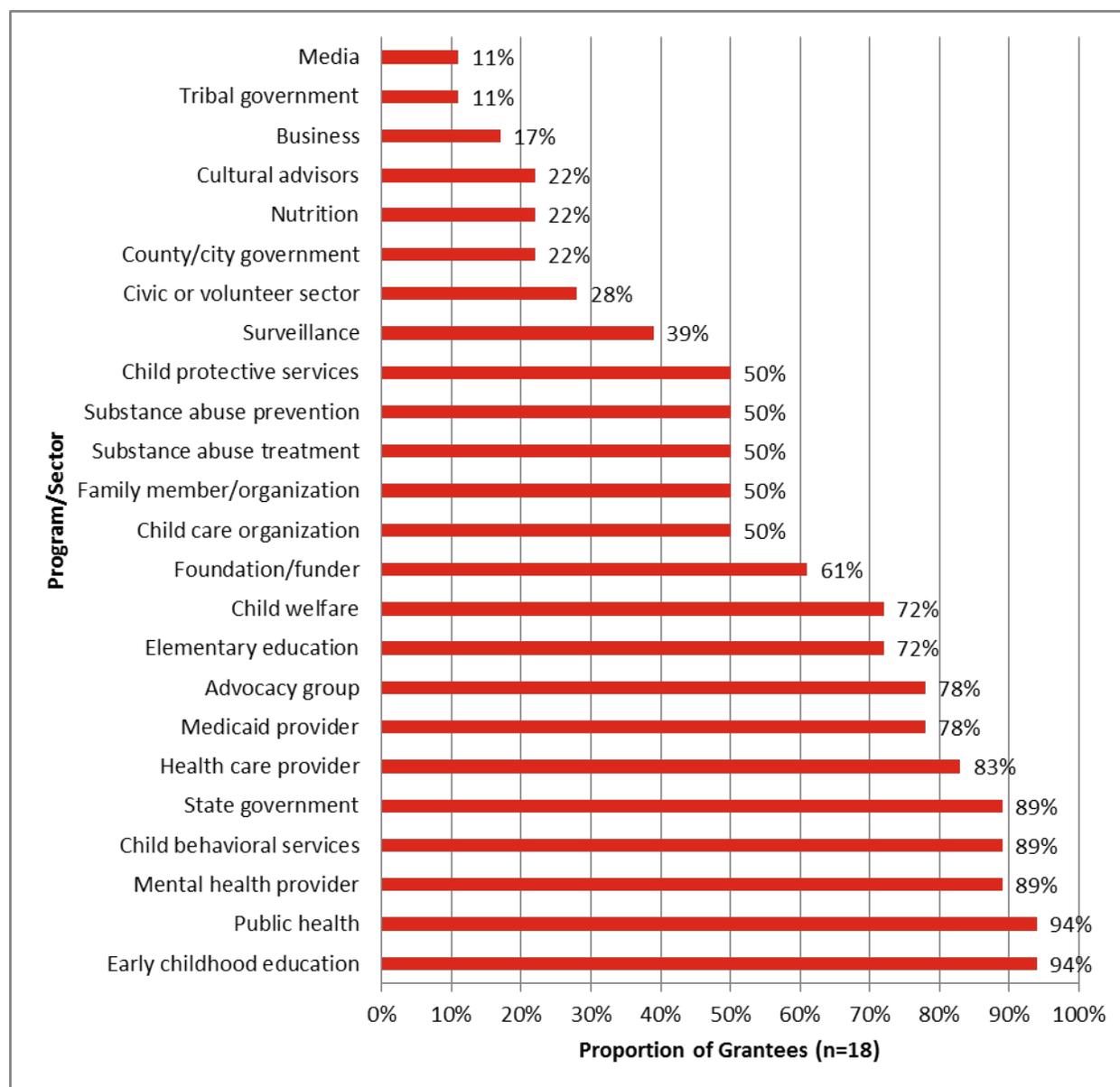
In their applications, grantees identified and obtained MOUs from agency partners, and these agencies were among those that initially provided representatives for the state/tribal YCWCs. Grantees also sought to broaden the state/tribal YCWCs' membership, bringing on additional public and private sector partners and parent representatives. In the first year, a total of 273 agencies and organizations were represented on state/tribal councils,²³ an average of 15 agencies per council. The breadth of representation, shown in Exhibit 3.1, facilitated the environmental scan and strategic planning activities and brought diverse perspectives to these activities. It also enabled grantees to more readily access data across the child-serving system, with YCWC representatives knowledgeable of the data and programs within their own agencies and bringing this information to the YCWC.

One of the initial challenges reported by grantees was finding parents to serve on the state/tribal YCWC. At the end of the first year, nine Cohort 1 and 2 grantees were continuing to look for an organization or individual who could represent parents and families. Additionally, once the strategic plan was completed, some states realized that implementation of their LAUNCH strategic plans required the participation of other partners (e.g., managed care organizations, mental health agencies) and continued to seek representatives from these other agencies. Therefore, membership of the YCWC evolved over the first year of the grant, and most grantees expected representation on the YCWC to expand over the next year.

²³ Organizations and agencies on Red Cliff's and the District of Columbia's YCWCs are included in these data.

State/tribal YCWCs assumed several key functions during the first year of Project LAUNCH. Most YCWCs contributed to the early planning activities of LAUNCH. More than 70 percent (n=13) assisted with the development of the environmental scan, which included identifying potential system and service barriers to children’s development and health, improving coordination across state/tribal systems, and needs assessment. All YCWCs (n=18) participated in the strategic planning process.

Exhibit 3.1. Proportion of Cohort 1 and 2 Grantees that Have Specific Programs/Sectors Represented on their State/Tribal YCWCs (n = 18 grantees, Cohorts 1 and 2)¹



¹ Cohort 3 grantees are not included in this exhibit because they were funded at the community level and therefore do not have state YCWCs.

Source: CSE Web Portal – October 2009, October 2010.

Grantees reported that several state/tribal YCWC-related factors were instrumental to their implementation of the project in the first year. These included:

- LAUNCH staff and YCWC members' regular attendance at meetings;
- Collaboration and cooperation among state/tribal partners;
- Collaboration at the Project LAUNCH leadership level (i.e., within the agency with lead responsibility for LAUNCH); and
- Previously working together across agencies on early childhood issues.

Grantees also reported important challenges in their first year. The main challenges to program implementation revolved around other program priorities within the agency responsible for Project LAUNCH (e.g., H1N1, for Cohort 1), the lack of active family member participation on the YCWC, the lack of collaboration from necessary state/tribal stakeholders, and the economic downturn and budget freezes experienced by partner agencies, as well as staff availability. Budget freezes, for example, affected the length of time to hire LAUNCH staff and put contracts in place and was thought to limit attendance at meetings.

In addition to the state YCWC, eight LAUNCH grantees (44 percent) created one or more work groups as part of the YCWC to take on specific systems change priorities. Work groups included those focused on:

- Developmental screening and assessment—e.g., to select a common screening/assessment tool across all services and systems serving young children and their families;
- Funding—e.g., to advocate for or change Medicaid reimbursement policies; to improve alignment of state funding for early childhood development, care, and education;
- Workforce development;
- Policy—e.g., to improve state policies supporting access to and integration of early childhood and family services; and
- Public awareness.

Members of the YCWC participated on these work groups. In some cases, others (e.g., staff working on related initiatives within agencies represented on the YCWC, were invited to join the work groups.

3.2.2 Formation of Community Child Wellness Councils

All grantees were required to establish a community YCWC to guide and provide oversight to project activities within the LAUNCH community. Like the state/tribal YCWC, the community YCWC could be a new entity or, alternatively, communities could choose to select an existing body to serve as the YCWC (SAMHSA, 2008; 2009; 2010). According to data reported in the cross-site evaluation web portal, slightly more than half (55 percent) formed a new YCWC at the community level for Project LAUNCH.²⁴

The community YCWCs across all cohorts met an average of four times during the first year. Across all LAUNCH communities, a total of 414 organizations and agencies participated on the community YCWCs, with a YCWC having an average of 18 organizational members. The early childhood education, health, and government sectors were broadly represented across grantees, with less representation from some types of organizations (e.g., criminal justice, corrections, law enforcement, media, and business) (see Exhibit 3.2). In a relatively short period of time, LAUNCH grantees had formed and convened

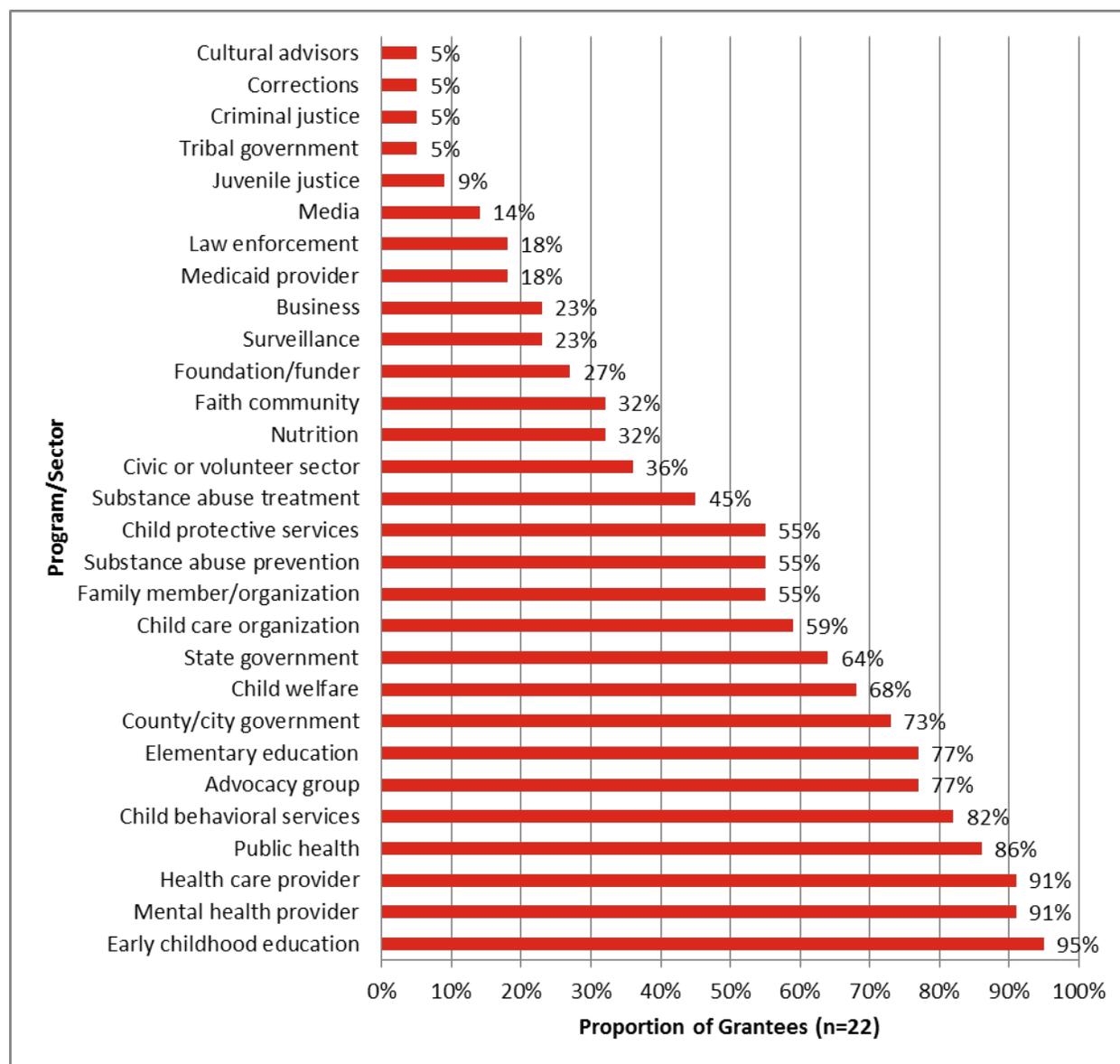
²⁴ The YCWCs for two LAUNCH grantees, Red Cliff and the District of Columbia, are included in the analyses of state/tribal-level data and are not included here.

