

LINKING ACTIONS FOR UNMET NEEDS IN CHILDREN'S HEALTH

# Implementation of Young Child Wellness Strategies in a Unique Cohort of Local Communities





**PROJECT LAUNCH:**  
**Implementation of Young Child  
Wellness Strategies in a Unique Cohort of  
Local Communities**

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## Foreword

I want to thank and commend all of the contributors for their initiative in writing this e-book. It required extensive commitment to sharing and learning from each other, and ultimately it greatly informs readers within and outside of the Project LAUNCH community. I hope that you will find as much inspiration and instruction within these pages as I have.

It is notable to me that the authors decided to lead off this publication not with a description of their direct services for children and families, but with their community collaboration and systems improvement efforts. I believe that this demonstrates their understanding that a well-coordinated and integrated system is the foundation for truly lasting community change. An inclusive planning process, a cross-disciplinary approach to training the workforce, and a commitment to the child and family at the center of all efforts are some of the ingredients for success that these grantees share.

Developed as a modular tool, this e-publication gives readers maximum flexibility to learn about those strategies and grantees that are most interesting and relevant to them, and to use this book as a reference tool. The authors worked diligently to capture and describe the essence of each Project LAUNCH core strategy, from developmental and behavioral screening, to mental health consultation, to the integration of behavioral health into primary care. For each strategy, they offer examples from two communities: bringing the strategy to life and illustrating both the commonalities across the sites and the uniqueness of each. The publication is rich with creative approaches, lessons learned, and illustrative data from communities as diverse as the Bronx, the Texas border, and the upper Northwest.

Finally, I want to extend gratitude to this group of grantees for helping us to deeply understand some of the unique opportunities and struggles of funding directly at the community level. Their experiences and analyses inform SAMHSA's thinking, and enhance our capacity to both guide and support grantees across the country in their efforts to improve outcomes for young children, families, and communities.

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# 1. Introduction

Early childhood is a critical time in human development. Any experience, positive or negative, can influence long-term outcomes for physical, emotional, social, and cognitive health (Center on the Developing Child at Harvard University, 2010). To ensure a strong foundation for success in school and in life, efforts designed to promote wellness and identify early learning or mental health challenges must begin well before kindergarten. Strong evidence shows that investing in early childhood can yield large dividends for children. Additionally, the ability of our systems to provide positive outcomes for children can be enhanced through strategic planning, well-developed partnerships, and coordinated family services. Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health), a federally funded United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) initiative, aims to enhance and improve the way systems function by bringing together all participants in each child’s life including caregivers, primary care providers, early childhood educators, and mental health providers. Project LAUNCH strives to incorporate all participants, at all levels of service provision, to strengthen our ability to achieve the best possible outcomes in social and emotional health and wellness for all children.

Project LAUNCH has funded states, local jurisdictions, and tribes interested in achieving these goals since 2008. Under Project LAUNCH, grantees are charged with (1) promoting the healthy development of children from birth to age 8 and their families by harnessing and coordinating existing resources and (2) increasing access to high-quality, evidence-based programs in five child-centric domains: developmental screening and assessment, home visiting, mental health consultation, family strengthening and training, and integration of behavioral health into primary care. By developing an understanding of the landscape of services and supports unique to each state and community and by evaluating strengths and opportunities for change, grantees begin to implement promotion and prevention strategies that best serve the needs of their communities at the child, family, and systems levels. Thus, while there are distinct cultural, geographic, and economic differences across LAUNCH sites in all cohorts, the fundamental components of the LAUNCH model remain the same for all grantees. To date, Project LAUNCH has funded 55 projects across six cohorts.

All LAUNCH grantees are expected to demonstrate local policy and practice improvements that can be sustained statewide. Unlike other LAUNCH cohorts, Cohort 3 grantees are distinguished by the fact that they were funded *solely at the community level* with no state or tribal oversight. This presented the six sites with a unique set of opportunities and challenges as they sought to bring policy and

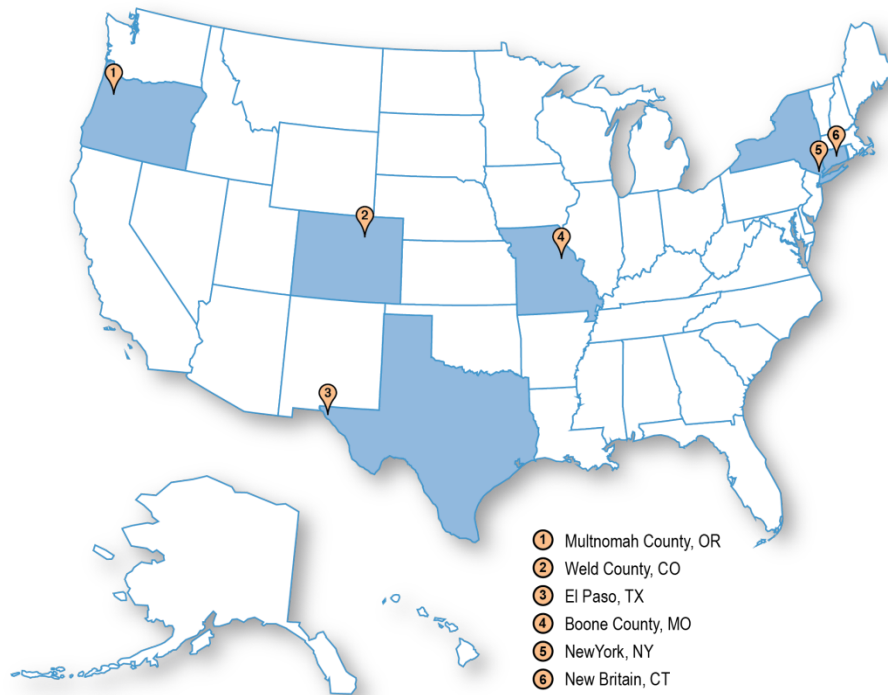
practice improvements to scale, enhance infrastructure, and implement direct services in the five domains or strategies.

The uniqueness of the community-based aspect of Cohort 3 grantees provided both challenges and opportunities. Grantees identified the flexibility and ability to control program activities within a community setting as key advantages to the local grants, whereas the ability to replicate successful activities and implement policy change on a statewide basis were limited. Additionally, the uniqueness of Cohort 3 made it challenging to evaluate the success of Cohort 3 grantees by measuring their progress against that of other cohorts. This e-book was developed to highlight and share the experience of the local communities in Cohort 3. This publication is designed to serve as a resource for future early childhood systems development activities implemented by LAUNCH grantees or by other early childhood programs with similar goals and interests.

Cohort 3 grantees funded in 2010 are located across the nation (Exhibit 1-1) and include:

- Boone County Project LAUNCH [profile]
- El Paso Project LAUNCH [profile]
- Multnomah Project LAUNCH [profile]
- Promising Starts—Wheeler Clinic’s Project LAUNCH [profile]
- New York City Project LAUNCH [profile]
- Project LAUNCH —Weld Systems Navigation Project [profile]

### Exhibit 1-1: Geographic Distribution of Cohort 3



This publication shares the contributions of this unique cohort to the field of young children’s mental health and family wellness by spotlighting accomplishments, evidence, and lessons learned within the context of the LAUNCH strategic framework. Narratives from the six grantees detail the successes and challenges of systems building from the ground up and emphasize the value-added benefits of funding directly at the community level. Recommendations for present and future LAUNCH projects and similar initiatives address strategies to build local, state, and national partnerships to support replication and sustainability. We hope you will find this resource of value for supporting local initiatives that promote young child and family wellness.



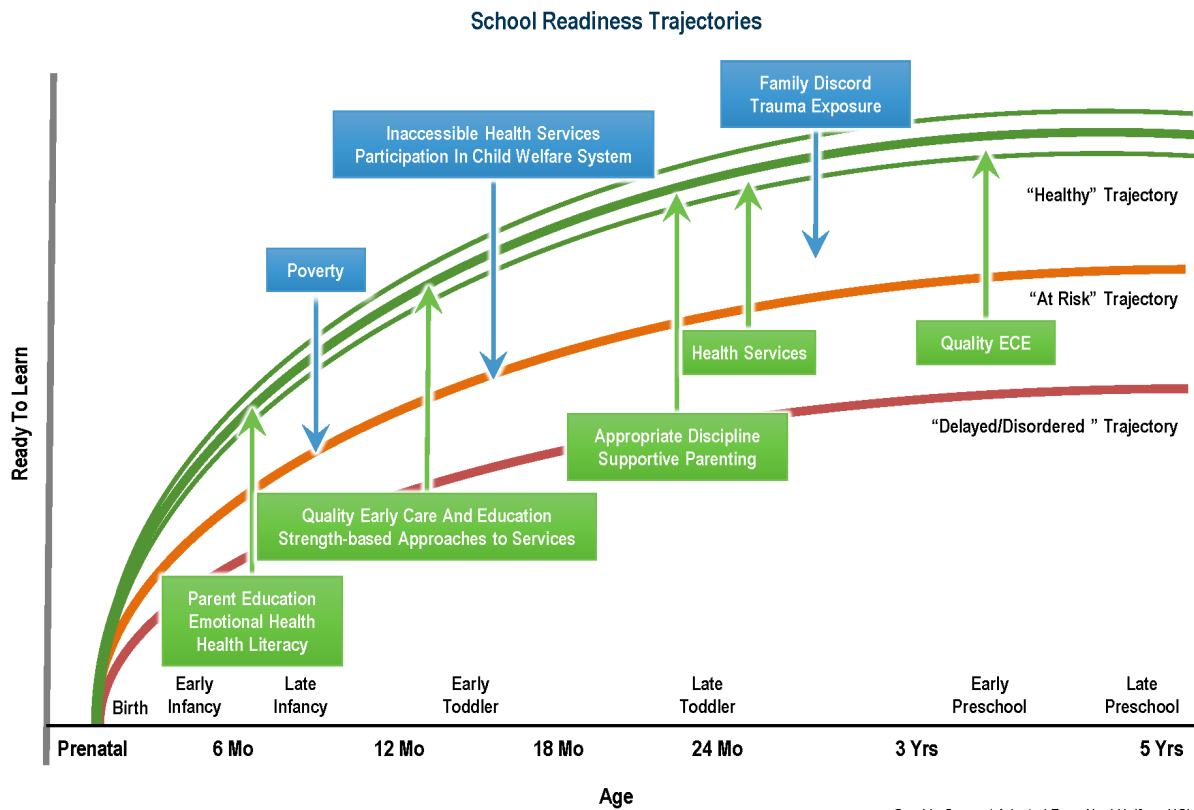


## 2. Systems Development

What happens in early childhood sets the stage for a child’s physical, emotional, social, and cognitive health. Studies have documented the importance of healthy development in the earliest years of life to children’s educational and life outcomes (Shonkoff & Phillips, 2000). Research studies indicate that children who experience delays in early development typically continue to perform more poorly than their peers as they age and have a greater risk of ongoing delays and poorer outcomes in education, careers, and social connections (Honigfeld & Meyers, 2013).

A variety of risk factors have been shown to impede healthy development (Exhibit 2-1; Dworkin, Honigfeld, & Meyers, 2009). Factors that increase a child’s risk for developmental delays and other barriers to learning include poverty, participation in the child welfare system, and trauma exposure. Similarly, protective factors, including quality early care and education, supportive parenting, and strength-based approaches to services, support healthy development and enhance learning and growth outcomes for children.