Key Findings in the First Year

YCWCs with considerable diversity for the LAUNCH initiative. Nevertheless, YCWCs were in the early phase of their development as an oversight body for Project LAUNCH. Grantees reported that they were continuing to recruit others to join the YCWC and that membership would grow over the next year.

Most LAUNCH grantees engaged their community YCWCs in needs assessment, strategic planning, identifying potential system and service barriers, and working toward coordination and collaboration in service delivery. Grantees reported that factors facilitating implementation in the first year included: regular attendance at YCWC meetings, shared goals among agencies and organizations represented on the YCWC, staff stability, and a supportive climate within the community. Challenges during the first year were similar to those experienced at the state/tribal level: lack of family participation on the community YCWC, some agencies reported to be missing from the community YCWC, and turnover in leadership positions within the community agency coordinating LAUNCH activities.

Exhibit 3.2. Proportion of Cohort 1, 2, and 3 Grantees that Have Specific Programs/Sectors Represented on their Community YCWCs (n = 22 grantees, Cohort 1, 2, and 3) ¹



¹ YCWCs for two grantees – Red Cliff and the District of Columbia—are included in Exhibit 3.1, not in this table.

Key Findings: Planning and Collaboration Activities

Planning activities occupied grantees' time during the first 6-9 months of Project LAUNCH:

- Early planning activities included recruiting and hiring project staff, conducting an environmental scan, and developing a strategic plan and an evaluation plan.
- In the early months of their grants, grantees created a planning and oversight council on young child wellness (YCWC) at both the state/tribal level and in the LAUNCH community.

Forming the Young Child Wellness Councils in the first months of the grant brought diverse participation and perspectives to the environmental scan and strategic planning process:

- In the first year, a total of 273 agencies and organizations were represented on state/tribal councils, an average of 15 agencies per council.
- Across all LAUNCH communities, a total of 414 organizations and agencies participated on the community YCWCs, with a YCWC having an average of 18 organizational members.
- One of the initial challenges reported by grantees was finding parents to serve on the state/tribal and community YCWCs. At the end of the first year, nine Cohort 1 and 2 grantees were continuing to look for an organization or individual who could represent parents and families on the state/tribal YCWC, and 10 (of 22) grantees across all cohorts were continuing to recruit for parent representation on the community YCWC.
- More than 70 percent of state/tribal YCWCs (n=13) assisted with the development of the environmental scan, which included identifying potential system and service barriers to children's development and health, improving coordination across state/tribal systems, and needs assessment. All YCWCs (n=18) participated in the strategic planning process.
- Some grantees created work groups as part of the state/tribal YCWC to focus on funding, workforce development, developmental screening and assessment, policy, public awareness, and health information and technology issues.

Grantees reported factors that facilitated implementation of their Project LAUNCH program as well as challenges they experienced in the first year:

- Factors facilitating implementation of Project LAUNCH included: regular attendance at YCWC meetings, collaboration and cooperation among partners, previously working together across agencies at the state/tribal level on early childhood issues, shared goals among agencies and organizations represented on the community YCWC, staff stability, and a supportive climate within the community.
- Challenges during the first year included : other program priorities within the state agency responsible for Project LAUNCH (e.g., H1N1), the economic downturn and state budget freezes, lack of family participation on the state/tribal and community YCWCs, representation missing from the YCWCs, and turnover in leadership positions within the community agency coordinating LAUNCH activities.

Source: CSE Web Portal – October 2009, October 2010.

4. Service Delivery in the First Year of Implementation

Project LAUNCH grantees are expected to implement five SAMHSA-defined prevention and promotion strategies in their communities: home visiting, family strengthening programs, mental health consultation in early care and education, integration of behavioral health in primary care, and developmental screening and assessment. In determining which services to support for a given strategy, grantees are expected to give priority to evidence-based models (i.e., those with “a demonstrated evidence base”) and services appropriate for the population of focus. Table 4.1 shows the progress grantees made during the first year of implementation towards implementing the five LAUNCH promotion and prevention strategies.

For Cohorts 1 and 2, the first year of implementation represented 6 months of service activity (April through September of the first grant year). Cohort 3 grantees were given more time for planning during their first year and were expected to start implementing services only in the last 3 months of that year.

Table 4.1. Planning and Implementation Activities in First Year (n = 24 grantees across three cohorts)^a

LAUNCH Strategy	Overall: Planning or Implementation (# of grantees, %)	Implementation		Planning	
		Initiated New Program/ Service (# of grantees, %)	Enhanced Existing Program/ Service (# of grantees, %)	New Program/ Service (# of grantees, %)	Enhancement of Existing Program/ Service (# of grantees, %)
Home visiting	22 (92%)	5 (21%)	11 (46%)	2 (8%)	4 (17%)
Family strengthening	22 (92%)	10 (42%)	5 (21% ^b)	5 (21%)	2 (8%)
Mental health consultation in child care/preschool settings	19 (79%)	10 (42%)	0 (0%)	8 (33%)	1 (4%)
Mental health consultation in school settings	12 (50%)	5 (21%)	0 (0%)	6 (25%)	1 (4%)
Integration of behavioral health in primary care	75%	50%	0%	25%	1 (4%)
Mental health consultation in home visiting programs/ human service agencies	25%	17%	0%	8%	0%
Developmental assessments	24 (100%)	24 (100%)	0 (0%)	24 (100% ^c)	0 (0%)

^a Each grantee represented once for each core strategy, although some grantees supported multiple programs in one of the four categories (implemented new or enhanced program, or planned new or enhanced program)

^b One grantee initiated a new family strengthening program and enhanced an existing program; this grantee is only counted once under “Initiated.”

^c Grantees planning to expand developmental assessments to additional parts of the service system

Source: CSE Web Portal-- October 2009, October 2010, October 2011; CSE telephone interviews with Project LAUNCH staff, 2009, 2010, 2011; Project LAUNCH End-of-Year Reports, Project LAUNCH Local Strategic Plans, 2009, 2010, 2011.

4.1 LAUNCH-Supported Home Visiting Programs: Year One

In the first of the five prevention and promotion strategies, Project LAUNCH grantees enhanced home visiting in their communities by either beginning a new evidence-based program or extending the reach of an existing program through support of additional staff. A program is defined as a specific service in which families enroll and participate for a set period of time. Those grantees that made enhancements focused on multiple ways to infuse mental health and socio-emotional development into their existing programs. By the end of the first year of implementation, 16 (67 percent) of the 24 grantees had initiated a new home visiting program or undertaken enhancements to the home visiting programs in their communities. Another 6 grantees (25 percent) were planning to initiate new or enhance existing home visiting programs to begin in the second year of implementation. Altogether, these 22 grantees were undertaking or planning enhancements to 25 different home visiting program

models. (The total number of LAUNCH-supported home visiting programs is greater than the number of grantees, because four grantees introduced enhancements to two programs in their communities.) In line with the goals of Project LAUNCH, the majority of the home visiting programs used evidence-based models—16 of 25 programs (64 percent), and 9 other programs (36 percent) were using models designated as promising practices (Table 4.2).²⁵ The remaining programs were local models or public health nurse home visiting to newborns that did not use a specified curriculum.

Enhancements implemented by Project LAUNCH grantees (Exhibit 4.1) were intended to increase the quality of the program in one or more of the following ways:

Home Visiting

- Number of grantees: 22 (92 percent)
- Number of home visiting programs supported by Project LAUNCH across grantees: 25
- Percent of home visiting programs that are evidence-based: 64 percent
- Number of families served in Year 1: 580
- Number of home visitors receiving LAUNCH-supported training: 115
- Number of children screened: 322
- Number of children referred: 67
- Number of parents screened: 721
- Number of parents referred: 51

²⁵ The designation of “evidence-based models” is based on the rating of home visiting programs developed as part of the federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). In this initiative, grantees were funded to implement evidence-based home visiting programs that aim to improve maternal and newborn health, prevent child maltreatment, improve school readiness and achievement, reduce crime and domestic violence, improve families’ economic self-sufficiency, and improve coordination and referrals for community resources and supports. To be called an “evidence-based early child home visiting service delivery model” program, the program had to meet at least one of two criteria: 1) at least one high- or moderate-quality impact study of the model finds favorable statistically significant impacts in two or more of eight outcome domains; or 2) at least two high- or moderate-quality impact studies of the model using non-overlapping analytic study samples find one or more favorable, statistically significant impacts in the same domain (Avellar et al., 2013). HHS conducts a review each year, funded by the Office of Planning Research and Evaluation (OPRE), called Home Visiting Evidence of Effectiveness (HomVEE), which assesses the evidence of effectiveness of identified home visiting models. Other agencies have also rated the level of evidence for home visiting programs. For example, SAMHSA’s National Registry of Evidence-Based Programs and Practices uses a system for rating the quality of the research on an intervention. The RAND Promising Practices Network designates programs as “promising practices” if the program has been shown to have impact but the evaluation design of the study displays some weaknesses such as a poorly matched comparison group.

- Introducing systematic child or maternal screening/assessment to the programs, providing training for providers on assessment tools, and, in some cases, supporting the assessment itself by other staff consulting with or working with the providers;
- Enhancing the knowledge and skills of providers through training on issues of young child mental health and socio-emotional development;

Table 4.2. Number of Evidence-based and Promising Home Visiting Programs Planned or Undertaken by Project LAUNCH Grantees in the First Year of Implementation (n = 22 grantees, Cohorts 1, 2, and 3) ^{i, ii}

	Evidence-Based Program Models (# of programs) ⁱ	Promising Practice Program Models (# of programs)
LAUNCH- initiated home visiting program	<ul style="list-style-type: none"> • Parents As Teachers (PAT) (3) • Nurse Family Partnership 	<ul style="list-style-type: none"> • First Born • Positive Behavior and Intervention Supports (PBIS) • Child First
LAUNCH- enhanced home visiting program	<ul style="list-style-type: none"> • Parents As Teachers (PAT) (7) • Nurse Family Partnership (3) • Healthy Families (2) 	<ul style="list-style-type: none"> • Early Head Start (2) • NCAST (Nursing Child Assessment Satellite Training) Promoting Maternal Mental Health During Pregnancy • Promoting First Relationships (component added to public health home visiting program) • Touchpoints (component added to public health home visiting program) • Positive Behavioral Interventions and Supports--PBIS (component added to Healthy Start home visiting program)

Source: CSE Web Portal-- October 2009, October 2010, October 2011; CSE telephone interviews with Project LAUNCH staff, 2009, 2010, 2011; Project LAUNCH End-of-Year Reports, Project LAUNCH Local Strategic Plans, 2009, 2010, 2011.

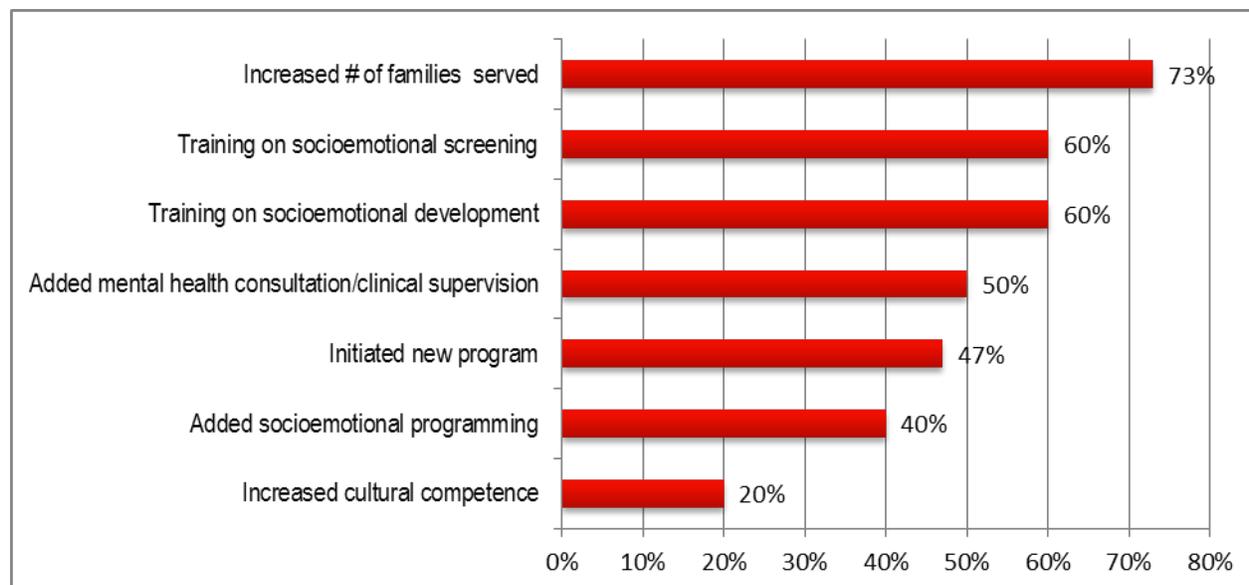
ⁱ One additional home visiting program supported by a LAUNCH grantee was neither an evidence-based nor a promising practice program model.

ⁱⁱ Number of programs (n=26) exceeds number of grantees supporting home visiting programs (n=22) because four grantees supported two home visiting programs.

- Enhancing the cultural competence of the program to increase the program’s appropriateness for the families in the community;
- Expanding the focus of the program by bringing in supplemental programs or practices focused on socio-emotional development for the child and family (including Touchpoints [2 programs], PBIS [2], Promoting First Relationships, and Growing Healthy Kids); and
- Providing professional mental health consultation to support home visitors in understanding and working with the highest-risk families with serious mental health/parenting issues, including reflective supervision.²⁶

²⁶ “Reflection in a supervisory relationship is intended to create an environment characterized by safety, calmness and support, in which supervisor and supervisee explore the range of emotions (positive and negative) related to

Exhibit. 4.1. LAUNCH-Supported Enhancements to Home Visiting Programs Undertaken by LAUNCH Grantees in the First Year of Implementation (n=18 programs supported by 16 grantees, Cohorts 1, 2, and 3)



Source: CSE Web Portal-- October 2009, October 2010, October 2011; CSE telephone interviews with Project LAUNCH staff, 2009, 2010, 2011; Project LAUNCH End-of-Year Reports, 2009, 2010, 2011.

4.1.1 Families Served in LAUNCH-Supported Home Visiting Programs

In the first year of implementation, LAUNCH-supported home visiting programs served 580 families. Depending on the program, families were intended to receive between 3 and 12 home visits across the year. Although the proportion of planned home visits that were successfully completed was not reported by grantees, across the home visiting programs more than 5,000 home visits were made during the year.

4.1.2 LAUNCH-Supported Workforce Enhancement for Home Visitors

In 12 of the 18 home visiting programs enhanced by grantees during the first year of implementation, staff received Project LAUNCH-supported training on children’s socio-emotional development and on screening measures for socio-emotional development. An additional two programs received training only on the first topic. Across these programs, in the first year of implementation, 115 home visitors received some form of training supported by Project LAUNCH.

the families and issues the supervisee is managing. Reflective supervision focuses on experiences, thoughts and feelings directly connected with the work. The role of the supervisor is to help the supervisee to answer her own questions, and to provide the support and knowledge necessary to guide decision-making. In addition, the supervisor provides an empathetic, nonjudgmental ear to the supervisee. Working through complex emotions in a ‘safe place’ allows the supervisee to manage the stress she experiences on the job” (Zero to Three, 2011. <http://www.zerotothree.org/about-us/areas-of-expertise/reflective-practice-program-development/three-building-blocks-of-reflective-supervision.html>).

4.2 LAUNCH-Supported Family Strengthening Programs: Year One

The second of five LAUNCH prevention and promotion strategies is family strengthening and parent skills training, to help families support their child’s health and well-being. In the first year of implementation, 15 (63 percent) of grantees began services in the area of family strengthening, and another 7 (47 percent) planned to implement family strengthening services in the second year of implementation. Across all grantees, funding was used to initiate or enhance 37 family strengthening programs. A program is defined as a specific service in which families enroll and participate for a set period of time. The number of programs ranges from one to five per grantee, with most grantees starting or enhancing one or two programs. Seventeen (17) different program models were supported by Project LAUNCH (Table 4.3). Five of the 17 are evidence-based family strengthening models. Of the 37 distinct programs supported by LAUNCH, 23 (62 percent) are evidence-based models. Another seven are programs designated as promising practices, and seven are locally-developed family support programs.

Family Strengthening

- Number of grantees: 15 (63 percent)
- Number of home visiting programs newly initiated or enhanced by Project LAUNCH: 37
- Percent of LAUNCH-supported home visiting programs that are evidence-based: 62 percent
- Number of families served in Year 1: 963
- Number of providers receiving LAUNCH-supported training: 150
- Number of children screened or assessed: 704
- Number of children referred: 26
- Number of parents screened or assessed: 123

Table 4.3. Evidence-based and Promising Family Strengthening Programs Implemented or Planned by Project LAUNCH (n = 24 grantees, Cohorts 1, 2, and 3)

Evidence-Based Family Strengthening Program Model (# of programs)	Promising Practice Family Strengthening Program Model (# of programs)	Locally-Developed Family Strengthening Program Model (# of programs)
<ul style="list-style-type: none"> • Incredible Years Parent Training (11) • Nurturing Families: <ul style="list-style-type: none"> — Nurturing ABCs (1) — Play and Learn (1) • Parent Child Interaction Therapy (PCIT) (3) • Parenting Wisely (3) • Strengthening Families <ul style="list-style-type: none"> — Parent cafes (2) — Parent training (2) 	<ul style="list-style-type: none"> • Video IPP (1) • Centering Pregnancy and Parenting (2) • Wraparound Case Management (1) • Newborn Behavioral Observation (1) • Circle of Security (1) • Chicago Parent Program (1) 	<ul style="list-style-type: none"> • Culture and language program (1) • Community family events (1) • Parent support groups (1) • Parent-child book groups (1) • Parent leadership activities (2) • Parent education provided with ‘211’ (1)

Source: CSE Web Portal-- October 2009, October 2010, October 2011; CSE telephone interviews with Project LAUNCH staff, 2009, 2010, 2011; Project LAUNCH End-of-Year Reports, Project LAUNCH Local Strategic Plans, 2009, 2010, 2011.

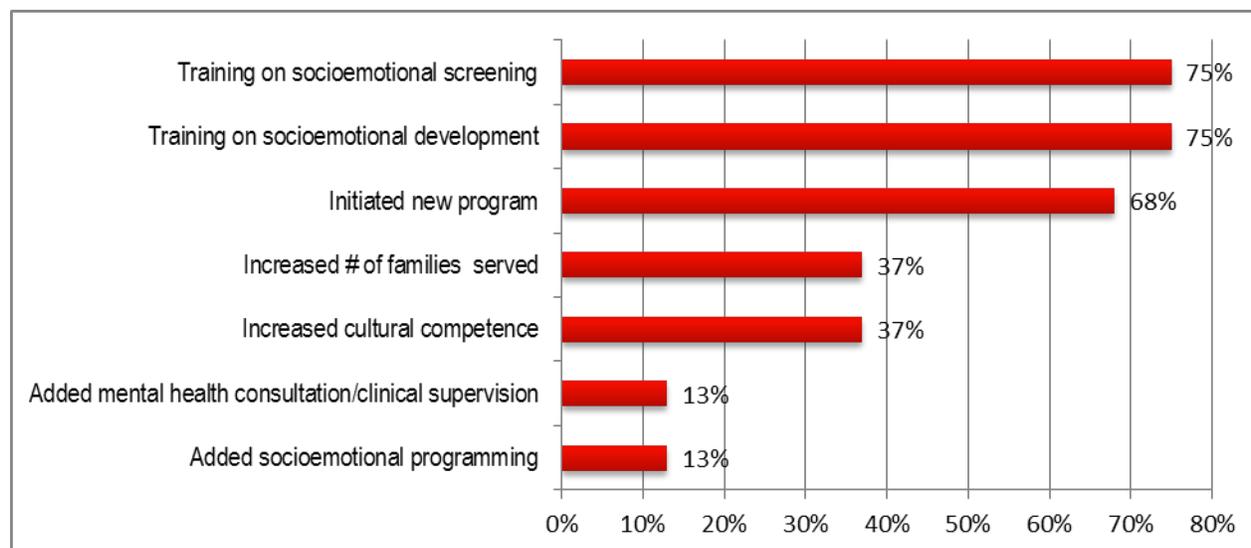
While the majority of family support programs supported in LAUNCH were either evidence-based or promising practices, some LAUNCH grantees adopted locally-developed activities that had no evidence base. The grantees that supported these local approaches did so for various reasons. For one grantee, the locally-developed family support activities were intended to build cultural identity and sense of community, and existing models did not target their specific community needs. Two other grantees who believed in the importance of supporting parent leadership did not identify evidence-based models in the

area; these grantees adopted activities that had been used previously but had not been evaluated. Finally, one grantee continued to support existing parent groups that had been instituted as a home support for the academic achievement activities being delivered in a community early childhood program.

The majority (n=25, 68 percent) of the family strengthening programs that Project LAUNCH grantees supported were newly initiated as part of LAUNCH. As was true for enhancements to home visiting programs, grantee enhancements to family strengthening programs (n=12, 32 percent) were based on infusing mental health and socio-emotional development into the programs. The types of support for family strengthening programs in LAUNCH communities (Exhibit 4.2) include:

- Increasing the size or reach of the program;
- Introducing systematic child or maternal screening/assessment to the programs, providing training for providers or, in some cases, supporting the assessment itself by other staff consulting with or working with the providers;
- Enhancing the knowledge and skills of providers through training on issues of young child mental health and socio-emotional development;
- Enhancing the cultural competence of the program to increase the program’s appropriateness for the families in the community; and
- Expanding the focus of the program by bringing in supplemental programs or practices focused on socio-emotional development for the child and family.

Exhibit 4.2. LAUNCH Support of Family Strengthening Programs in the Community (n=24 grantees, Cohorts 1, 2, and 3)



Source: CSE Web Portal-- October 2009, October 2010, October 2011; CSE telephone interviews with Project LAUNCH staff, 2009, 2010, 2011; Project LAUNCH End-of-Year Reports, 2009, 2010, 2011.

4.2.1 Children and Families Participating in LAUNCH-Supported Family Strengthening Programs in the First Year

Grantees (n= 15) that supported family strengthening services in the first year of implementation served 963 families. More than twice as many families participated in LAUNCH-supported family strengthening programs in the first year of implementation, compared with the number of families in home visiting

programs. This is related to the fact that the family strengthening programs tend to be more short-term (e.g., a specific number of sessions) and often have repeated cycles in a year (e.g., more than one group of families participate in a year), whereas home visiting programs tend to work with a small number of families over multiple years, with new families enrolled on an individual basis as other families reach the end of their eligibility (e.g., the child reaches a pre-specified maximum age such as his/her third birthday).

4.2.2 LAUNCH-Supported Professional Development for Staff of Family Strengthening Programs

Of the 15 grantees who started or enhanced services in family strengthening in the first year, 11 (75 percent) provided training to program staff on topics related to understanding and/or assessing children's socio-emotional development (see Exhibit 4.2, above). Across these programs, in the first year of implementation, 150 staff in family strengthening programs received some form of training supported by Project LAUNCH.

4.3 Mental Health Consultation Services: Year One

The third and fourth of the LAUNCH prevention and promotion strategies are mental health consultation in early care and education settings (preschool and elementary school) and integration of mental health in primary care.²⁷ Compared with the other LAUNCH strategy areas, mental health consultation in early care and education and primary care had a slower roll-out for at least three reasons:

- Very few communities had mental health consultation already in place at the time of the LAUNCH grant award (although this was less likely for Cohort 3 grantees, because the concept of mental health consultation has grown in acceptance since the time of the first LAUNCH grants in 2008).
- Unlike home visiting and family strengthening, grantees did not have the benefit of “branded” models or evidence-based practices that they could adopt for their communities.
- Implementation of consultation and integration models required coordinating two or more sectors in the service community—the professionals who would provide the mental health consultation and the agencies/organizations where consultation would be provided and received.

In key informant interviews, grantees noted the time and effort required to establish new relationships across providers and create new infrastructure, stating that the provider groups (in health care, early childhood, and elementary schools) typically did not have a history of collaboration and coordination with other service systems. Further, different provider groups were not necessarily comfortable sharing their work with children and families with other professionals such as mental health clinicians. Building trusting relationships among providers who had not previously worked together was a challenge, and breaking down these barriers was recognized as requiring substantial time and effort by LAUNCH staff.