**Exhibit 2-1: Impact of Risk Factors on Child’s Readiness to Learn**



Coordinated efforts to identify problems and promote wellness typically are not initiated until a child reaches school. Through Healthy People 2020, the federal Office of Disease Prevention and Health Promotion emphasizes the need for a strong public health infrastructure to promote health services successfully and maintain the capacity to prepare for and respond to any threat to health (U.S. Department of Health and Human Services, 2010). A variety of research-based tools and strategies have been identified to support the development of this infrastructure (Education Development Center, 2015).

Project LAUNCH aims to promote the health and well-being of children from birth to age 8 through the development of infrastructure using a public health model. Development of this infrastructure requires intensive collaboration, communication, and shared planning of service providers and family members. All LAUNCH grantees support infrastructure development through the formation of community-wide wellness councils for collaboration and partnership, program leadership and capacity, and enhanced program service and evaluation capacity. In addition, each grantee adapts the system development process to meet unique local community needs. This summary presents highlights of the systems development process and results that occurred in three communities funded by Project LAUNCH.

### Grantee Spotlight: El Paso Project LAUNCH

**El Paso Project LAUNCH** serves families with children from birth to age 8 in the El Paso, Texas, neighborhoods of South Central and Chihuahuita. These communities are located on the border between the United States and Mexico, considered to be medically underserved, and designated as mental health shortage areas. The area experiences high rates of poverty, low educational attainment, high rates of migration, high numbers of individuals without health insurance, and a low ratio of health workers per capita. In addition, the area receives a regular influx of immigrants fleeing the cartel violence in neighboring Juarez, Mexico. Many of these families have experienced a high degree of violence and trauma.

**Overview:** In 2010, El Paso Project LAUNCH formed the Young Child Wellness Council to engage key players across the child-serving system. The council convened early childhood partners to integrate and coordinate programs, policies, data, and funding. The project joined with families and public and private partners to scan communities and identify unmet needs. The council then created strategic plans that guided collaborative efforts to improve the early childhood system for El Paso County.

For 5 years, the council met monthly to discuss and create early childhood system priorities that included developmental and social-emotional screening, family strengthening, and home visiting. Average attendance at each month's meeting was 22 members. El Paso Project LAUNCH direct services were developed in response to council planning efforts and recommendations. Council members were provided with continual professional development throughout the course of the project.

A major strength of the local council was the development of collaborative leadership in the core group. Under the leadership of the LAUNCH Young Child Wellness Project coordinator, council members developed action plans to accomplish the goals and objectives of the strategic plan. Through the process, each work group considered the problem, identified a potential solution, and created an action plan to achieve the solution (Exhibit 2-2). The council met on a monthly basis for two hours, with the majority of members attending regularly.

**Exhibit 2-2: El Paso Project LAUNCH Council Definitions of Social and Emotional Wellness**

<b>Workgroup 1</b>	<i>“The ability to bounce back through problems while learning that you have self-worth and value, developing healthy relationships, and being a positive part of your community.”</i>
<b>Workgroup 2</b>	<i>“Social and emotional health is when your heart is happy! It is acceptance of who you are and the confidence to express it; the ability to live knowing you have the support of your community.”</i>
<b>Workgroup 3</b>	<i>“Social and emotional health is the ability to have positive relationships with yourself and the world around you and to handle what life throws your way.”</i>

**Results:** Partnerships formed as a result of these efforts were highly successful and resulted in achievements such as the receipt of funding for home visiting in El Paso and the development of a community of practice for early childhood education providers. Additionally, council workgroups identified, classified, and promoted early childhood and family behavioral health and wellness services countywide, categorized these services into a wellness directory, and shared the directory on a free downloadable mobile application.

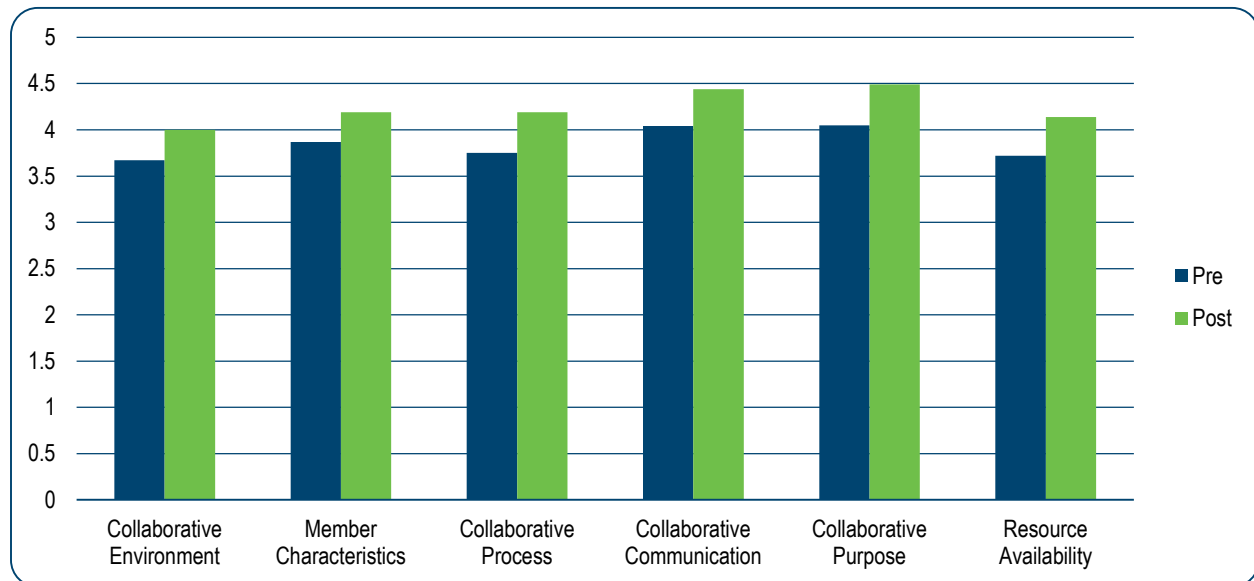
Council workgroups improved coordination and collaboration through the promotion and implementation of infant mental health and wellness trainings for providers and parents. With council assistance, LAUNCH early childhood mental health consultants trained more than 1,500 professionals in infant mental health and related topics and promoted infant mental health with more than 500 parents across the community. Council workgroups also created a shared social media campaign to promote healthy development and prevent child abuse and neglect.

In addition, to promote and better understand screening in our community, the project’s Young Child Wellness Council screening workgroup, in collaboration with the Community Academic Partnerships for Health Sciences Research, authored the resource, “Developmental Surveillance and Referral in a Traditionally Medically Underserved Border Community,” which describes screening and referral in El Paso. The article will be published in a future issue of *Maternal and Child Health Journal*.

The level of coordination and networking of the Young Child Wellness Council was measured using the Wilder Collaboration Factors Inventory (Mattessich, Murray-Close, & Monsey, 2001). This tool measures specific system-level outcomes.

As shown in Exhibit 2-3, survey results identified growth in all areas of collaboration since the council’s inception. By Year 4, the council had achieved a high degree of collaboration across the board.

**Exhibit 2-3: Wilder Collaboration Factors Inventory Pre-Post Data 2011 to 2015**



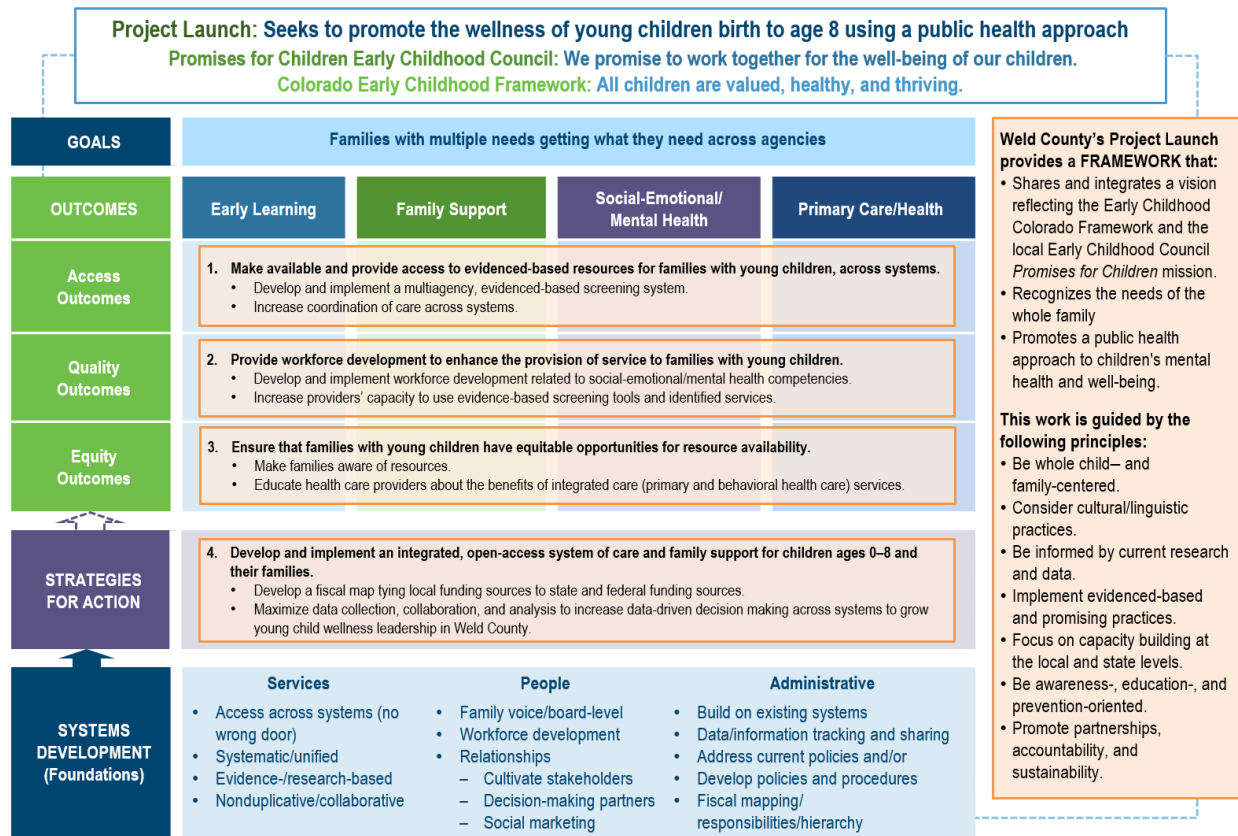
### Grantee Spotlight: Project LAUNCH—Weld Systems Navigation Project

**Project LAUNCH —Weld Systems Navigation Project** is an early childhood capacity-building project in Weld County, Colorado, one of the fastest-growing counties in the country, partly because of a recent increase in refugees who have settled in the area. Project goals are aligned with the Colorado Early Childhood Framework and include the following: (1) ACCESS and the availability of evidenced-based resources to families with young children across systems; (2) the QUALITY of workforce development to enhance service provision to families with young children; (3) EQUITY, to ensure that families with young children have equitable opportunities for available resources; and (4) SYSTEMS DEVELOPMENT, to create an integrated open-access system of care and family support for children ages 0–8 and their families.