Further, in many settings, there was no infrastructure to support mental health consultation models. For example, the agencies supporting the mental health consultants needed systems for training the clinicians

²⁷ Early childhood mental health consultation (ECMHC) is provided by a professional consultant with mental health expertise working collaboratively with early childhood education staff, programs, and/or families to improve the ability of staff, programs, and families to prevent, identify, treat, and reduce the effect of mental health problems among children from birth through age 8. Integration models seek to bring mental health expertise into the primary care practice both through having mental health consultants on site and through training primary care staff to be able to recognize, assess, and provide appropriate referrals to help their patients who have mental health needs.

on issues of working within different provider settings. Referral networks needed to be established for children and parents who might be identified as needing additional services on the basis of the mental health consultation. Protocols needed to be developed to support communication between providers and the mental health consultants, including a protocol for requesting consultation, a protocol for referrals, and a system for providing feedback to providers in a timely manner about the results of consultation. As one grantee said, “Capacity building with partners often takes longer than we would like. But we believe that this investment in time and energy will enhance our partners’ capacity to become more experienced and integrate this new component into their practices.” Taken together, these barriers required grantees to adopt longer-term timelines for implementation of their consultation models.

Grantees who did implement a consultation model in the first year typically prioritized their initiation of services among the settings, focusing on either child care and early education or on primary care, but not both. The choice between these settings depended on pre-existing relationships with the settings. Elementary schools were least often selected as a setting for introducing mental health consultation in the first year of implementation.

4.3.1 Mental Health Consultation in Child Care/Preschool Programs

For mental health consultation in early childhood settings, the biggest barriers to implementation identified by the grantees were limited staff time for additional training and collaboration and staff turnover. The rate of turnover among early childhood staff meant that LAUNCH had to continue providing the orientation to consultation each time a new provider entered the setting. Regardless, in the first year of implementation, 9 (38 percent) of the 24 Project LAUNCH grantees initiated mental health consultation in preschool or child care settings. Across these grantees, mental health consultation was provided to 40 programs serving approximately 1,500 children. The mental health consultation across these grantees was provided by trained master’s-level licensed clinicians, who, although not co-located, offered:

- Professional development to program staff on understanding and supporting children’s socio-emotional development;
- Classroom observation and consultation on ways to improve the curricula and/or environment to better support children’s mental and behavioral health; and
- On an as-needed basis, short-term consultation on individual children and families where there were concerns about the child’s mental or behavioral health.

Mental Health Consultation in Child Care/Preschool Programs

- Number of grantees: 9 (38 percent)
- Number of programs receiving mental health consultation: 40
- Number of children served by programs receiving mental health consultation: 1,500
- Number of early childhood care providers receiving LAUNCH-supported training: 108
- Number of children screened or assessed: 99
- Number of children referred: 62

LAUNCH supported the use of early childhood curricula in preschool and child care settings that focused on socio-emotional development. Different programs opted for one of four different curricula: (1) the Incredible Years Dina Dinosaur preschool curriculum, which is designed to improve peer relationships

and reduce aggression at home and school;²⁸ (2) the Second Step Program for Socio-Emotional Skills for Early Learning, also designed to build self-regulation skills and socio-emotional competence; (3) the Devereux Early Childhood Assessment (DECA) Program, a child assessment²⁹ combined with teacher strategies for use in the classroom and with individual children to promote social/emotional skill development, school readiness, and resilience; and (4) AI's Caring Pals, a program for use in family child care settings that develops social skills and healthy decision-making in children between 3 and 8 years old. Incredible Years was selected most frequently.

LAUNCH-supported workforce enhancement for early childhood care providers

In the first year of implementation, LAUNCH grantees provided training to 108 staff in 22 early childhood programs. The training covered general information about children's socio-emotional development, implementation of socio-emotional curricula, and use of socio-emotional assessments to systematically identify children with mental or behavioral health concerns.

4.3.2 Mental Health Consultation in Elementary Schools

Introducing mental health consultation into school settings was described as challenging by some grantees. For example, determining the appropriate models for school settings was difficult, as was establishing relationships between the child and family service system and the school system, which had not previously collaborated.

Despite the challenges, five grantees began to deliver mental health consultation in eight elementary schools in the first year. Mental health consultants were licensed mental health professionals and, as the consultants did in early education settings, most often worked with individual children that the school (teacher or counselor) identified as having behavioral concerns. The consultant provided short-term counseling and assessment and determined if the child should be referred for more comprehensive evaluation. The LAUNCH mental health consultants typically worked separately from the special education departments in the schools. As one grantee explained, the value of the mental health consultation to the school system is to provide more prevention-oriented evaluation and assessment to students who are not candidates for the more intensive evaluation associated with Individual Educational Plans development.

Mental Health Consultation in Elementary Schools

- Number of grantees: 5 (21 percent)
- Number of schools receiving mental health consultation: 8
- Number of school staff receiving LAUNCH-supported training: 359
- Number of children screened or assessed: 14
- Number of children referred: 14
- Number of parents screened: 9
- Number of parents referred: 6

LAUNCH-supported workforce enhancement for staff in elementary schools

In the first year of implementation, LAUNCH grantees provided training to 359 school staff in 8 elementary schools. The trainings covered general information about children's socio-emotional

²⁸ Dina Dinosaur is delivered in the classroom 2-3 times a week in 15-20 minute circle time discussions, followed by small group practice activities. Home activities manuals encourage parent involvement in teaching children school rules, social skills, and problem-solving.

²⁹ The DECA is a standardized measure of young children's attachment, self-control, and initiative.

development, implementation of socio-emotional curricula, and use of socio-emotional assessments to systematically identify children with mental or behavioral health concerns.

4.3.3 Integration of Behavioral Health in Primary Care

Nine of the 24 (38 percent) LAUNCH grantees began implementing integration of behavioral health activities in primary care settings before the end of the first year of implementation. Grantees reported that this implementation required substantial effort and often was met with challenges. In planning for implementation of a model to integrate behavioral health into primary care, multiple grantees commented on the need for a “programmatically infrastructure” to integrate screening and follow-up supports into pediatric practices, a process that requires commitment, planning, and dedication of staff time and resources. As one grantee described the challenge, “Integration [of behavioral health] needs investment in relationship-building and trust-building. We need to build an infrastructure for ongoing communication (for example, infrastructure around distributing screening instruments, supporting parents with language or literacy barriers, scoring completed tools, and providing feedback to providers in a useful and timely manner).”

Integration of Behavioral Health in Primary Care

- Number of grantees: 9 (38 percent)
- Number of children served by primary care settings participating in Project LAUNCH: Fewer than 100 to more than 20,000
- Percent of grantees where mental health consultants are co-located in primary care setting: 44 percent (4 of 9)

Other barriers that grantees faced included:

- *The medical culture itself not being collaborative.* Grantees noted that they had to devote “significant time and resources to the cultivation of relationships and buy-in from pediatricians and primary care practitioners. A radical shift was required to change the mindset of clinicians—to encourage them to concentrate on prevention modalities as well as treatment.”
- *Busy schedules within pediatric practices.* Medical providers are so busy that it is difficult to find time for in-service training or to consult with a mental health professional about a child with mental or behavioral health concerns.
- *The paramount importance of determining reimbursement and billing procedures.* In most states, there are few options for physicians to bill for developmental screening and mental health services for young children. Grantees found it challenging to get physician participation in initiatives that have little or no sustainable funding options.
- *Placing emphasis on prevention rather than intervention.* This change in emphasis requires a paradigm shift in thinking for providers.

The mental health consultants hired by Project LAUNCH to work with health professionals were all licensed clinicians. For all but one of the nine grantees, the mental health consultants were available to consult with pediatricians and/or families after children were screened and found to have mental health or behavioral problems. The consultants also provided general training to the primary care providers on children’s socio-emotional development. The health facilities that received the mental health consultation services ranged in size from large urban health centers with more than 20,000 children enrolled to smaller health facilities with fewer than 100 families enrolled. In almost half of the nine grant programs (44 percent), the mental health consultants were physically co-located in the health care centers and were part of the clinical team.

The mental health consultation services were delivered at different levels of intensity with different groups of children in the health care settings. A small number of children received short-term counseling and evaluation when the screening that was conducted identified developmental or behavioral concerns. Other children, including children seen by the health care staff who were outside of the targeted age range for Project LAUNCH (e.g., children older than 8 years of age), received the benefits of being screened and having a health care provider (i.e., pediatrician) with enhanced knowledge of children's socio-emotional development, how to identify behavioral concerns, and the kinds of follow-up assessment and referrals that are appropriate and available in the community. Therefore, ultimately, all of the children enrolled in the health facilities with mental health consultants could be seen as benefitting from the enhanced knowledge and practice of the health care providers.

LAUNCH-supported workforce enhancement for staff in primary care settings

In the first year of implementation, the nine LAUNCH grantees who were integrating behavioral health in primary care provided training to 495 staff in 30 primary care settings. The training focused on providing staff with general information about children's socio-emotional development and appropriate referrals for children with mental or behavioral health concerns.

4.3.4 Mental Health Consultation to Home Visitors, Family Strengthening Programs

A small number of LAUNCH grantees also adopted an innovative strategy for infusing prevention and identification of child and family mental health issues into the local service system: providing mental health consultation to staff in settings other than early care and education or primary care. Three LAUNCH grantees provided a mental health consultant to their home visiting staff during the first year of implementation, while five other grantees began to plan for this type of consultation activity to begin in the second year of implementation. In addition, one grantee also provided mental health consultation to staff in their family strengthening program. The mental health consultants provided some of the same training and support to the home visitors and family strengthening program staff as were being provided to early childhood staff and primary care physicians. This included staff professional development on young children's socio-emotional development and the critical role of the parent-child relationship in the child's earliest years and consultation on concerns with individual children or families seen by the program staff. Beyond these activities, however, the mental health consultants are providing support directly to the program staff to help them deal with their own stress and to bolster their confidence in meeting the needs of the families they are trying to help. All of these mental health consultants are licensed clinicians.

Across the three grantees, 144 staff of home visiting and family strengthening programs received mental health consultation through discussions at staff meetings (including reflective supervision) and one-on-one consultation with the mental health consultant about families with specific mental health concerns. In the case of one grantee, the mental health consultant accompanied home visitors on home visits to provide support on evaluating the status of the parent, engaging in discussions with the parent around mental health issues, and working directly with the parent on a short-term basis.

4.4 Developmental Screening and Assessment: Year One

Use of standardized child screening and assessment measures across a range of programs and child-serving settings is the fifth LAUNCH-supported prevention and promotion strategy. Although the environmental scans conducted by the grantees as part of planning showed that developmental screening was already occurring in some parts of the child and family service system, LAUNCH grantees identified important gaps:

Key Findings in the First Year

- Assessments occurring prior to Project LAUNCH often did not encompass the mental and behavioral health domain;
- Only rarely did screening include other family members, especially screening of parents for mental health and/or substance abuse; and
- Assessments were not always linked to appropriate referrals for children or parents who were identified as needing additional evaluation or services.

In the first year of implementation, the total number of children and parents who were screened or assessed and those who were subsequently referred for services are as follows:

- Grantees screened or assessed 6,799 children in the first year of their Project LAUNCH grant. The largest numbers of screening were conducted in primary care settings that were part of LAUNCH programs to integrate mental health in primary care.
- Overall, approximately 12 percent of the children who were screened were referred for additional evaluation or services.
- Of the 1,285 parents who were screened or assessed, 19 percent were referred for additional evaluation or services.

Measures of children's behavioral and mental health were included as part of nearly all of the screening and assessment supported by Project LAUNCH. For child screening, grantees overwhelmingly selected standardized measures with known psychometric adequacy. The ASQ-SE (Ages and Stages—Socio-Emotional), for children 6 – 60 months, was the most commonly used screening measure. Other measures of socio-emotional development that were supported by LAUNCH include the Modified Checklist for Autism in Toddlers (M-CHAT), for children 16 – 30 months, and the Pediatric Emotional Distress Scale (PEDS), for children 2 – 10 years. All three of these measures are available at no cost.

In Year One, nine 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. Several grantees chose to use depression scales that are appropriate for a wider population, such as the Patient Health Questionnaire (PHQ-9). Seven grantees expanded screening to include substance use. None used a formal screener. Instead, four included questions about substance use as part of a parent intake survey, and three used the Kempe Family Stress Checklist, which includes questions on parental substance use.

Grantees made progress toward the systems goal of supporting systematic screening and assessment in multiple parts of the child service setting and had plans to expand screening to other programs and settings in the second year of their grant:

- Five grantees supported child assessments in three settings: primary care, early childhood, and home visiting programs.
- Seven grantees supported child assessment in two settings: home visiting programs and either early care and education or primary care settings (six of the seven grantees) or primary care and early care and education (one grantee).
- Nine grantees supported child assessments in a single setting: home visiting programs (four grantees), primary care settings (five grantees), or as part of a LAUNCH intake process (two grantees).

In the first year, the numbers of children and family members screened by programs within the five core strategies are shown in Table 4.4.

Table 4.4. Developmental Screening/Assessment Supported by Project LAUNCH in Year One of the Grant

Type of Program/ Setting	Children		Parents	
	# Screened/ Assessed	# Referred (%)	# Screened/ Assessed	# Referred (%)
Home Visiting	322	67 (21%)	721	51 (7%)
Family Strengthening	704	26 (4%)	123	47 (38%)
Early Childhood	99	62 (63%)	NA	NA
Elementary Education	14	14 (100%)	9	6 (67%)
Primary Care	5,660	622 (11%)	432	134 (31%)
All programs/ settings	6,799	791 (12%)	1,285	238 (19%)

LAUNCH grantees also supported child assessments in two other types of settings – LAUNCH program intake and community health fairs. Seven grantees conducted 247 child assessments as part of a common intake process for the LAUNCH program. Two of these grantees only supported assessments as part of intake; the other five assessed children themselves as part of their intake and supported assessments in home visiting programs or primary care settings as well. Two of the seven grantees organized community health fairs, where one-time child screenings and referrals were provided for 181 children, with 18 percent referred for follow-up. However, even where grantees were working in multiple systems and across the different parts of the system, all providers were not necessarily using the same measures.

In all settings where LAUNCH grantees supported screening and assessments in Year One, socio-emotional development and behavior were included. The ASQ-SE (Ages and Stages—Socio-Emotional), for children 6 – 60 months, was the most commonly used screening measure. Other measures of socio-emotional development include the Modified Checklist for Autism in Toddlers (M-CHAT), for children 16 – 30 months, and the Pediatric Emotional Distress Scale (PEDS), for children 2 – 10 years. As indicated by the target ages for these measures, the first year of implementation focused on assessments of preschool children. Identifying appropriate measures for school-age children in the LAUNCH community was recognized by grantees as a bigger challenge.

4.5 LAUNCH Family Referrals/Coordination: Year One

Seven (29 percent) of the 24 LAUNCH grantees initiated centralized planning with families. This included assessment of family needs and referral to available services, both LAUNCH-supported and other services in the communities. In the first year of implementation, these grantees saw 247 families for intake and referrals. As part of the intake process, all families were assessed for family needs. In addition, 93 children were screened on their socio-emotional development. All of the families were referred to services in the community that could address family needs.

4.6 Cross-Training and Workforce Development: Year One

In their first year, some grantees supported provider training in each sector of the child service system in which they were implementing LAUNCH-supported services (home visiting, family strengthening, mental health consultation in early education and care, integration of behavioral health in primary care) and also trained providers in the use of developmental assessments. Others offered provider training in some of these settings.

LAUNCH grantees also provided training to providers in the LAUNCH community who were unaffiliated with a LAUNCH-supported service, but for whom training would enhance services being delivered in the target community. The cross-agency community trainings were an opportunity for grantees to begin to work system-wide on common frameworks for approaching child and family services. In the first year of implementation, 472 providers attended community-wide trainings. Examples of trainings include:

- Training on Touchpoints, an approach developed by Barry Brazelton that enhances the ability of pediatricians, nurses, early educators, home visitors, and other professionals to support parents;³⁰
- Child abuse and prevention webinars provided to staff in county child protection agencies;
- Training on promoting social and emotional development in young children from the Center on Socio-Emotional Foundations for Early Learning (CSEFEL) for child care providers;
- Training for primary care and social service agency providers on the ASQ-SE; and
- Training to orient providers in their community to Project LAUNCH.

³⁰ Touchpoints is designed to enable providers to “touch into” the family system when their involvement is most likely to be appreciated and their messages most likely to be helpful; to provide a common language of child behavior and development for families and providers; and to provide an adaptable, culturally-sensitive way of working that engages a community’s heritage, assets, and self-strengthening capacities on behalf of its young children.

Key Findings: Service Delivery in the First Year of Implementation

Home Visiting

- Sixty-seven percent of grantees (n=16) began implementing enhancements to home visiting programs in their communities; an additional 25 percent (n=6) were planning enhancements. In the first year, Project LAUNCH was supporting efforts to enhance 25 different home visiting programs. Sixty-four percent of these programs were evidence-based.
- LAUNCH-supported enhancements to home visiting programs included: introducing systematic child or maternal screening/assessment; providing training for providers on assessment tools or on issues of young child health and socio-emotional development; enhancing the program's cultural competence; introducing new practices focused on socio-emotional development; and providing mental health consultation.
- In the first year, 580 families were served by home visiting programs supported by Project LAUNCH.
- Across the home visiting programs, 322 children were screened and 67 (21 percent) were referred for additional mental health-related evaluation or intervention services.
- A total of 721 parents were screened in four home visiting programs, with 51 (7 percent) referred for follow-up services.

Family Strengthening

- Fifteen grantees began services in the area of family strengthening, and seven grantees started planning for family strengthening programs. Across these 15 grantees, 37 programs and 17 distinct program models were started or enhanced by Project LAUNCH. Six of the models and 23 of the 37 LAUNCH-supported programs (62 percent) were evidence-based.
- In the first year, 963 families participated in LAUNCH-supported family strengthening programs.
- Eleven of the 15 grantees implementing family strengthening programs provided training to 150 program staff on topics related to understanding or assessing children's socio-emotional development.
- Nine of the 15 grantees conducted systematic child screenings and assessments, and all but one of the nine included measurement of children's socio-emotional development as part of their screening efforts.
- A total of 704 children were screened and 26 (4 percent) were referred for additional mental health-related evaluation or referral. Systematic assessment of parents occurred in three family strengthening programs, implemented by three grantees.

Mental Health Consultation in Early Care and Education Settings

- Project LAUNCH grantees supported the use of four early childhood, socio-emotional curricula in preschool and child care settings.
- Grantees provided training to 108 staff in 22 early childhood programs on children's socio-emotional development, implementation of socio-emotional curricula, and use of socio-emotional assessments.

Key Findings: Service Delivery in the First Year of Implementation (cont'd)

- Ninety-nine children were assessed in early childhood programs. However, the assessments were not program-wide but were instead focused on children for whom staff had some concerns. More than half of those assessed (63 percent) were referred.

Mental Health Consultation in Elementary Schools

- Five grantees began to deliver mental health consultation in elementary schools in the first year, using licensed mental health professionals working in eight schools.
- Grantees provided training to 359 school staff in 27 early childhood programs.
- Three of the five grantees conducted assessments of children as part of their consultation activities. Assessments targeted children whom school staff or the consultant had identified as having mental or behavioral health concerns. Only 14 students were assessed, and all received referrals for needed services.
- One grantee also assessed the parents of children with behavioral health issues. Of the nine parents assessed, six were referred for additional services.

Integration of Behavioral Health in Primary Care

- Nine grantees implemented integration of behavioral health activities in 10 primary care settings. Mental health consultants were co-located in the health centers in four of the nine grant programs.
- Grantees provided training to 495 staff in primary care settings.
- The nine grantees undertook systematic assessment of child development, including screening on socio-emotional development as well as for cognitive and physical development. In the first year, 5,660 children were assessed, and 11 percent were referred for additional evaluation or follow-up services.

Mental Health Consultation in Other Settings

- Three grantees provided a mental health consultant to their home visiting staff, and five other grantees planned to implement this activity in their second year.
- Across grantees that began this activity, more than 144 staff participated in mental health consultation through discussions at staff meetings (including reflective supervision) and one-on-one consultation about families with specific mental health concerns.

Developmental Screening and Assessment

- Grantees screened or assessed 6,799 children in the first year across all core LAUNCH strategies. The largest numbers of children screened were in primary care settings. Overall, 12 percent of the children who were screened were referred for additional evaluation or services.
- Of the 1,285 parents screened or assessed, 19 percent were referred for additional evaluation or services.
- Standardized measures of children's behavioral and mental health were included as part of nearly all screening and assessment, with the ASQ-SE being the most commonly used measure.

Workforce Development in LAUNCH Community

- LAUNCH provided training to 472 providers unaffiliated with a LAUNCH-supported service, covering several topics: Touchpoints, child abuse prevention, social and emotional development, and the ASQ-SE.

5. Establishing Priorities for Systems Change

Project LAUNCH addresses both service delivery and systems change. While the majority of LAUNCH funds go toward service implementation, the LAUNCH initiative also emphasizes systems change across multiple aspects of the child services delivery system. Data collected from grantees during telephone interviews and site visits indicate that systems change activities are aimed at ensuring availability and access to quality prevention services for young children and families; sustaining services over time; addressing service gaps in order to improve the health, well-being, and school readiness of young children and families and reduce health disparities; and eliminating fragmentation in systems and funding streams.

This chapter presents grantees' priorities for systems change at the state/tribal and community levels and their accomplishments in the first year.

5.1 Systems Change Activities Identified in Strategic Plans

5.1.1 State/Tribal Priorities for Systems Initiatives

State/tribal YCWCs are leading the systems change activities for Project LAUNCH.³¹ Grantees have brought together agency representatives from across the child-serving system to be on the YCWCs, and, in doing so, have assembled individuals with the relevant experience, knowledge, and authority to be able to bring about state-wide systems change. In addition, the state/tribal project director for LAUNCH has a major role in facilitating systems change efforts.

In their strategic plans, most grantees identified systems change activities they planned to work on as part of Project LAUNCH. Systems change activities that were eventually undertaken are described in Section 5.2. Activities can be grouped into five categories:

1. **Policy development:** Reviewing existing state/tribal policies and practices to determine where improvements are needed; revising and aligning policies, when necessary; and implementing new policies to enhance outcomes for children and families.
2. **Funding:** Addressing barriers to reimbursement for specific services; collaborating with Medicaid agencies and others to ensure coverage for LAUNCH services; and collaborating with agencies to develop blended funding streams.
3. **Workforce development:** Preparing and implementing state-wide workforce development plans; and developing quality standards, career pathways, and certification and licensing programs.
4. **Data systems enhancement:** Enhancing or developing new data or other tracking systems.
5. **Collaboration:** Working to strengthen interagency coordination and collaboration on early childhood programs; and developing policies and procedures to ensure information sharing across agencies and systems and coordination of program planning and service delivery.

Illustrative examples of planned systems change activities within each of these five categories are shown in Table 5.1. By building on other investments and activities in the early childhood system that predated

³¹ SAMHSA awarded Cohort 3 grants directly to local communities. For grantees in this cohort (n=6), systems improvement activities are led by the community YCWC. In addition, these grantees are coordinating with state leaders in early childhood to ensure that planning and policy reforms, as well as early childhood goals and objectives at the state and community levels, are aligned.

LAUNCH (e.g., ECCS), many grantees reported that they will be able to leverage the systems development work already started in these areas and build upon it under Project LAUNCH.

Table 5.1. Illustrative Examples from Strategic Plans of Grantees' Planned Systems Change Activities at the State/Tribal Level (n = 18 grantees, Cohorts 1 and 2)^a

Policy Development/ Standardized Procedures and Practices

- Establish standards of practice for screening, assessment, and referral
- Select and promote use of common tools (e.g., assessment tool) to be used across all systems and services
- Align policies and procedures across all state agencies serving young children
- Develop policy recommendation for a minimum Medicaid benefit package for children, aligned with the minimum benefit package for health care reform and the Bright Futures initiative

Funding

- Create funding mechanism to enable universal screening
- Increase coordination of funding across programs and services (e.g., through the creation of blended funding models or dedicated funding streams)
- Develop fiscal strategies that support leveraging federal funds and improving utilization of state funds

Workforce Development

- Develop a certification program for providers working with young children
- Provide training and technical assistance on a broad range of behavioral health topics, including perinatal depression, exposure to violence, and trauma to early childhood education and health providers (e.g., primary care providers) across the state

Data Systems Enhancement

- Make recommendations to collect specific data components in state information systems
- Create a system for tracking and monitoring professional development activities

Public Awareness

- Address stigma through public awareness campaign
- Increase awareness of infant mental health endorsement opportunities

Collaboration

- Connect to, advocate with, and inform the agendas of multiple state-level initiatives in the areas of parent education and leadership development
 - Increase coordination of data collection, sharing, and analysis across early childhood agencies, programs, and initiatives
 - Identify common data needs across agencies and develop data sharing agreements
-

Source: Project LAUNCH State/Tribal Strategic Plans, 2009, 2010.