**Overview:** To promote systems development, the Weld Systems Navigation Project formed a Young Child Wellness Council, developed a *Blue Print* planning model, engaged local partners in workforce development, supported Colorado's Endorsement for Culturally Sensitive Relationship-Focused Practice Promoting Infant Mental Health (IMH-E<sup>®</sup>; Colorado Association for Children’s Mental Health, 2015), and supported the state replication of the project with private partners. Project goals, objectives, and activities were guided and aligned with the Colorado Early Childhood Framework, as shown in Exhibit 2-4.



### Exhibit 2-4: Project LAUNCH—Weld Systems Navigation Project: Colorado Early Childhood Framework



The Young Child Wellness coordinator engaged child-serving organizations in the newly formed Young Child Wellness Council. The council met monthly during the first three years of the project and bimonthly during the remaining years. Council members were initially engaged in project work groups and annually completed the Wilder Collaboration Factors Inventory, an online tool that assesses factors related to collaboration efforts such as shared vision, concrete attainable goals and objectives, and open and frequent communication (Mattessich, Murray-Close, & Monsey, 2001). Year 5 results showed that the council members perceived the project and council to be strong (score of 4.0 or higher on a 5.0 scale) in 15 of the 20 factors. These factors included collaborative group seen as a legitimate leader in the community; favorable political and social climate; mutual respect, understanding, and trust; appropriate cross section of members; members see collaboration as in their self-interest; ability to compromise; members share a stake in both process and outcome; flexibility; adaptability; appropriate pace of development; open and frequent communication; established informal relationships and communication links; shared vision; unique purpose; and skilled leadership.

Project partners included Family Connects/Northeast Behavioral Health, a local organization serving families through home visiting programs and child care consultation; the county's

Department of Human Services; a private pediatric provider; Envision, an Early Intervention Part C organization that serves individuals with developmental disabilities; Nurse Family Partnership; a behavioral health center; a federally qualified health care center; United Way; family consumers; and other child-serving organizations.

The Young Child Wellness coordinator developed a *Blue Print* planning model with each local partner. The *Blue Print* process aligns project goals with each partner's goals; assesses partner readiness to engage in the project; and identifies the need for staff professional development, patient or client screening and assessment, use of evidence-based practices for early mental health intervention, and resources to promote sustainability. This planning tool, including “talking points,” action steps, and indicators for success, was invaluable in documenting the progress of each partner in the project.

The Weld Systems Navigation Project provided partner organizations with professional development for staff on key early childhood topics, weekly guidance on the use of tablets to conduct electronic screenings, early childhood mental health consultation, and reflective supervision. These support strategies were successful in developing the capacity of primary care partners to integrate young child developmental screenings into their practices.

The project's Young Child Wellness coordinator also served on state and national child mental health organizations, namely the Colorado Association for Infant Mental Health and the Alliance for the Advancement of Infant Mental Health® (formerly the League of States for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health) to promote the work of Project LAUNCH. As a result, the Weld Project provided resources for the adoption of Michigan's Infant Mental Health Endorsement model in Colorado.

**Results:** These collaborations achieved positive outcomes for families and providers throughout Weld County and project replication by funders in Colorado. Project activities resulted in the following outcomes:

- a workforce trained in early childhood screening tools (54 providers trained) and evidence-based and promising practices (81 clinicians trained);
- increased use of evidence-based screening tools (more than 12,861 children and adults screened);
- increased use of evidence-based practices and programs for the promotion of early childhood and family wellness (954 children and adults involved);
- increased use of early childhood mental health consultation for provider practice (308 provider consultations) and families (1385 family consultations);

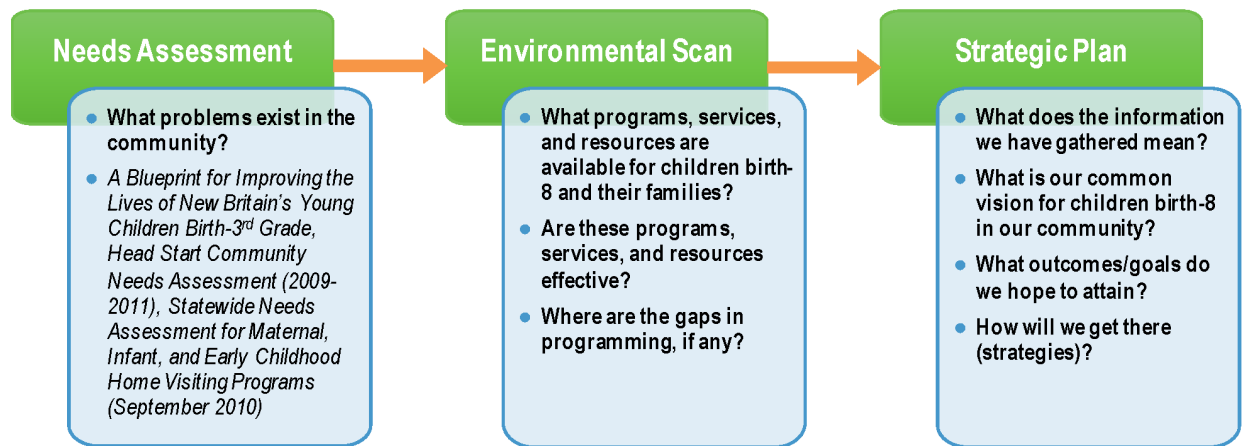
- increased collaborations and partnerships to obtain additional funding such as the local Colorado Community Response Program; increased staffing for Envision (Part C) due to higher service requests; and
- full replication of the project for other communities by private funders in Colorado called LAUNCH Together (Early Milestones Colorado, 2016).

### Grantee Spotlight: Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH

The **Wheeler Clinic**’s program strives to improve and expand services and systems for children ages 0–8 in New Britain, Connecticut. New Britain is a diverse, midsized city with a population of 73,000. In New Britain, 31.6% of children live in poverty, more than 50% of children entering kindergarten are overweight or obese, 41.7% of mothers receive inadequate prenatal care, and a significant number of children are substantiated for abuse and neglect (The Connecticut Home Visiting Needs Assessment Group, 2010).

**Overview:** The New Britain Health and Wellness Council was formed to implement key strategies identified through the planning process to guide implementation. These strategies are summarized in Exhibit 2-5.

**Exhibit 2-5: Model Used to Initiate Collaboration**



Council membership included representation from the early care and education community, mental health providers, family support programs and services, schools, domestic violence and substance abuse treatment organizations, and state agencies such as the Connecticut Departments of Children and Families and Mental Health and Addiction Services. The council was designed to include both state and local entities to strengthen relationships and collaboration around issues impacting children and their families and to promote expansion and sustainability.

For Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH, the strategic plan needed to identify and develop the infrastructure necessary to support implementation of the five key direct services shown in Exhibit 2-6.

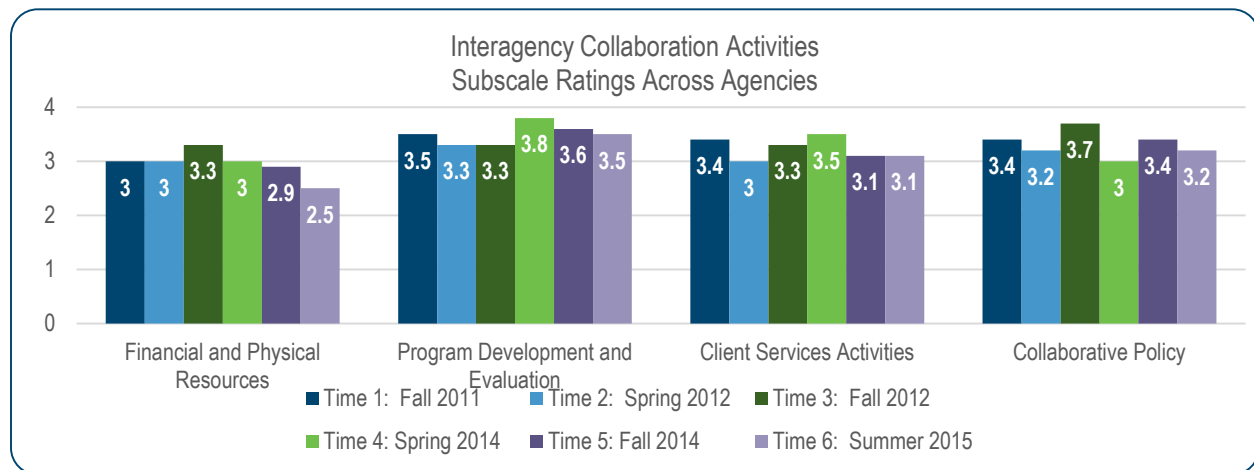
**Exhibit 2-6: Infrastructure Design**



Research indicates that infrastructure development in growing programs faces a number of challenges (Darrow, Goodson, & Caven, 2013). While working to learn about the program models and adapt structures accordingly, there is a need to adhere to budgets, time constraints, and resource limitations. These challenges can be addressed through the evaluation process (Lorentson, Oh, & LaBanca, 2014), particularly when program leadership works in partnership with evaluation experts.

Over time, a changing council operations structure was identified. Collaboration improved during the first 4 years as workgroups formed and began to focus on specific topics, but decreased slightly as council membership grew and expanded during Year 5. Results indicate that the expansions to membership that occurred during Year 5 are creating challenges to partners’ ability to successfully build and sustain the coalition. Despite these challenges, the availability of consistent evaluation data regarding collaborations across specific activities of the council and a strong partnership between the leadership council, program staff, and the evaluation team are strengths that will support further infrastructure and leadership development. Moving forward beyond this transition period, the larger group will emphasize continuity to allow the collaboration to strengthen.

**Exhibit 2-7: Promising Starts—Wheeler Clinic's New Britain Project LAUNCH Interagency Collaboration Activities**



### Lessons Learned, Opportunities, and Conclusions

Cohort 3 grantees experienced a wide range of systems development successes during the five years of implementation. Key successes identified by the majority of grantees included the development of a shared vision and purpose among council members; incorporation of family members into council activities; the evolution of task-specific work groups to promote council efforts; and the development of strong collaborating partnerships and systems development. Systems development included work across early care and education, home visiting, primary care, mental health, peer advocate, and child welfare systems. Grantees supported communities of practice within local communities, provided critical training and networking opportunities, and increased partners’ capacity to address mental health collaboratively through enhancements to children’s mental health programs and services.

A number of recommendations for systems development at a local level emerged from the experiences of Cohort 3 grantees. Local-level project directors and evaluators identified the need for the close involvement of high-level leaders within the community over a period of time as critical for the creation and promotion of systems change. Grantees emphasized the priority of creating systems change by supporting community partners to achieve their program goals through the networking process, to frame efforts within a relevant framework or standard, to tie activities to state and national efforts, and to be patient with the change process.

A number of local Cohort 3 projects found that the flexibility and relatively high degree of project control inherent in a community-based project resulted in successes and innovations not yet possible at the state level. In the words of one Cohort 3 project lead:

*“It is OK to get out ahead of the state a bit. We move more quickly than the state sometimes—*



*this can help the state implement their plans.”*

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### 3. Developmental and Behavioral Screening & Assessment

*“A vital and productive society with a prosperous and sustainable future is built on a foundation of healthy child development.”*

– Center on the Developing Child, 2015

Research has shown that in the United States, 17% of children have a developmental or behavioral disability such as autism, intellectual disability, or Attention-Deficit/Hyperactivity Disorder (CDC, Developmental Screening Fact Sheet, 2015). Identifying developmental and social-emotional delays early in life is key to ensuring that children have the opportunity to achieve learning outcomes and reach their optimal health. Regular, routine monitoring of children’s development with research-based developmental screening tools can help providers identify delays or potential delays in children’s physical, cognitive, social, and emotional wellbeing (Centers for Disease Control and Prevention [CDC], Developmental Monitoring and Screening for Health Professionals, 2015).