^aSAMHSA awarded Cohort 3 grants to communities; therefore, the table does not include Cohort 3 grantees.

5.1.2 Local Priorities for Systems Initiatives

Grantees also wrote in their community strategic plans about planned systems change activities at the community level. Table 5.2 provides examples of the activities that were outlined in communities' strategic plans. Community-level systems change activities also can be organized into the five categories described above. While LAUNCH is supporting systems activities at both the state/tribal and community

levels, grantees' community-level strategic plans focus more on service enhancements and service delivery than on systems change.

Table 5.2. Illustrative Examples from Strategic Plans of Grantees Planned Systems Change Activities at the Community Level (n = 20 grantees, Cohorts 1, 2, and 3)^a

Policy Development/Standardized Procedures and Practices

- Establish common referral and screening forms across systems
- Review and refine standards, policies, protocols, and program tools for consistency and application
- Adopt organizational policy changes for implementing evidence-based programs (EBPs)

Funding

- Develop business partnerships to support advocacy and corporate philanthropy roles in investment for early childhood
- Work with insurance companies on coverage of services no longer covered by provider centers, such as speech and language, OT/PT, and other developmental supports
- Obtain commitment from funding streams to support and fund training efforts as a component of service delivery

Workforce Development

- Establish a workforce development plan that supports staff competency and promotes a change in the early childhood system to reflect the LAUNCH core principles
- Incorporate early childhood topics (e.g., medical home, trauma, infant mental health) into training and technical assistance initiatives for early childhood providers
- Provide support on preparing for Infant Mental Health endorsement to providers at all levels (training, informational materials, example portfolio)

Data Systems Enhancement

- Develop a comprehensive, up-to-date information and referral system
- Obtain cross-agency commitment for sharing appropriate client data across systems

Public Awareness

- Develop outreach plan for family services
- Promote awareness of purpose of home visitation
- Expand promotion of parent training and other services in Spanish
- Develop and implement public awareness campaign

Collaboration

- Share screening results across early care, health, and education providers
- Ensure that community partners understand and support the state plan for early childhood and accept the document as a framework
- Establish MOUs between programs for generating referrals, tracking common outcomes, and sharing information

Source: *Project LAUNCH Community Strategic Plans, 2009, 2010, 2011.*

^aStrategic plans were not available for two grantees.

5.2 Systems Change in the First Year

5.2.1 State/Tribal and Community-Level Systems Change

The systems change activities grantees are working on are ambitious. To accomplish objectives for systems change, grantees will require considerable planning and coordination among key policymakers and program staff. In the first year of Project LAUNCH, almost all grantees began to work on systems change, realizing that many of the changes they are working on will take time, and some may even take the full 5-year grant period to achieve.

Illustrative Year One outcomes within each systems change category—at both the state/tribal and community levels—are highlighted below. Because grantees are just getting started in implementing systems change, this section provides illustrative examples of systems change initiatives. Later CSE reports will describe activities within each systems change category in greater detail and document the types of systems changes occurring across the Project LAUNCH initiative.

Policy

Because of Project LAUNCH, integration of behavioral health in pediatric clinics has received considerable visibility in several communities and at the state/tribal level. One grantee reported that several state policy groups, including the state chapter of the American Academy of Pediatrics' Children's Mental Health Task Force and other state advisory councils, have become interested in behavioral health integration and are looking to LAUNCH as a 'learning laboratory' for this policy issue.

Another grantee reported that collaboration on the state YCWC between Medicaid managed care organizations, the community YCWC, and state agencies resulted in a policy change when a Medicaid managed care plan eliminated the predetermination requirement for primary care offices to receive reimbursement for developmental screenings of children. The managed care organizations on the state YCWC have also agreed to share their Medicaid claims data about developmental screenings of children in the LAUNCH community with the state Title V agency. With these data, the state expects to be able to answer key questions about developmental screenings and develop strategies to increase the number of children screened. The state hopes that the information and experiences gained through LAUNCH will have a positive influence in the LAUNCH community and more broadly across the state.

Funding

Many grantees have chosen to enhance existing service delivery programs, rather than begin new programs, within the LAUNCH community. One grantee noted that this enhancement means that LAUNCH services are being implemented with blended resources and funds. Looking ahead and recognizing the economic constraints that state governments now face, grantees have reported that blending resources to implement LAUNCH programs will make it easier to sustain program services at the end of the grant period. One grantee, however, stated that the cuts in state and federal budgets generate concern among providers that they will lose funding. While some agencies at the state level are promoting blended or braided funding, the fear that comes with budget reductions may limit what programs are willing and able to do in this area.

Workforce Development

Most grantees are exploring avenues for strengthening the early childhood workforce statewide. For example, an activity within the first year includes taking steps toward developing an endorsement

program for all professionals working with young children as well as a state early childhood mental health association.

As discussed in the previous section of this report, at the community level, grantees are providing training for staff who are delivering Project LAUNCH-supported programs. In addition, some grantees are conducting training for other providers in the community. For example, one grantee reported providing training on the Ages and Stages Social and Emotional (ASQ-SE) development screening tool to all early childhood teachers in the school district so that they would have an evidence-based tool for screening children. Another grantee has begun to host “community conversations” for providers and parents on the effect that exposure to violence has on families, including cycles of abuse, depression, and isolation. Providers’ concerns about this issue came to light during YCWC meetings and other discussions with providers. By sponsoring regular meetings on this topic, the extent of the problem in the community is now being recognized, and the community plans to develop services and training for providers to address families’ specific mental health needs. Almost 500 providers, not affiliated with Project LAUNCH direct services, have received training as a result of the LAUNCH initiative in their communities.

Data Systems Enhancement

One of the early system outcomes for Project LAUNCH has been the development or enhancement of data systems at the community level. In part, these efforts were motivated by the evaluation requirements for Project LAUNCH. Grantees were expected to report to SAMHSA and the cross-site evaluation on the number and characteristics of children and families served through LAUNCH-supported programs. An early assessment to determine whether grantees had systems in place to provide these data revealed that the capacity for collecting and reporting the required data varied across providers and many lacked a systematic way (either paper or electronic tools) for tracking children and families who participated in their programs. As data systems become more established in provider settings, Project LAUNCH coordinators anticipate that providers may see their potential for client management and for monitoring program performance and quality improve.

Some state/tribal and community YCWCs also were planning to address data sharing issues across systems and service providers to enable providers in different programs to share client data. One grantee began developing a referral and tracking database that gives early childhood providers information about programs and services available in the community and the ability to follow-up on referrals made to other programs.

Public Awareness

Grantees are conducting activities to increase families’ and the general public’s awareness of early childhood development and services available to families within the community. Grantees have developed informational materials for families to make them aware of the community’s early childhood resources—e.g., parent education, home visiting. Materials have included a positive parenting calendar, brochures on Project LAUNCH services, resource guides, and fact sheets. Grantees have also held events in recognition of Mental Health Awareness Day. Materials have been disseminated widely with collaboration from community partners, and some have been translated into other languages.

Several grantees are also planning public awareness campaigns to inform parents about developmental milestones and programs (e.g., Text4Baby) that support maternal and child health. Grantees are also educating providers about services in the communities so that they can connect families to other programs, when needed. Finally, grantees are conducting activities to make childcare providers aware of training programs and, in several grantee sites, the availability of infant mental health endorsement

opportunities. For one grantee, this includes sharing information about the benefits and levels of endorsement and the training available to support this early childhood credential.

Collaboration

The majority of grantees reported that the formation of their state/tribal and community YCWCs has improved sharing and coordination across agencies. While some YCWC members knew each other before LAUNCH, bringing agency and organizational leaders and service providers together has renewed and strengthened relationships. Other accomplishments noted in the first year were the development of a strategic plan, a state legislative agenda, public awareness materials, and integration of LAUNCH with other early childhood initiatives and work groups (e.g., linkages with an existing work group on mental health consultation; coordination and communication with systems of care activities within the LAUNCH community; and participating in state system of care resource team meetings).

In many states and communities, multiple systems building activities are ongoing at the same time as Project LAUNCH. These other initiatives—ABCD III, ECCS, MIECHV, and many state- and community-specific initiatives—have given Project LAUNCH staff at both the state/tribe and community levels an opportunity to participate on other advisory groups working on important systems change efforts, such as development of a system of universal screening of expectant mothers and development of a universal screening tool. In some states, grantees reported that they are also working closely with MIECHV program staff to ensure that the two programs are aligned and that lessons learned from LAUNCH inform activities under the new home visiting program. In the first year, there is clear evidence that LAUNCH funds are being leveraged through collaboration with these other initiatives.

Key Findings: Systems Change

Planned systems change activities were outlined in grantees' strategic plans:

- Grantees outlined their intent to focus on six types of systems change activities: policy development, expanding funding for early childhood prevention services, workforce development, data systems enhancement, public awareness, and interagency collaboration.
- Examples of community-level systems change activities that were planned included: establishing a common screening instrument across state systems; adopting policies for implementing evidence-based programs; obtaining commitment from funding streams to support training as a component of service delivery; incorporating early childhood topics (e.g., medical home, trauma, infant mental health) into training and technical assistance initiatives for early childhood providers; developing an information and referral system; sharing screening results across early care, health, and education providers; and implementing a public awareness campaign.

Almost all grantees began to work on systems change activities at both the state/tribal and community levels in their first year:

- Examples of early systems changes that were reported to be attributed, in part, to Project LAUNCH included:
 - Changing a policy to eliminate the Medicaid predetermination requirement in order to receive Medicaid reimbursement for developmental screenings of children.
 - Using multiple funding streams (blended funds), including Project LAUNCH funds, to support early childhood services.
 - Developing plans to create an endorsement program for professionals working with young children and a state early childhood mental health association.
 - Providing training for all early childhood teachers in the school district on the ASQ-SE screening instrument, so they would use an evidence-based tool for screening children.
 - Enhancing provider data systems, in part as a result of Project LAUNCH evaluation requirements.
 - Beginning to look at ways to share data across systems and service providers.
 - Developing and disseminating informational materials to families.
 - Strengthening relationships, information sharing, and collaboration across state/tribal and community agencies and provider organizations.
- While all but the last two examples were implemented by one grantee, almost all grantees reported strengthened relationships across agencies as an outcome of Project LAUNCH in their first year. The formation of YCWCs with broad agency representation and participation of the YCWCs in Project LAUNCH planning activities have facilitated relationship building.
- Grantees indicated that many of their systems change efforts will take time and potentially even the full 5-year grant period to accomplish. Systems changes, such as changes in Medicaid reimbursement policies, blended funding streams, and adoption of workforce standards require strong leadership and collaboration within and across systems. At a time when states are faced with budget and staff shortages, systems change was recognized as an important focus of Project LAUNCH, yet challenging to accomplish.

6. Looking Toward Year 2

6.1 Year 2 Implementation for Project LAUNCH Programs

As the data reported by grantees from the first year of implementation indicate, the Project LAUNCH grantees made progress towards their goals to change the local child service system and to deliver high-quality, evidence-based services that meet the needs of the families in their communities. These changes were accomplished despite the deepening national recession and fiscal pressures on services and funding at all levels. In the midst of budget cuts and service reductions, Project LAUNCH was reported to stand out as a catalyst for other community agencies and institutions in their work to build a coordinated and comprehensive service system to promote healthy child development. LAUNCH grantees also recognized the ways in which the recession negatively impacted the overall health of their communities. It increased the risk factors faced by families of young children and by the children themselves and threatened the existence of many of the protective services that had been established for children and families at risk.

6.2 Next Steps for the Cross-Site Evaluation

The cross-site evaluation will report on the progress and interim outcomes of Project LAUNCH in its next report. This report will continue to use web data reported by grantees on service delivery (which is updated every 6 months) and systems development (which is updated annually), evaluation reports submitted to SAMHSA, and information from interviews with Project LAUNCH staff in each of the 24 sites. Telephone or site visit interviews are conducted annually with the state/tribal project director for Project LAUNCH (Cohorts 1 and 2) and the Project LAUNCH community coordinator (all cohorts). During site visits, cross-site evaluation team members will also conduct additional interviews with key stakeholders such as members of the state/tribal or community YCWCs and providers.

In addition, in Year 2, the CSE began working with four of the Cohort 1 and 2 evaluators who received separate funding from SAMHSA to conduct special studies that evaluate child outcomes. Another three grantees, also from Cohort 1 and 2, were awarded special studies in May 2012. The special studies are expected to provide rigorous information about the effectiveness of Project LAUNCH in improving child outcomes that will not otherwise be available from the local evaluations. At the end of 5 years, the cross-site evaluation will synthesize the results of the one special study that will be completed at that time, along with preliminary data from other studies. The results of the special studies will address the fourth evaluation question about the effect of LAUNCH on the health and well-being of young children in Project LAUNCH communities.

To receive funding, a special study had to meet six criteria:

- The study had to use a rigorous design--either a randomized or quasi-experimental design with an appropriately matched comparison group.
- The study had to be designed to estimate impacts on one or more child outcomes that are aligned with the key objectives of Project LAUNCH.
- The design had to include measurement of child outcomes during the period before the start date of the LAUNCH grant and at multiple points during the LAUNCH grant period.
- The study had to use appropriate analysis methodologies aligned with the design.

Key Findings in the First Year

- The study had to be based on a clearly-articulated logic model that showed a valid hypothesized pathway to the child outcome(s) from the activities being supported by Project LAUNCH.
- The study had to demonstrate the availability of data to address the research questions of the study.

The designs of the special studies are summarized in Table 6.1.

Table 6.1. Designs of Project LAUNCH Special Studies

Site/ Study	Research Question	Outcome Measure	Sample/Sample Size	Design/Analytic Plan	Expected Date for Impact Results
1	What is the impact of the LAUNCH-supported child and family services on children's school readiness?	State-developed child development checklist (nine domains), administered pre-post during preschool year	At-risk 4-year-olds in state pre-kindergarten program Approximately 100 preschool children/year in programs in LAUNCH communities and 100 in programs in each non-LAUNCH community	Comparison of children in state pre-kindergarten program in LAUNCH counties vs children in same program in 1-3 comparison counties. Study combines 4 cohorts of children (2010 – 2014). Multiple time points: 5 years of program-level baseline measures (average child readiness scores for programs pre-LAUNCH); LAUNCH: 2010-2014.	Late fall, 2014
2	What is the impact of the LAUNCH-supported services for families and children on the rate of reported cases of child maltreatment?	State Child Protective Services database	19 census tracts in LAUNCH community and a sample of matched census tracts outside of LAUNCH community	Comparison of rates of maltreatment over time in LAUNCH census tracts and non-LAUNCH census tracts. Short interrupted time sample with multiple baseline points (pre-LAUNCH years) and multiple years during LAUNCH.	Late fall, 2014
3i	What is the impact of the LAUNCH-supported services for families and children on kindergarten entry readiness scores?	Child assessment completed by kindergarten teachers as part of LAUNCH special study Parent survey on parent-child relationship, understanding of child development, parent mental health	200 kindergarten children in 9 elementary schools in the school district in the LAUNCH community	Comparison of average kindergarten readiness scores for children entering kindergarten from LAUNCH zip codes and children in same schools from non-LAUNCH zip codes. Two time points: Baseline: fall 2011; LAUNCH: fall 2013	Late fall, 2013

Key Findings in the First Year

Site/ Study	Research Question	Outcome Measure	Sample/Sample Size	Design/Analytic Plan	Expected Date for Impact Results
3ii	What is the impact of the LAUNCH-supported services for families and children on student achievement in grade 2?	Grade 2 CA Standards Test (CST) For ELs, CA English Language Development Test (CELDT) % students with identified special needs, % students suspended, % retained in grade	2 nd grade students 9 elementary schools (sample size not known)	Comparison of average achievement scores for children from LAUNCH zip codes and children in same schools from non-LAUNCH zip codes. Multiple time points: Baseline: 2010- 2011; LAUNCH: 2013 - 2014	Late fall, 2014
4i	What is the impact of the LAUNCH-supported services for families and children on readiness at kindergarten entry?	District administered kindergarten assessment: Measures of Academic Progress (MAP) (literacy & numeracy)	TBD	Comparison of trend lines for children from LAUNCH zip codes and children from non-LAUNCH zip codes in the same elementary schools across pre-LAUNCH and LAUNCH years. Multiple time points: Baseline: 2011; LAUNCH: 2012-2014	Spring, 2015
4ii	What is the impact of the LAUNCH-supported services for families and children on children's academic outcomes in grade 1?	District administered kindergarten assessment: Measures of Academic Progress (MAP) (literacy & numeracy), attendance, suspensions	TBD	Comparison of outcomes for children from LAUNCH zip codes and children from non-LAUNCH zip codes in the same elementary schools across pre-LAUNCH and LAUNCH years. Multiple time points: Baseline: 2011; LAUNCH: 2012-2014	Spring, 2015
5i	What is the impact of the LAUNCH-supported services for families and children on the developmental status and school readiness of children at ages 1 - 5?	Assessments administered by early childhood program: Preschool: PPVT, Social Skills Rating System, Boehm-3 Preschool I/T: Bayley Scales Developmental data for 4 & 5 year olds will be augmented with data from 1-3 year olds beginning in 2009/2010.	Between 32 and 50 children assessed in annual cohort. (Sample represents > 90% of children in this age group in the tribal community at each time point.)	Time lag design comparing children's developmental status pre-LAUNCH and during LAUNCH. Multiple time points: Baseline: 2005-06: LAUNCH: 2006 – 2013	Spring, 2014

Key Findings in the First Year

Site/ Study	Research Question	Outcome Measure	Sample/Sample Size	Design/Analytic Plan	Expected Date for Impact Results
5ii	What is the impact of the LAUNCH-supported services for families, children, and schools on student academic outcomes in grades K – 3 (ages 6 – 8 years)?	District data on grades, state proficiency test (grade 3), attendance, special needs	Sample size TBD. Sample will represent > 90% of children in this age group in the tribal community	Time lag design comparing children's academic outcomes pre-LAUNCH and during LAUNCH. Multiple time points: Baseline: 2005-06; LAUNCH: 2006 – 2013	Spring, 2014
6i	What is the impact of the LAUNCH-supported early intervention services for families and children on the birth outcomes of newborns and their mothers?	Birth weight (low and very low birth weight babies) and other birth outcomes from state databases	LAUNCH county and matched comparison county	Short interrupted time sample following trends over 3 years pre-LAUNCH and 4 years of LAUNCH. Multiple time points: Baseline: 2006 – 2008; LAUNCH: 2009 - 2013	Late fall, 2013
6iii	What is the impact of LAUNCH-supported early intervention services on the health outcomes of babies born to opiate dependent mothers on the well-being and perceptions of the mothers and on use and costs of acute health care?	Primary data collection involving interviews with mothers multiple times pre- and postnatally	Opiate-dependent mothers who receive LAUNCH support services pre- and postnatally and similar mothers who experience the current standard of care	Comparison of outcomes for two groups of mothers during 2012-13	Spring, 2014

References

Administration for Children and Families. (2012). *Head Start Program Performance Standards and Other Regulations*. 45 CFR 1304. U.S. Department of Health and Human Services. Accessed on April 5, 2012.

<http://eclkc.ohs.acf.hhs.gov/hslc/standards/Head%20Start%20Requirements/1304/1304.24%20Child%20mental%20health..htm>.

Avellar, S., Paulsell, D., Sama-Miller, E., & Del Grosso, P. (2013). *Home Visiting Evidence of Effectiveness Review: Executive Summary*. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Washington, DC.

Boyd, J., Barnett, W.S., Bodrova, E., Leong, D.J., Gomby, D., Robin, K.B., & Hustedt, J.T. (2005). *Promoting children's social and emotional development through preschool education*. Preschool Policy Brief. New Brunswick, NJ: National Institute for Early Education Research.

Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments in Nature and Design*. Cambridge, MA: Harvard University Press.

Center for Mental Health in Schools at UCLA. (2005). *Youngsters' Mental Health and Psychosocial Problems: What Are the Data?* Los Angeles, CA: Author.

Child Trends and Center for Child Health Research. (2004). *Early Childhood Development in Social Context*. Washington, DC.

Committee on Evaluation of Children's Health, National Research Council and Institute of Medicine. (2004). *Children's Health, the Nation's Wealth: Assessing and Improving Child Health*. Washington, DC: National Academies Press.

Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Washington, DC; Substance Abuse and Mental Health Services Administration and National Institute of Mental Health.

Duran, F., Hepburn, K., Irvine, M., Kaufmann, R., Anthony, B., Horen, N., & Perry, D. (2009). *What Works: A Study of Effective Early Childhood Mental Health Consultation Programs*. Washington, DC; Georgetown University Center for Child and Human Development.

Finello, K.M., & Poulsen, M. K. (2011). Unique system of care issues and challenges in serving children under age 3 and their families. *American Journal of Community Psychology*, July 28, 2011 (published online).

Gilliam, W.S. (2005). *Prekindergarteners Left Behind: Expulsion Rates in State Prekindergarten Systems*. New Haven, CT: Yale University Child Study Center.

Gilliam, W.S. (2008). *Implementing Policies to Reduce the Likelihood of Preschool Expulsion*. *Foundation for Child Development Policy Brief*. *Advancing Pre-K*. Number 7, January 2008.

Goodson, B.D., Walker, D.K., & Gwaltney, M.K. (2012). *Cross-Site Evaluation of Project LAUNCH: Evaluation Design*. OPRE Report 2012-23. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Johnson, K., & Knitzer, J. (2006). "Early Childhood Comprehensive Systems that Spend Smarter: Maximizing Resources to Serve Vulnerable Children." New York: Columbia University: National Center for Children in Poverty.

Johnson, N., Oliff, P., & Williams, E. (2011). An Update on State Budget Cuts: At Least 46 States Have Imposed Cuts That Hurt Vulnerable Residents and the Economy. Center on Budget and Policy Priorities, February 9, 2011. Accessed December 14, 2012 from <http://www.cbpp.org/cms/?fa=view&id=1214>.

McNichol, E., & Lav, I.J. (2009). "State Budget Troubles Worsen." Washington, DC: Center on Budget and Policy Priorities.

National Academy for State Health Policy (NASHP). (2011). "About ABCD." Accessed on November 17, 2011. <http://www.nashp.org/abcd-history>.

National Center for Mental Health Promotion and Youth Violence Prevention. (2012). "Project LAUNCH Strategies." Accessed on March 30, 2012. <http://projectlaunch.promoteprevent.org/strategies/>.

National Institute for Health Care Management. (2005). *Children's Mental Health: An Overview and Key Considerations for Health System Stakeholders*. Issue Paper. Washington, DC: NIHCM.

National Research Council and Institute of Medicine. (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Committee on Integrating the Science of Early Childhood Development. Jack P. Shonkoff and Deborah A. Phillips, Editors. Board on Children, Youth, and Families. Washington, DC: The National Academies Press.

National Research Council and Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

O'Connell, M.E., Boat, J., & Warner, K.E. (Eds.). (2009). *Preventing Mental, Emotional and Behavioral Disorders among Young People: Progress and Possibilities*. Washington, DC: National Academy Press.

Pelletier, H., & Abrams, M. (2003). *ABCD: Lessons from a Four-State Consortium*. The Commonwealth Fund and National Academy for State Health Policy.

Purington, K. (2009). *State Strategies for Care Coordination, Case Management, and Linkages for Young Children; A Scan of State Medicaid, Title V and Part C Agencies*. Washington, DC: National Academy of State Health Policy.