Developmental and social-emotional screening is unique as it can be implemented in a number of settings by various types of professionals (U.S. Department of Health and Human Relations, Administration for Children and Families, 2015). Developmental screening results can be used to identify developmental or behavioral challenges experienced by a child and can prompt a provider’s or parent’s ability to address these challenges.

All Project LAUNCH grantees promote the use of comprehensive screening in a wide range of settings, including child care, primary care, early childhood education programs, and mental health and substance abuse treatment programs serving families of young children. LAUNCH grantees champion screening efforts across their communities to ensure the increased use of validated screening instruments, with an emphasis on screening for social and emotional challenges or delays. Each LAUNCH program developed unique strategies to create, enhance, and promote screening campaigns across their communities. The Cohort 3 LAUNCH grantees utilized diverse approaches to the promotion of screening in their respective communities and experienced a range of successful

**Exhibit 3-1: NYC Project LAUNCH**



**Screening Promotion**

efforts and lessons learned. A summary of successes, challenges, and opportunities is provided in Exhibit 3-2.

### Exhibit 3-2: Cohort 3 Successes, Challenges, and Opportunities

Cohort 3 Successes	Cohort 3 Challenges and Opportunities
<ul style="list-style-type: none"> <li>• Implemented early childhood screens in pediatric primary care clinics (e.g., well child visits).</li> <li>• Trained primary care providers to conduct screens and refer families to various services.</li> <li>• Established nontraditional community screening sites (e.g., child care, residential substance abuse centers, mental health providers).</li> <li>• Promoted and embedded the use of electronic tablets for screening.</li> <li>• Used strength-based protective factors screenings.</li> <li>• Conducted and coordinated large numbers of screens and documented referrals.</li> <li>• Increased Part C referrals with more state funding.</li> </ul>	<ul style="list-style-type: none"> <li>• Buy-in from providers for changes in screening practices or adoption of new screening tools may take more time.</li> <li>• Linguistic and literacy needs of parents must be addressed; limited staff time/availability is challenging.</li> <li>• Implementation of screenings varies from site to site, and challenges at sites are unique.</li> <li>• Integration of screen results into electronic medical records can be costly and requires commitment.</li> <li>• Identifying potential funding for universal screening can be challenging.</li> <li>• Establishing partnerships with primary care providers to create buy-in for universal screening, especially social and emotional screening, takes time and effort.</li> </ul>

### Grantee Spotlight: Boone County Project LAUNCH

Our mission is to develop an accessible, seamless early childhood system for all children, birth to age 8, in Boone County, Missouri. Our strategic goals include: promote the integration of ASQ® screening in primary and early care settings; promote timely and coordinated referral for early intervention services; promote knowledge of behavioral health integrations models in pediatric care; increase competence of early care professionals and decrease challenging behaviors in early care and education (ECE) settings; increase access to evidence-based home visitation services (Parents as Teachers); and increase access to evidence-based parent education programs such as Incredible Years.

**Overview:** Boone County Project LAUNCH has worked extensively with partner organizations to increase access to the evidence-based screening tools Ages & Stages Questionnaires®, Third Edition (ASQ-3™) and Ages & Stages Questionnaires®: Social-Emotional (ASQ:SE™) in a variety of settings to ensure that children receive needed services at the earliest opportunity. In collaboration with the Wellness Council, LAUNCH staff developed a step-wise, multipronged approach to support and promote the integration of universal screening into practice in primary/pediatric care, child care, and similar settings. The approach included training and support, outreach to primary care and early care and education providers, and strategies to reduce barriers to integration of screening into practice.

To promote appropriate referrals, an ASQ® decision-support tool was developed and disseminated during trainings. Additionally, LAUNCH staff were available to provide resources and consultation to sites implementing ASQ® screening. Recent reports from First Steps, Missouri’s early intervention

agency, indicate that Boone County has the highest referral rate in the state, a statistic that is directly attributable to LAUNCH efforts.

In addition to training, screening, and referral support, the LAUNCH team worked to educate primary care, early care, and education providers on the benefits of screening. Boone County Project LAUNCH was fortunate to have strong pediatrician advocates for ASQ<sup>®</sup> screening as members of the Wellness Council. These partners worked diligently to promote American Academy of Pediatrics guidelines (American Academy of Pediatrics, 2014) within their practices. Sustained efforts by these physician champions and dedicated LAUNCH staff have resulted in full-scale integration of screening at three large primary care centers, one of which is a federally qualified health center. South Providence Pediatrics, one of these centers, installed a tablet-based electronic screening system to facilitate promoting integration of behavioral health into primary care.

### What Parents Had to Say About Screening

*“Thank you so much. I have been concerned about my son and now I know what I can do to get him on track.”*

—WIC Parent

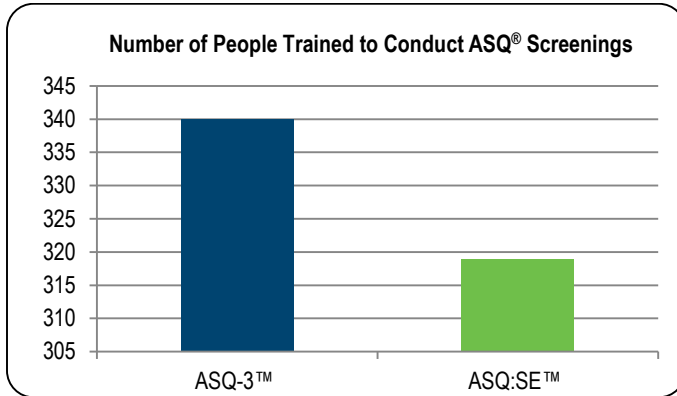
Promotion of ASQ<sup>®</sup> screening has also been a component of the program’s early childhood mental health consultation model, which supports child care providers in resource-constrained urban and rural communities. The program emphasizes the importance of early identification and intervention through both training and coaching. The recent addition of a screening coach to facilitate screening, referrals, follow-up, and parent engagement has been well received. Recent efforts have focused on engaging families in the screening process.

Despite advancements in the primary care and early education arenas, many families not enrolled in home visiting programs or connected to ASQ<sup>®</sup>-trained providers still lacked access to standardized screening. In response, LAUNCH staff sponsored ongoing community screening clinics at the Women, Infants, and Children (WIC) office, public library, and parent support group meetings with the intent of meeting families in familiar settings and providing education and support using a strengths-based approach. The clinics have been widely successful in expanding access to screening, raising awareness, and connecting families to community resources.

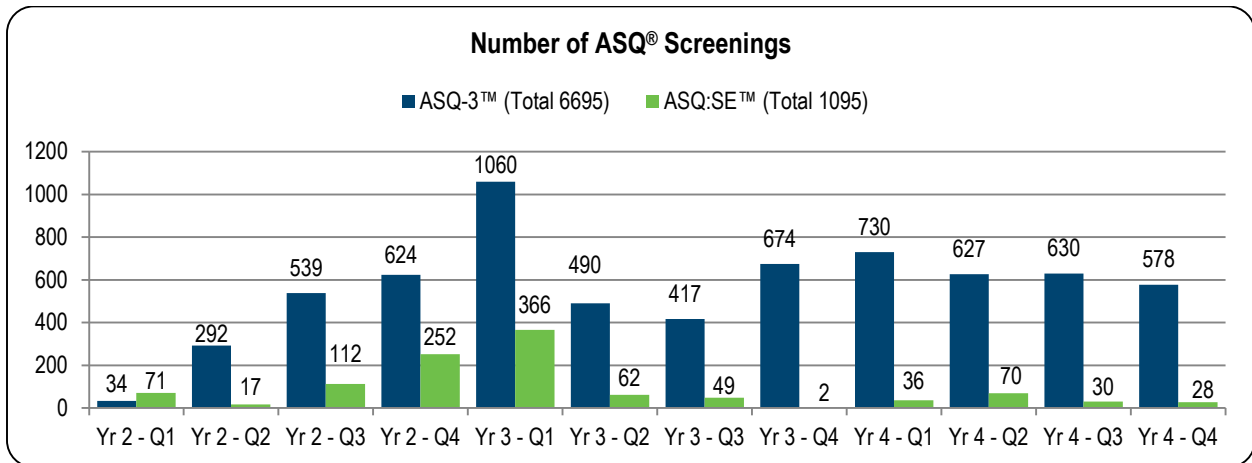
**Results:** In response to community-wide interest in screening using ASQ<sup>®</sup> tools, Boone County Project LAUNCH recruited nearly 40 providers from various sectors to attend a training/education event in the fall of 2011; 18 attendees, including LAUNCH staff, were also trained as trainers to increase capacity within their organizations. ASQ<sup>®</sup> kits were provided to participating agencies to reduce barriers to implementation. In the first 4 years of grant funding, approximately 650 providers were trained or retrained in ASQ-3<sup>™</sup> and ASQ:SE<sup>™</sup> (Exhibit 3-3). As a result, 7790 children were screened in Boone County prior to kindergarten entry (Exhibit 3-4). Of these, 602 children were referred for follow-up assessment and care (Exhibit 3-5).



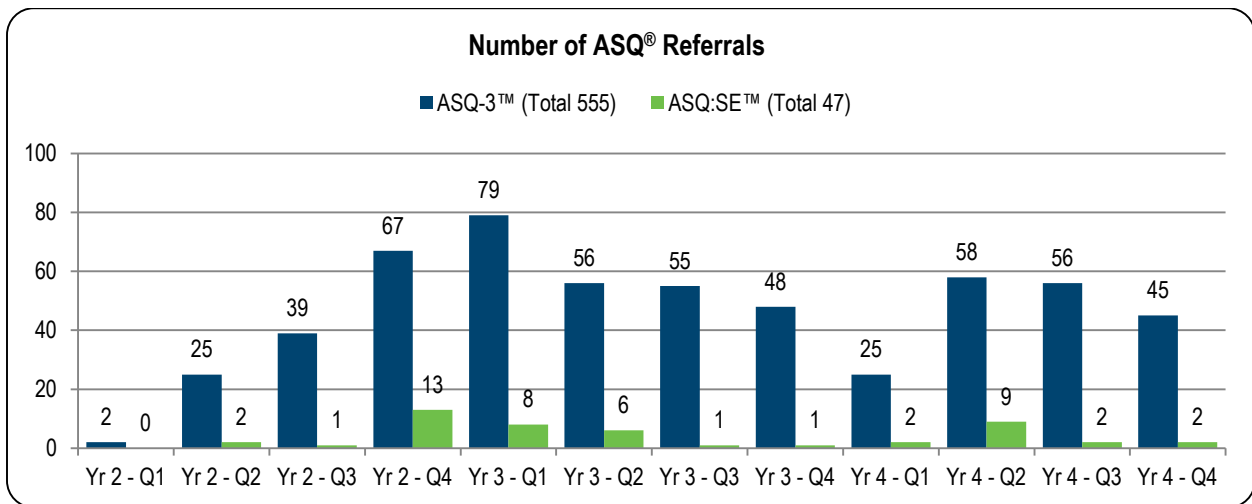
**Exhibit 3-3: Boone County: Providers Trained in ASQ:SE™ Screenings**