Raghavan, R., Bright, C.L., & Shadvin, A.L. (2008). Toward a policy ecology of implementation of evidence-based practices in public mental health settings. *Implementation Science* (May 16, 2008) online.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2008). Cooperative Agreements for Linking Actions for Unmet Needs in Children's Health. Request for Applications (RFA) No. SM-08-011. Rockville, MD.

SAMHSA. (2009). Cooperative Agreements for Linking Actions for Unmet Needs in Children's Health. Request for Applications (RFA) No. SM-09-009. Rockville, MD.

SAMHSA. (2010). Cooperative Agreements for Linking Actions for Unmet Needs in Children's Health. Request for Applications (RFA) No. SM-10-012. Rockville, MD.

Thompson, R.A. (2002). The roots of school readiness in social and emotional development. *Set for Success: Building a Strong Foundation for School Readiness Based on the Social-emotional Development of Young Children*. 1(1), 8-29. Kansas City, MO: The Ewing Marion Kauffman Foundation.

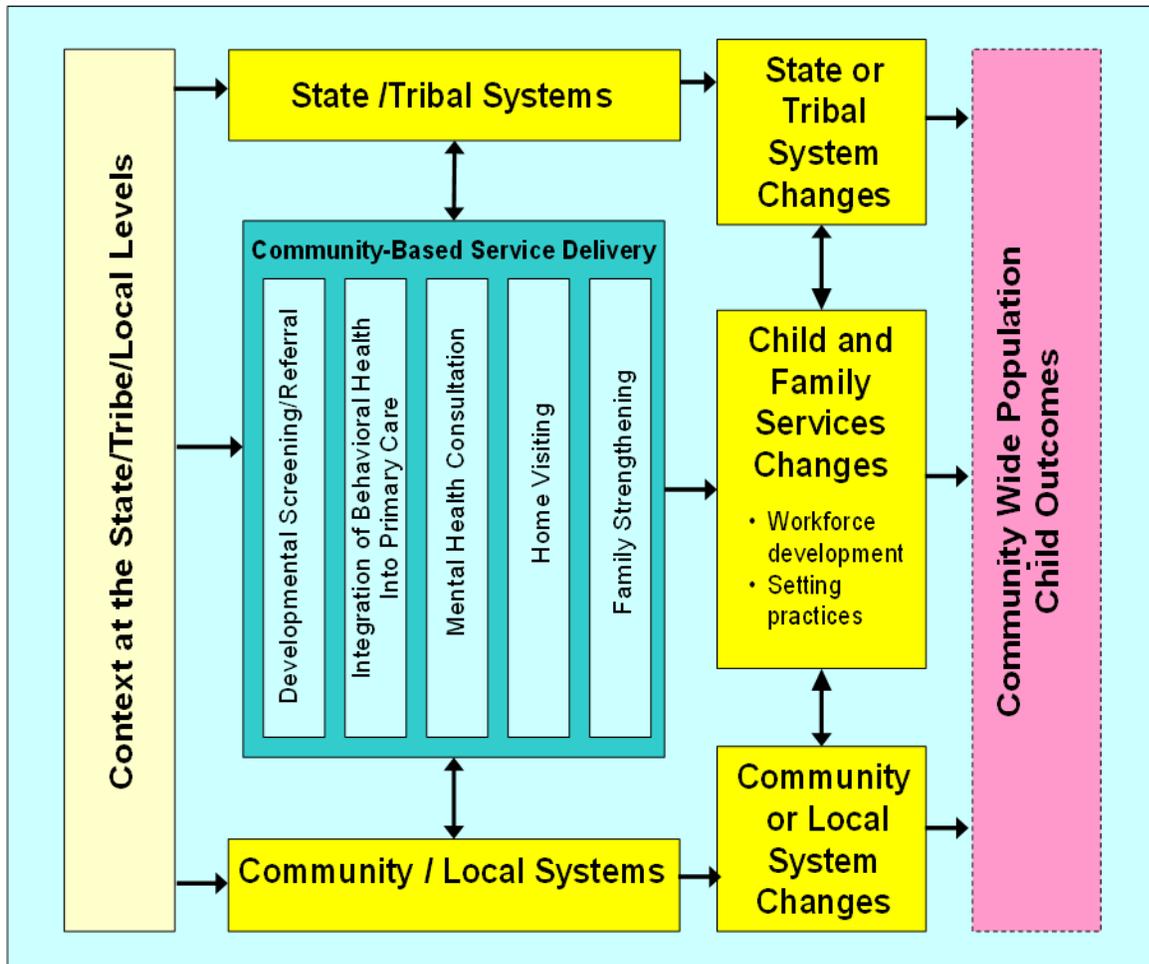
Zeanah, P., Nagle, G., Stafford, B., Rice, T., & Farrer, J. (2004). *Addressing Social-Emotional Development and Infant Mental Health in Early Childhood Systems: Executive Summary*. In N. Halfon, T. Rice & M. Inkelas (Eds), *Building State Early Childhood Comprehensive Systems Series*, No. 12. National Center for Infant and Early Childhood Health Policy, Los Angeles, CA.

Zero to Three, National Center for Infants, Toddlers and Families (2011). "Three Building Blocks of Reflective Supervision." Accessed December 14, 2012. <http://www.zerotothree.org/about-us/areas-of-expertise/reflective-practice-program-development/three-building-blocks-of-reflective-supervision.html>.

Appendix A Logic Model for the Cross-Site Evaluation

The CSE is guided by a logic model framework that links the state/tribal/community context to Project LAUNCH systems development and service delivery activities, systems changes and service delivery system outcomes as well as longer term community-wide child outcomes.

The framework for the CSE shows the presumed logical relationship between Project LAUNCH activities to enhance systems and services and the four domains of outcomes.



Appendix B Sources for Table 3.3

Demographic Characteristics and Economic Characteristics: Cohorts 1, 2 and 3: U.S. Census Bureau, 2005-2009 American Community Survey.

Social Characteristics:

% without high school diploma and % speaking a language other than English at home: Cohorts 1 and 2: U.S. Census Bureau, 2006-2008 American Community Survey 3-Year Estimates.

Cohort 3: Retrieved 1/5/2012 from U.S. Census Bureau, 2005-2009 American Community Survey.

% graduation rate: Cohorts 1 and 2: Retrieved 5/24/11 from <http://www.countyhealthrankings.org/>; <https://reportcards.nysed.gov/counties.php?year=2010>; <http://www.cps.edu/SchoolData/Pages/SchoolData.aspx>; http://profiles.doe.mass.edu/state_report/gradrates.aspx; http://mpsportal.milwaukee.k12.wi.us/portal/server.pt?open=512&objID=367&mode=2&in_hi_userid=2&cached=true; <http://www.dmps.k12.ia.us/AboutDMPS/FactsFigures.aspx>.

Cohort 3: Retrieved 1/5/2012 from <http://www.countyhealthrankings.org/>; <http://schools.nyc.gov/Accountability/data/GraduationDropoutReports/default.htm>.

Health Indicators:

% births to women receiving late or no prenatal care: Cohorts 1 and 2: Retrieved 3/30/2011 from <http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=11>.

Cohort 3: Retrieved 1/5/12 from <http://datacenter.kidscount.org/>; <http://communityhealth.hhs.gov/homepage.aspx?j=1>; <http://www.chd.dphe.state.co.us/Resources/vs/2009/Weld.pdf>.

Teen birth rate: Cohorts 1 and 2: Retrieved 3/31/2011 from <http://www.cdc.gov/nchs/data/databriefs/db46.pdf>.

Retrieved 6/3/2011 from <http://www.acphd.org/user/data/datareports.asp>; http://www.health.state.ny.us/statistics/chac/chai/docs/fp_westchester.htm; <http://www.odh.ohio.gov/healthStats/disparities/pregnancy.aspx>; <http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=NC&group=All&loc=4950&dt=1%2c3%2c2%2c4>; http://www.mass.gov/Eeohhs2/docs/dph/research_epi/birth_report_2008.pdf; <http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/08v1/Documents/4-03.pdf>; http://library.constantcontact.com/download/get/file/1103406220568-53/IOWAStateFactSheet_v2011+final_2.pdf; http://www.kdheks.gov/hci/adol_teen_preg/Adolescent_Teenage_Pregnancy_08.pdf;

Cohort 3: Retrieved 1/5/2012 from <http://datacenter.kidscount.org/>; <http://www.countyhealthrankings.org>.

% low birth weight babies: Cohorts 1 and 2: Retrieved 3/31/2011 from <http://communityhealth.hhs.gov>; <http://www.idph.state.il.us/health/infant/infmort0507.htm>; <http://www.healthyohioprogram.org/comprofiles/athens.pdf>; <http://www.healthyohioprogram.org/comprofiles/hocking.pdf>; <http://www.healthyohioprogram.org/comprofiles/vinton.pdf>; <http://www.healthyohioprogram.org/comprofiles/meigs.pdf>; <http://www.schs.state.nc.us/SCHS/data/trends/pdf/Guilford.pdf>; <http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=OR&group=All&loc=5351&dt=1%2c3%2c2%2c4>; <http://www.neighborhoodinfodc.org/pdfs/412282-Kids-Counts-Fact-Book-2010.pdf>.

Cohort 3: Retrieved 1/5/2012 from <http://datacenter.kidscount.org/>; <http://communityhealth.hhs.gov/homepage.aspx?j=1>.

Appendix C Description of Other Early Childhood Initiatives

Assuring Better Child Health and Development (ABCD)

Thirteen Project LAUNCH grantees (12 states, representing 13 community sites (2 sites in Oregon), and the District of Columbia) had received ABCD grants before being awarded a LAUNCH grant. These grants, awarded by The Commonwealth Fund, aimed to improve the delivery of early childhood development services by strengthening primary health care services and systems for young children from birth to age 3 (NASHP, 2011; Pelletier and Abrams, 2003). States used these grants to strengthen the capacity of the health care system and to promote the healthy mental development of young children by encouraging routine developmental and behavioral screening of young children and screening for parental depression in primary care settings (NASHP, 2011).

Comprehensive Community Mental Health Services for Children and Their Families.

Since 1992, states have received support to build local systems of care under this SAMHSA-funded program. This program continues today as a national resource for promoting local system of care development. As the program has grown and been informed by knowledge from the fields of child development and pediatric neuroscience, as well as early System of Care grant demonstrations, SAMHSA has expanded the range of system of care models. In the last several years, SAMHSA migrated the program from one focused more exclusively on children with serious emotional disturbance to include children identified as at risk for problems in social and emotional development and funded among others early childhood system of care demonstrations in three LAUNCH states—Massachusetts, Connecticut, and California.

Early Childhood Comprehensive Services (ECCS)

All LAUNCH-funded states and the District of Columbia have ECCS initiatives. Funded by the Health Resources and Services Agency (HRSA) in 2002, ECCS provided grants for strategic planning and development of comprehensive approaches to early childhood service delivery. States prepared a state Comprehensive Early Childhood Plan based on a needs assessment or environmental scan. Plans were expected to address five core components: access to health care and medical homes, social-emotional development and mental health, early care and education, parenting education, and family support. Through strategic partnerships among public and private sector agencies and organizations, states focused on developing a coherent funding and service delivery infrastructure to support services for young children and their families. The services were directed toward enhancing social, emotional, and behavioral health and children's readiness for school.

Evidence-Based Home Visiting to Prevent Child Maltreatment (EBHV).

Seven LAUNCH states had EBHV programs when they first received funding for LAUNCH, although the program was only state-wide in one (Illinois). The EBHV initiative provided funding from the Children's Bureau within the Administration for Children and Families (ACF) to build infrastructure and service delivery systems enabling implementation of evidence-based home visiting programs with fidelity. EBHV grantees are leveraging these grants with other funding sources to implement programs that include Nurse Family Partnership, Parents as Teachers, and Triple P (Positive Parenting Program).

Maternal, Infant, and Early Childhood Home Visiting (MIECHV)

The MIECHV program was created by the Affordable Care Act. All states were eligible for funding in 2010, which coincided with the first year of Project LAUNCH funding for Cohort 3 grantees. Through the MIECHV program, nurses, social workers, other professionals, and paraprofessionals meet with at-risk families in their homes to assess needs and provide services and information to promote families' health, improve parenting skills, promote healthy child development, and prevent child abuse. Home visitors also connect families to needed programs and supports, including health care, developmental services for children, early education, and nutrition education or assistance (HRSA, 2011).