**Exhibit 3-4: Boone County: Number of ASQ® Screenings (N = 7,790)**

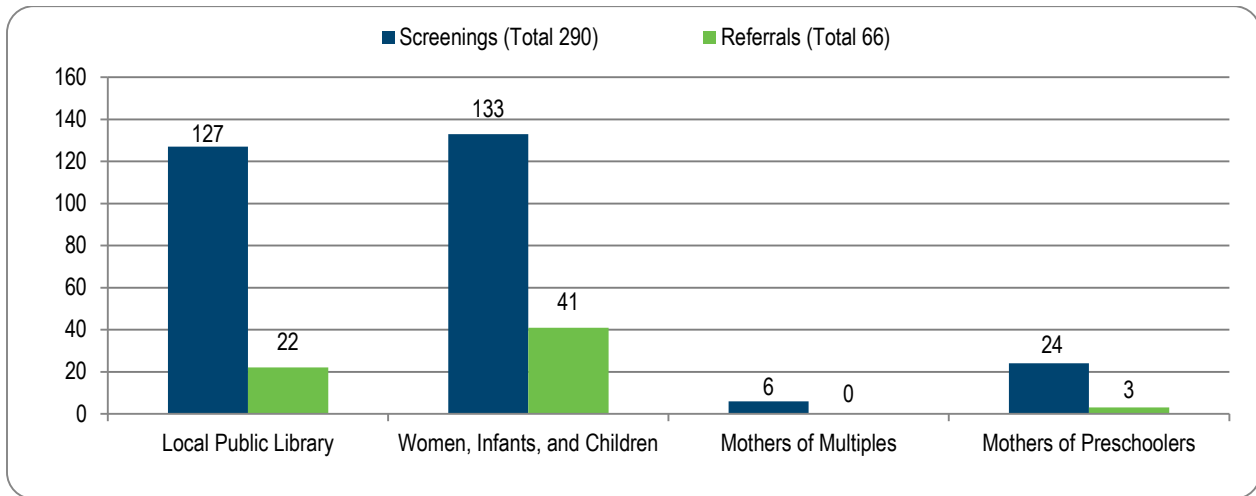


**Exhibit 3-5: Boone County: Number of ASQ® Referrals (N = 602)**



In addition, Project LAUNCH staff and other trained providers sponsored 25 community screening clinics, which resulted in 290 ASQ-3™ and ASQ:SE™ screenings and 66 referrals (Exhibit 3-6).

**Exhibit 3-6: Boone County: ASQ-3™ and ASQ:SE™ Community Screenings (N = 290) and Referrals (N = 66)**



### Grantee Spotlight: El Paso Project LAUNCH

El Paso Project LAUNCH serves families with children from birth to 8 years old in the El Paso, Texas, neighborhoods of South Central and Chihuahuita. These communities are located on the border between the United States and Mexico, are considered to be medically underserved, and are designated as mental health shortage areas. The area experiences high rates of poverty, low educational attainment, high rates of migration, high numbers of individuals without health insurance, and a low ratio of health workers per capita. Additionally, the area receives a regular influx of immigrants fleeing the cartel violence in neighboring Juarez, Mexico. Many of these families have experienced a high degree of violence and trauma.

**Overview:** El Paso Project LAUNCH worked to increase the use of validated screening instruments with an emphasis on social and emotional functioning to ensure that developmental issues or concerns in children ages 0 to 8 were identified and addressed early. The project utilized two primary strategies to conduct this work: training providers to integrate screening into their work (Exhibit 3-7) and promoting and coordinating screening for parents and providers. El Paso Project LAUNCH trained local professionals, such as the Head Start Mental Health and Disabilities staff, pre-K and early care and education staff, pediatric medical residents, parent educators, home visitors, and substance abuse prevention and intervention professionals on the importance of developmental milestones, the use of screening tools, and how and where to refer children for services.

### Exhibit 3-7: El Paso Project LAUNCH Screening Tools

El Paso Project LAUNCH promoted and trained on six screening tools:

- 1) Ages and Stages Questionnaire (ASQ®)
- 2) Ages and Stages Questionnaire-Social-Emotional (ASQ:SE™)
- 3) Parent Evaluation of Developmental Status
- 4) Modified Checklist for Autism in Toddlers (no-cost validated tool)
- 5) The Edinburgh Postnatal Depression Screening (no-cost validated tool)
- 6) The CAGE-AID, which is a parental substance abuse screening (no-cost validated tool)

The project worked closely with the State Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, Texas Health Steps (Exhibit 3-8). This program mandated in 2011 that providers utilize either the ASQ® or Parent Evaluation of Developmental Status to receive screening reimbursements during certain well baby checkup visits. To compliment and help kick off this mandate, El Paso Project LAUNCH coordinated an ASQ® and ASQ:SE™ Training for Trainers to help build the community’s capacity to implement the policy.

### Exhibit 3-8: El Paso Project LAUNCH Partner Quote

#### What Texas Health Steps Employees Are Saying

*“As a result of the current collaborating efforts between Project LAUNCH and Texas Health Steps [THSteps], all medical providers enrolled as THSteps providers are receiving the Wellness Resource Directory, providing them with a comprehensive listing of resources available throughout the city to assist in providing care to children and adolescents. Also, medical providers and their staff that have completed the developmental/autism screening training [and] are now utilizing the THSteps-approved screening tools in efforts to identify children at risk of developmental delay or autism earlier and refer those children to appropriate resources...”*

—2012 Texas Health Steps Employee

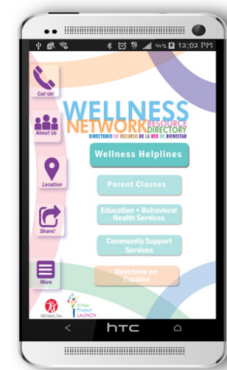
Over the course of the project, 572 professionals were trained to implement screens and properly refer children for developmental and social-emotional concerns. The program offered training and ongoing technical assistance to various primary care, early care and education, and mental health providers to ensure that screening protocols and practices were embedded into their practice. To support these efforts and to ensure sustainability, the program worked closely with the local medical school to provide second- and third-year medical residents with in-depth training and opportunities to conduct developmental and social-emotional screening with children residing with their mothers at a residential substance abuse treatment center (Exhibit 3-9).

**Exhibit 3-9: El Paso Project LAUNCH 5-Year Total Number Professionals (N = 572) and Residents (N = 17) Trained**

Professionals Trained	Medical Residents Provided With In-Depth Training on Social and Emotional Screening
572	17

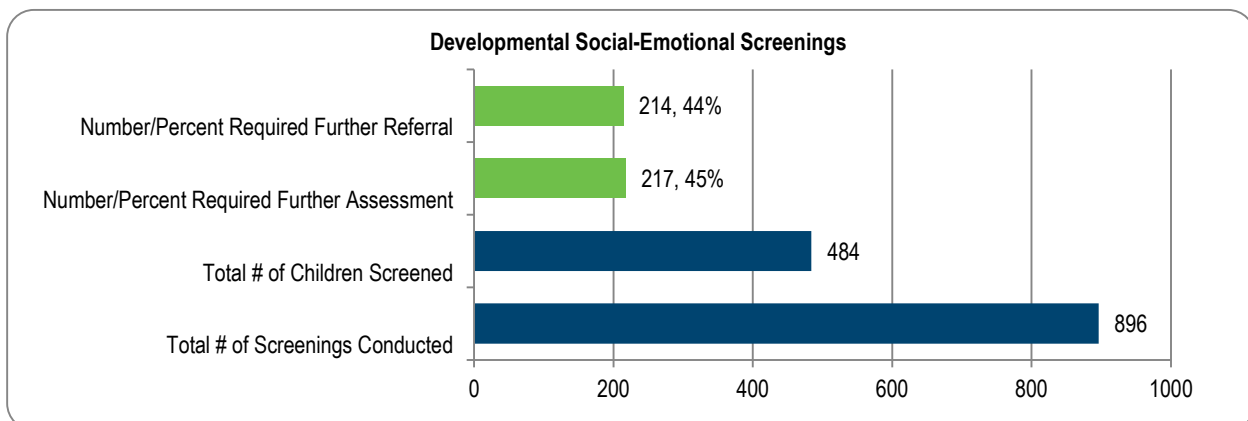
Additionally, the program educated parents and providers on the importance of conducting child screening to identify concerns early and understand developmental milestones. Finally, as a resource for providers conducting screening and families seeking services, El Paso Project LAUNCH created the Wellness Network Resource Directory (Exhibit 3-10). The directory is continuously updated in real time and was created in partnership with the local 2-1-1, the local public health department, United Way of El Paso County, and the Pan American Health Organization. The directory helped uncover and organize community-based services and organize them according to the continuum of care from health promotion to recovery services. Over the course of the grant, the project shaped the directory into a free downloadable mobile application available for parents, early childhood providers, and medical providers.

**Exhibit 3-10: El Paso Project LAUNCH Wellness Network Resource Directory Mobile Application**



**Results:** Over the course of the project, 484 children were screened for developmental and social-emotional delays and challenges (Exhibit 3-11). Forty-five percent of the children screened were referred for further assessment or treatment. These data highlight the need for continual promotion and training related to screening and early identification of delays or potential delays. Again, over the course of the project, 572 professionals were trained to implement screening and properly refer children for developmental and social-emotional concerns.

**Exhibit 3-11: El Paso Project LAUNCH Child Screens (N = 896 Screens, 484 Children)**



**Exhibit 3-12: El Paso Project LAUNCH Young Child Wellness Council Screening Workgroup 2012–2014**



Finally, to help promote and better understand screening in the community, the project’s Young Child Wellness Council screening workgroup (Exhibit 3-12), in collaboration with the Community Academic Partnerships for Health Sciences Research, authored the resource, *Developmental Surveillance and Referral in a Traditionally Medically Underserved Border Community*, which describes screening and referral in El Paso. The article will be published in a future issue of *Maternal and Child Health Journal*.



## Grantee Spotlight: Project LAUNCH—Weld Systems Navigation Project

**Project LAUNCH —Weld Systems Navigation Project** is an early childhood capacity-building project in Weld County, Colorado, one of the fastest-growing counties in the country, partly due to a recent increase in refugees who have settled in the area. The goals of the project are aligned with the Colorado Early Childhood Framework and include the following: (1) ACCESS and availability of evidenced-based resources to families with young children, across systems; (2) QUALITY of workforce development to enhance service provision to families with young children; (3) EQUITY to ensure that families with young children have equitable opportunities for available resources; and (4) SYSTEMS DEVELOPMENT to create an integrated open access system of care and family support for children 0–8 and their families.

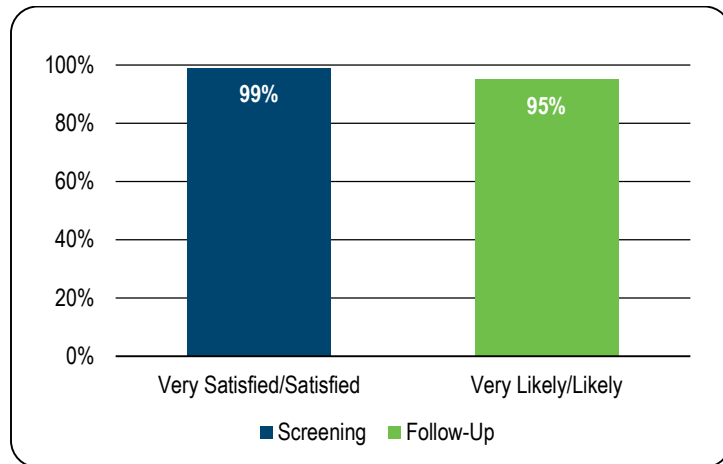
**Overview:** In the Weld Systems Navigation Project, developmental screenings and assessments supported by the project included ASQ-3™; ASQ:SE™; the [Edinburgh Postnatal Depression Scale](#) (Cox, Holden, & Sagovsky, 1987); the Environmental Screen Questionnaire (ESQ) reproduced with permission from Brooks-Cole Publishing Company; the M-CHAT Autism Screen (Robins, Fein, & Barton, 2009); the [Pediatric Symptom Checklist](#); and the [Patient Health Questionnaire](#) (PHQ-9) depressive screen. Local trainings with 54 Project LAUNCH partners were conducted by the Young Child Wellness coordinator and Project LAUNCH consultants throughout the project. These included trainings on (1) project overview, infant mental health; (2) screen tools/electronic tablet; and (3) trauma assessments. The trainings were conducted with providers and staff at the local behavioral health center, a private pediatric clinic, a federally qualified health care center, the county human services agency, Early Intervention Part C, and other provider groups.

**Results:** The Weld Systems Navigation Project and its partners screened 12,861 children and parents. Among these, 418 children were referred for further services. The number of referrals was lower than expected, as one large site was unable to document its referrals. The use of electronic tablets with [Patient Tools®](#) support for child and parent screenings has promoted screening efficiency. High screening satisfaction was reported by both parents and clinical staff. As a result, the number of electronic young child screenings, which are now included in pediatric well child visits, have soared at primary care sites. Young child and parental screenings were also conducted at the Project LAUNCH site, with Department of Human Services-referred families, by the Home Instruction for Parents of Preschool Youngsters ([HIPPY program](#)), and at community events such as children’s festivals.

Parents completed the Parent Satisfaction Survey after each screen ( $N = 10,211$ ). Results summarized in Exhibit 3-13 indicate very high satisfaction (99%) with the screening experience and high likelihood that parents would attend a follow-up visit or referral source if needed (95%). Consistency in conducting the satisfaction survey, however, varied. In some clinics, the Parent Satisfaction Survey was implemented after information was provided to parents, but in other clinics, the survey was given immediately after the screening, before information for parents was provided in another clinic room.

With new electronic tablets that were purchased in 2015, the ease of conducting the screen, presenting results, educating parents, and implementing the Parent Satisfaction Survey was enhanced.

**Exhibit 3-13: Project LAUNCH—Weld Systems Navigation Project: Parent Screening Satisfaction, Years 1–5 (N = 10,211)**



The Project LAUNCH staff and external providers reported the following benefits of the electronic screening tablet: (1) Every child is screened during a well child visit in designated primary care settings; (2) The number of parents and providers who can see the screening results immediately following the screen has increased; and (3) There is quick access to information for a consult with a physician due to the electronic screening.

Project LAUNCH early childhood mental health consultants, HIPPIY mentors and assistant coordinator, The Children’s Health Place private pediatric providers, and Sunrise Community Health (a federally qualified health care center) providers and staff completed an annual provider survey. During Year 4, many staff and external providers on the project (N = 36) self-reported some or substantial increases in their knowledge of children’s socioemotional and behavioral health and development (53%), increases in their use of screening and/or assessment of children (58%), increases in their knowledge about the available options for follow-up services for children with mental or behavioral health issues (48%), or their use of mental health consultation for children with mental or behavioral health issues (43%) as reported in the annual provider survey. More than one-third of staff or external providers (39%) reported some or substantial increases in their use of screening and/or assessment tools (e.g., Edinburgh Postnatal Depression Scale or Screening, Brief Intervention, and Referral to Treatment (SBIRT) with parents of children ages 0–8.

On the annual provider survey, medical personnel at the private and public primary care clinics (N = 25) reported many positive changes in their practice and work setting related to the electronic screen process, provider training, and consultation they received (Exhibit 3-14).

**Exhibit 3-14: Project LAUNCH—Weld Systems Navigation Project: Medical Provider Changes in Work Practice/Setting, 2013–2014 (N = 25)**

Benefits of Electronic Screening for Medical Providers	Benefits of Electronic Screening for Families
<ul style="list-style-type: none"> <li>• Improves check-in: tablet cues appropriate screens for corresponding ages</li> <li>• Promotes accurate electronic scoring of screens</li> <li>• Improves integration of screen results into the electronic medical record</li> <li>• Real time consultation with physician</li> <li>• Developmental screens at every well child checkup</li> </ul>	<ul style="list-style-type: none"> <li>• High parent satisfaction with screens</li> <li>• Parents learn about child development</li> <li>• Child developmental issues are identified sooner</li> <li>• Appropriate referrals and resources for families</li> </ul>

**Other Grantee Accomplishments**

In addition to Grantee Spotlights, other Cohort 3 grantees have made significant progress in screening. For instance, the NYC Project LAUNCH program in New York utilized the ASQ:SE™ and the Pediatric Symptom Checklist to screen children and helped integrate the tools into well child visits in pediatric primary clinics at one federally qualified health center and one municipal hospital. The ASQ:SE™ and [BRIGANCE®](#) early childhood screening and assessment tools were also incorporated into early care and education. NYC Project LAUNCH prepared a guidance document on developmental screening in pediatric primary care from the New York City Health Department that was distributed to more than 26,000 health care providers in the city.

The Project LAUNCH – Multnomah Education Service District, in coordination with the Oregon Pediatric Society, exceeded the target and trained a total of 748 primary care staff during the first 4 years of the grant. This grantee also facilitated 1,040 referrals from primary care physicians to early intervention/mental health services. However, it is important to note that this referral number may include a number of referrals by primary care physicians who were trained prior to the beginning of Multnomah Project LAUNCH.

Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH screened more than 120 children with the ASQ-3™. Focus group data collected annually identified the screening process as being highly successful at detecting potential developmental delays. In addition, this program, through its Mental Health in Primary Care System, trained 198 providers to administer the ASQ-3™. Overall, although Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH cannot attribute all screenings of children up to age three directly to Project LAUNCH, the number of developmental screenings billed to Medicaid in New Britain has increased substantially from 201 in 2009 to 4091 in 2013. Similarly, in the same time period, the number of pediatric providers billing Medicaid for developmental screenings has increased from 6 in 2009 to 81 in 2013.

## Lessons Learned, Opportunities, and Conclusions

Overall, Cohort 3 grantees had considerable successes in developmental screening efforts. Grantee experiences identified the following lessons learned: (1) formation of a screening work group is critical to successful implementation; (2) screening clinics at the community level are successful when they are structured to meet the unique needs of parents and caregivers including convenient locations and schedules; (3) partnering with parents is essential to optimize childhood developmental outcomes; (4) awareness of local resources among providers improves referral success; (5) creating networks of providers trained to screen, assess, and refer children and families to multiple services is essential to supporting and sustaining screening efforts; (6) a centralized and coordinated care screening and referral process is important; and (7) having a resource directory is essential in helping agencies identify and access community-based resources.

The American Academy of Pediatrics/Bright Future’s recommendations for general developmental screening (American Academy of Pediatrics, 2014), using tools such as the ASQ-3™, have promoted the integration of universal screening in pediatrics to ensure young child development. Despite the American Academy of Pediatrics/Bright Future’s recommendations, provider reimbursement for screening services, both developmental and social-emotional, during well child visits remains inconsistent across states and individual practices decreasing standardization in practices. In addition, primary care partners have had varying degrees of success with billing and reimbursement, especially with regard to commercial payers. It is critical that policy makers address this issue to ensure that reimbursement rates across payers are favorable to both primary care and mental health providers.

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## 4. Integration of Behavioral Health Into Primary Care

Pediatric primary care practices are one of the medical settings all young children are expected to visit at routine ages and stages in their early development. As such, a young child’s visits to her or his pediatrician present key opportunities for a medical provider to detect any developmental challenges the child is experiencing. Thus, pediatric providers can take appropriate steps to support the child or to refer the child to specialty health care and support services. The integration of behavioral health services into primary care can ensure that at-risk children are identified and treated as early as possible, particularly in early childhood when primary care is the only universal access point and a non-stigmatizing environment (American Academy of Child and Adolescent Psychiatry, 2009; Substance Abuse and Mental Health Services Administration, 2013).

A framework for models of integration developed by the Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions describes a continuum of integration of behavioral health into primary care with increasing degrees of collaboration, co-location of services, and medical record and system integration (Heath, Wise, & Reynolds, 2013). The framework emphasizes the need for skills and competencies among team members in interpersonal communication, care planning, collaborative teamwork, and computer information sciences, among others, for integrated teams to work effectively. On-site mental health clinicians in pediatrics are available to address developmental and behavioral concerns and can function as a consultant or even as a primary therapist. Flexible schedules for the clinicians are critical so they can be available for same-day consultations, brief follow-up interventions, supervision of screening, and informal consultations (Stancin & Perrin, 2014). Research showing the impact of maternal depression on children’s social-emotional development and behavioral health also highlights the importance of addressing parental mental health concerns in pediatric settings (Goodman et al., 2011).

Each Cohort 3 grantee promoted the integration of behavioral health into primary care in their communities in different ways. This was accomplished most commonly through the provision of training to primary care practices to increase provider understanding of mental health issues, as well as strategies that can be used to integrate behavioral health, social-emotional development, screening, and referrals into the primary care setting. In some cases, grantees developed partnerships with health care providers or associations of pediatricians/residents.

As an example, Multnomah Project LAUNCH partnered with the Oregon Pediatric Society (OPS) to develop and deliver a training module to primary care practices emphasizing the importance of behavioral health and illustrating the continuum of activities that practices can implement in order to integrate behavioral health. The module is available as a live training or online. Multnomah Project LAUNCH also supported OPS to deliver a second well-received module about adverse childhood experiences (ACEs) and trauma-informed care. Similarly, Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH, partnered with the [Child Health and Development Institute of Connecticut](#) to deliver training modules to pediatricians and also partnered with Help Me Grow, Child First, and other local partners to obtain enrollment data and counts of children screened.

Cohort 3 grantees documented strengths, challenges, and opportunities for the integration of behavioral health into primary care settings, as summarized in Exhibit 4-1.

**Exhibit 4-1: Cohort 3 Successes, Challenges, and Opportunities for the Integration of Behavioral Health Into Primary Care Settings**

Cohort 3 Successes	Cohort 3 Challenges and Opportunities
<ul style="list-style-type: none"> <li>• Trained primary care providers to conduct screens and properly refer families to various services.</li> <li>• Implemented early childhood screens in pediatric primary clinics (e.g., well child visits).</li> <li>• Established nontraditional community screening sites (e.g., child care, residential substance abuse centers, mental health providers).</li> <li>• Promoted and embedded the use of electronic tablets for screening.</li> <li>• Used strength-based protective factors screenings.</li> <li>• Conducted and coordinated large numbers of screens and documented referrals.</li> <li>• State Pediatric Society developed and implemented behavioral health, ACEs and trauma-informed care training modules for pediatric practices with project support.</li> <li>• Increased Part C referrals with more state funding.</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of initial buy-in from providers or providers who need more time or resources to adopt screening practices.</li> <li>• Linguistic and literacy needs of parents must be addressed with limited staff time and availability.</li> <li>• Implementation of screenings varies from site to site, and challenges at sites are unique.</li> <li>• Integration of screen results into electronic medical records is costly and requires commitment.</li> <li>• Difficulty identifying potential funding for universal screening.</li> <li>• Establishing partnerships with primary care providers to create buy-in for universal screening, especially social and emotional screening, takes time and effort.</li> <li>• Slow start to get the Behavioral Health Integration in Primary Care module initiated resulted in additional training modules for pediatricians.</li> </ul>

## Grantee Spotlight: New York City Project LAUNCH

Through the New York City Department of Health and Mental Hygiene (Health Department), New York City (NYC) Project LAUNCH works to expand and strengthen programs and services for children and their families citywide, with a particular focus in two of New York’s highest need communities: Hunts Point (Bronx) and East Harlem (Manhattan). NYC Project LAUNCH promotes the social and emotional well-being of children ages birth to 8 by improving collaboration between young child wellness systems; developing the workforce to increase their understanding of child development; providing support, education, and training to increase the use of positive parenting practices and to improve parent-child relationships; and guiding the transformation of public policy and funding.

**Overview:** In pediatric primary care, NYC Project LAUNCH integrated behavioral health by co-locating mental health clinicians and primary care assistants from an early childhood mental health agency into a pediatric clinic at a municipal hospital in East Harlem and a federally qualified health center in the South Bronx. Behavioral health staff conducted social-emotional screening, mental health consultation, staff training, and referrals on specific days of the week. The majority of patients at both large urban sites had Medicaid health insurance coverage. Co-location began at the hospital in East Harlem during the summer of 2011 and was available onsite four days each week and at the health center in the South Bronx during the fall of 2012 and onsite one day each week.

At pediatric clinics, primary care assistants from the co-located mental health agency routinely administered and assisted parents and caregivers in completing screening using the [Ages and Stages Questionnaires®: Social-Emotional \(ASQ:SE™\)](#) for children ages 6 months to 5 years and the [Pediatric Symptom Checklist \(PSC-17\)](#) for children ages 5–8 in the waiting room before well-child visits. The mental health clinician provided early childhood mental health consultation within the context of the pediatric practice to families identified as facing challenges through screening, a parent concern, or when referred by pediatricians. Mental health staff provided mental health assessment and follow-up, including short-term treatment, referral, and linkage of children and their families to Early Intervention (EI) for children ages 0–3, Committee on Preschool Special Education (CPSE) for children ages 3–5, mental health, and other community resources, as needed. To increase workforce capacity, mental health clinicians also conducted 36 trainings to staff from the pediatric primary care partner sites on early childhood mental health, how to use social-emotional and developmental screening, referrals, and information about EI and CPSE or other services.

In addition to implementing direct services and training, NYC Project LAUNCH worked to promote behavioral health integration and screening more broadly in New York City. To better understand models of mental health integration in pediatric primary care practices in the city, NYC Project LAUNCH and the health department conducted a telephone survey in 2013, exploring successes and challenges and systematically examining themes and patterns that emerged. A two-item questionnaire about availability of mental health services was sent by e-mail to medical directors of 55 pediatric clinics in the five boroughs, including federally qualified health centers and municipal

and nonmunicipal hospital sites. The study sample included 16 respondents from medical or behavioral health directors at these health facilities, with mental health services in at least one nonschool-based pediatric clinic. Telephone interviews were conducted with closed- and open-ended questions on topics including staffing, communication, financing, clinical services, challenges, and successes.

**Successes and Challenges to Behavioral Health Integration in Pediatrics Across New York City, 2013**

Results of the survey on integrating behavioral health in 16 pediatric clinics in health centers and municipal and nonmunicipal hospitals in New York City indicate that there are different degrees of integration in these sites with respect to the co-location of mental health staff; ways of staffing these positions (through outside agency, as staff of pediatric department, as staff of psychology department); the use of integrated electronic health records and shared records; and informal versus formal case and programmatic consultations.

Perceived benefits to integrating behavioral health in pediatrics included improved communication among health and mental health providers, easier access to mental health care for families and referring providers, improved effectiveness of the primary care practice, improved child health and mental health outcomes, and better experiences for families. Perceived challenges to effectively or fully integrating behavioral health in pediatrics include the lack of integrated treatment plans, inconsistent screening for mental health in children, joining professional cultures within medical and mental health teams, and the need for various combinations of sources of payment and funding to cover costs. No practices were able to fully fund behavioral health integration in pediatric primary care through billing alone.

Findings support the need for further site- and system-level strategies for implementing effective models of integration as well as adequate reimbursement, funding, and infrastructure support in pediatric primary care practices at hospitals and health centers in New York City.

To promote broader awareness of early childhood development and mental health throughout the city, NYC Project LAUNCH and the health department designed and produced a number of health promotion materials in 10 languages that relate to the development and well-being of children ages 0–10 for parents and caregivers and the providers that serve them. The materials include strategies to promote social and emotional development through healthy relationships and assess growth through developmental milestones. Additionally, materials include posters for pediatric waiting rooms emphasizing the importance of developmental screening, as shown in Exhibit 4-2. Materials were made available in several languages online and through the NYC 311 system (See Promotion & Public Awareness Section).

**Exhibit 4-2: Poster for Pediatric Primary Care Clinic Waiting Rooms**



To promote developmental screening in pediatrics citywide, NYC Project LAUNCH wrote a Health Department City Health Information (CHI) bulletin on developmental screening in pediatric primary care. The CHI includes recommendations based on

the American Academy of Pediatrics’ policy statements and clinical reports (American Academy of Pediatrics [AAP] Committee on Children With Disabilities, 2001; AAP Committee on Psychosocial Aspects of Child and Family Health, 2009; AAP Task Force on Mental Health, 2010; & Earls, 2010), including periodicity tables and guidelines for general developmental, social-emotional, autism-specific, and maternal depression screening with validated tools, as well as raising awareness about the impact of ACEs, trauma, and toxic stress in early childhood. In October 2015, the NYC Health Department released the CHI by e-mail to more than 27,000 health care providers in New York City and posted the bulletin online: [Identifying Developmental Risks and Delays in Young Children](#) (New York City Department of Health and Mental Hygiene, 2015).

**Results:** In NYC Project LAUNCH communities, an average of 1,018 children were screened by the primary care assistants annually between July 2011 and July 2015 in East Harlem with approximately 19% having positive screens, an indication of a potential social-emotional delay or challenge. Similarly, an average of 197 children were screened annually in the South Bronx between October 2012 and July 2015 with approximately 32% having positive screens (Exhibit 4-3). Families that had a child with a positive screen, a parent concern, or a pediatrician referral met with the mental health consultant for assessment, short-term treatment, and/or referral.

Data indicate that early childhood mental health consultants provided valuable services to a substantial number of families. At the East Harlem site, more than 670 families received a referral, and approximately 57% confirmed that they attended the first visit within the grant year initially referred, a linkage rate in line with findings from similar initiatives (Godoy et al., 2014). In the South Bronx site, more than 115 families received a referral, and approximately 44% confirmed that they completed the first visit within the grant year initially referred.

**Exhibit 4-3: Average Number of Children and Families Served, East Harlem (Years 1–5) and South Bronx (Years 3–5)**

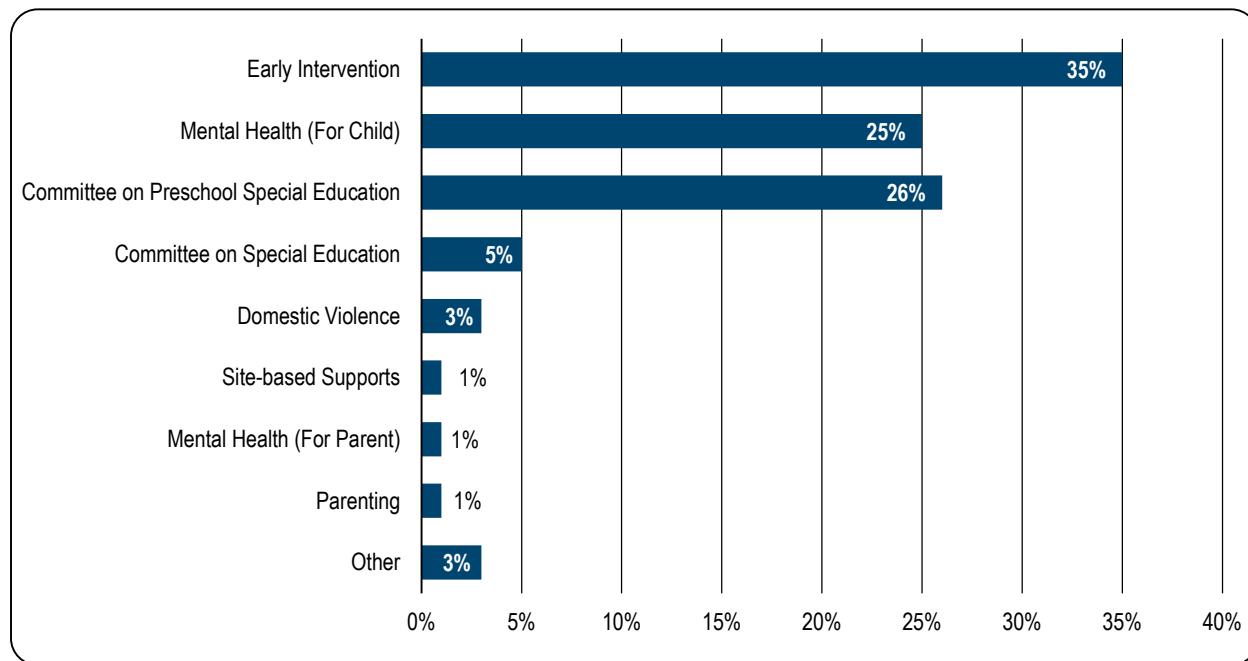
Annual Averages	East Harlem Site (4 days per week)	South Bronx Site (1 day per week)
<b>Children screened</b>	1018 children	197 children
<b>Positive screens</b>	19% (190) children	32% (64) children
<b>Families received consultation from mental health clinician</b>	242 families	77 families
<b>Families received referrals</b>	151 families	39 families

The referrals provided by consultants helped connect families with critically important supports and a variety of services including child mental health, EI (Early Intervention), and CPSE (Committee



on Preschool Special Education). A summary of the types of referrals made can be seen in Exhibit 4-4. However, given that this model did not include screening for maternal depression, fewer referrals were made for parent mental health, an area of opportunity for the future.

**Exhibit 4-4: Types of Referral Made, East Harlem and South Bronx (Average Years 1–5)**



Pediatric clinic providers reported positive changes in their knowledge about young children’s mental health and available services to address mental health problems, with the strongest gains in East Harlem. Some examples of these changes are summarized below:

- In the East Harlem site, where a consultant started in Year 2, worked 4 days a week, and provided trainings, among clinic providers (staff physicians, nurses, and residents), 87% reported substantial or some change in their knowledge about young children’s mental health; similarly, 87% reported substantial or some gains in their knowledge about services.
- In the South Bronx site, where a consultant started in Year 3, worked only 1 day a week, and provided trainings, fewer clinic providers reported substantial or some gains in these areas: 80% for knowledge about young children’s mental health and 70% for knowledge about services.
- In their responses to a vignette describing a parent’s concern about her child’s behavior, 59% of clinic providers across the two sites indicated that they would refer the child to the on-site mental health consultant, suggesting their positive view of the consultation service and its benefit to families.

Evaluation findings concerning the types of referrals that were made suggest that greater attention to parent mental health may be needed. Few referrals were made to address the needs of parents (adult

mental health providers), which may have resulted in part from the absence of parent mental health screening. Findings regarding the limited referral and linkage confirmation may be due to a shortage of child mental health providers and long wait lists, prompting clinicians to provide short-term treatment until families could see a provider in the community.

### Clinic Providers' Feedback on Behavioral Health Integration

*"It has made the referral service much quicker and easier. It is a blessing to have them [mental health specialists]. It makes patient care more complete and efficient."*

—Pediatrician

*"Pediatricians knew about referral but not follow-up, before LAUNCH. Many made unsuccessful referrals to Early Intervention. Pediatricians, residents, and attending[s] increased awareness of socioemotional concerns, know what to ask."*

—Primary care assistant

*"I set up the appointment or hand them off. It comforts patients to see that I have a rapport with the mental health consultants because some parents can be reluctant. I think in this population, families are not as educated about mental health or services, so they can be shy in asking for services. For other referrals like psychiatric, families get lost, do not follow up themselves if they have to keep up with appointments—but Project LAUNCH makes that simple; they are down the hall."*

—Pediatrician

The evaluation of integrated services in NYC Project LAUNCH neighborhoods shows that the screening, consultation, and referral services in the pediatric settings were generally successful in identifying a significant number of young children in need of supports for their mental health. The early childhood mental health consultants were able to provide developmental guidance to help parents better understand and support their children’s development; referrals to community mental health, EI, and CPSE; and in some cases, brief treatment. Many of the pediatric clinic providers became much more knowledgeable about both young children’s behavioral health and services that can address problems.

### Grantee Spotlight: Project LAUNCH—Weld Systems Navigation Project

Project LAUNCH — Weld Systems Navigation Project is an early childhood capacity-building project in Weld County, Colorado, one of the fastest-growing counties in the country, partly due to a recent increase in refugees who have settled in the area. The goals of the project are aligned with the Colorado Early Childhood Framework and include the following: (1) ACCESS and availability of evidenced-based resources to families with young children, across systems; (2) QUALITY of workforce development to enhance service provision to families with young children; (3) EQUITY to ensure that families with young children have equitable opportunities for available resources; and (4) SYSTEMS DEVELOPMENT to create an integrated open access system of care and family support for children 0-8 and their families.

**Overview:** In Weld County, Colorado, the Weld Systems Navigation Project supported the integration of behavioral health services into primary care pediatric practices by promoting early

childhood screening assessments, providing early childhood mental health consultation, and identifying early childhood resources for providers and the families they serve in a private pediatric clinic as well as a federally qualified health center. The project assisted in the development of a comprehensive process that providers in primary care settings can use to implement screening activities. The process includes guidance on the selection of appropriate screening tools, training for front office staff and providers on the use of these tools, mental health consultation for providers about their practice and regarding individual families, “response-to-need” which includes how the provider will address family concerns, and interface with electronic medical records for screening results documentation. Using the *Blue Print* planning model (previously described in the Systems Development section), “response to need” is a process developed by each partnering organization to respond to needs based on the outcomes of client/patient screening. These can be addressed in-house or through community referrals. This comprehensive process contributes to effective and efficient office flow and screening reimbursement and appropriate screens for children and parents.

The project’s young child wellness coordinator met with clinic administrators and used the *Blue Print* planning process to initiate this integration work. A Project LAUNCH early childhood mental health consultant and system navigator were available to assist each site weekly throughout the project. Project LAUNCH staff provided consultations to providers and families, project assistance such as provider trainings on mental health-related topics and screening tools, and trouble-shooting any technical screening issues, and information about young child and family resources.

**Results:** Primary care providers and staff involved in the project ( $N = 19$ ) completed an online primary care provider survey and reported larger system changes, including increased setting-wide use of a common battery of screening and assessment tools for behavioral health; increased understanding of common developmental milestones in socioemotional health; and increased understanding of referral options for children with behavioral health concerns. They also reported increased coordination across providers of assessments and referrals for children with mental or behavioral health concerns.

## Lessons Learned, Opportunities, and Conclusions

Grantees found that successful integration required—a coordinated and streamlined system for screening and referrals, including increased capacity for early childhood mental health treatment in the community. Developing a strong working relationship between pediatricians and mental health clinicians is essential to successful integration into primary care. Raising pediatrician and resident awareness through training on early childhood social-emotional development, the importance of prevention and early intervention, and the role of the mental health providers are key to building connections across systems. When the pediatricians have a good understanding of social-emotional development in early childhood, they utilize mental health services more and make appropriate referrals. Providing maternal depression screening and pediatrician training on the relationship

between parental mental health and young child wellness would further strengthen integration models. Collaborating with the pediatrician on specific cases through open and ongoing communication improves overall care, because all parties are informed of progress and can connect children to services in a timely manner. In addition, a strong working relationship between the screening and mental health staff and other pediatric clinic staff assists with supporting the structure, logistics, and flow of the integration.

Co-locating mental health services from an outside agency in a pediatric clinic also takes time, due to logistics and business arrangements related to onsite space, integrated health records, communication, professional and cultural differences, confidentiality, and billing issues. In addition, hospital settings may have prolonged clearance processes that can delay services, particularly if there are staffing changes. When the co-located mental health staff from outside agencies are onsite at the pediatric clinic, they conduct screening for all children coming in for well-child visits at specific ages. Transitioning to having the pediatric site staff conduct screening themselves or developing automated ways to integrate screening into well-child visits requires additional resources.

Recommendations to enhance and sustain models of integration include developing funding, infrastructure, workforce training, and data systems to support site-specific and system-level strategies. At the site level, this would include adequate resources for an early childhood mental health consultant to work five days a week to ensure sufficient capacity, especially in settings with a high volume of children with positive screens for mental health problems; training for the consultant and clinic providers in conducting both child and adult mental health screens and responding to positive screens; and resources for staff to successfully link to appropriate community services for referrals, including those for parental mental health. Funding at the site level can be leveraged from billing, grants, and internal operating costs. At the system level, this would include identifying sources of funding for early childhood mental health consultation in pediatric settings across hospital and health center networks or regions. Potential funding sources include the Mental Health Block Grant, the Maternal and Child Health Block Grant, and improving Medicaid and other insurer billing and reimbursement rates. Additional recommendations are to (1) develop training initiatives to expand the workforce of community-based child mental health clinicians trained in evidence-based models, including parent-child interaction treatment; and (2) develop an information system to streamline screening and community referrals and improve data collection and quality improvement.

Current federal and state health care reform initiatives present an opportunity to promote mental health integration and closely monitor results and successes. Implementing and sustaining mental health integration in primary care is a challenging endeavor, but it is critically important given the prevalence and potential long-term impacts of childhood mental health conditions. Pediatric primary

care providers have an essential role in identifying these conditions, intervening early, and improving the health, mental health, and developmental outcomes of children.

Mental health integration in pediatric care settings shows promise as an effective method for greatly increasing the number of young children whose behavioral health problems are identified and addressed early in their lives. Wider-scale implementation of screening and integrated services provided by mental health consultants represents a potentially strong approach to reducing mental health problems in children and the toll these problems take on children’s development and success in school. Because almost all young children are regularly seen in pediatric settings for well-child care, this approach can reach large numbers of children and help both parents and pediatricians understand and support children’s mental health as a key part of their development. However, more work is needed to improve funding and infrastructure to increase capacity for mental health consultant co-location and other models of integration in pediatrics at health centers and hospitals.

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## 5. Enhanced Home Visiting

Evidence-based home visiting programs delivered by well-trained staff have shown positive outcomes such as healthy child development, reduced child maltreatment, school readiness, family self-sufficiency, and long-term financial benefits for states. For every dollar spent on these programs, a return on investment of up to \$5.70 is achieved through reduced child abuse and neglect, improved children’s health, and the promotion of future student academic success (National Conference of State Legislatures - Maternal, Infant and Early Childhood Home Visiting Programs 2015).

According to The National Conference of State Legislatures:

*“State lawmakers play an important role in establishing effective home visiting policies in their states. They can determine how different sources of funding can be leveraged to sustain and improve the quality of states’ existing home visiting systems. They may also develop legislation to ensure the state is investing in research-based home visiting models that demonstrate effectiveness and that accountability measures are in place.”*

As a core strategy of Project LAUNCH, enhanced home visiting involves enhancing evidence-based home visiting programs with early childhood or maternal mental health consultation for mothers and their families. Early childhood or maternal mental health consultation is delivered to providers and families. Early childhood mental health consultation involves a partnership between a professional consultant with early childhood mental health expertise and home visiting programs, staff, and families. This approach includes home visitor training on behavioral health topics and evidence-based and promising practice curricula, integration of social-emotional and behavioral health screening in home visiting programs, limited and brief mental health interventions with families, identification of additional resources and referrals, and reflective supervision for home visitors.

This integrated model of home visiting programs with early childhood mental health consultation can promote family wellness by enhancing the capacity of home visitors to identify and address the unmet mental health needs of children and parents (Goodson, Mackrain, Perry, O’Brien, & Gwaltney, 2013). The results of this type of home visiting model with early childhood mental consultation has shown increased attachment of parents or caregivers to their children and development of improved parenting skills with family supports or consultation that address individual socioemotional needs of children and families. They also create home environments that are positive climates for children’s learning and growth, reduce maternal depression, and increase social and emotional well-being and behavioral health of young children.

Examples of evidence-based programs home visiting programs that were enhanced with early childhood or maternal health consultation by Project LAUNCH Cohort 3 grantees were:

- **Child First:** An in-home care coordination and case management program that includes an emphasis on behavioral health and connects families with community-based services (New Britain, CT). The enhancement included expanded sites, trained staff and incorporation of new information through intensive clinician training. They were able to launch the second wave of Child First replication sites as a direct result of LAUNCH funds which covered a large portion of training not only the staff in New Britain, but also in Middletown, Meriden, and expanded sites in New London/Norwich. With grant funds, the project did a cost share effort to train all Child First clinicians in Child Parent Psychotherapy beginning in October 2012. LAUNCH funds were leveraged to enhance the model with evidence-based, trauma-informed intervention, which integrated well with the model’s fidelity framework.
- **Healthy Families America (HFA):** An early childhood home visiting service delivery program for overburdened families at risk of adverse childhood experiences, with services that begin prenatally or right after the birth of a baby (Multnomah County, OR). The enhancement provided home visitors with early childhood mental health consultation and also training in Early Childhood Positive Behavior Interventions and Supports (EC PBIS) These supports were blended seamlessly and were incorporated into professional development, individual child and family consultation, and reflective supervision.
- **Nurse Family Partnership (NFP):** A maternal health program delivered by trained maternal and child health nurses that educates first-time mothers and parents for healthy pregnancies and infants (New York City, NY and Weld County, CO). In Weld County, this program was enhanced with monthly case conferencing, consultation to NFP nurses and accompanying home visits to address maternal mental health needs by the maternal mental health consultant as well as reflective supervision for the nurses by the Project LAUNCH Young Child Wellness Coordinator.
- **Parents as Teachers (PAT):** A home visiting program with trained educators who work with parents during the critical early years of their children's lives, from conception to kindergarten (Boone County, MO and Weld County, CO). For Boone County LAUNCH, an RFA or Request for Assistance titled “Expanding and Enhancing Home Visiting Services” was sent out to home visiting agencies in Boone County, Missouri. The RFA was written to promote the enhancement of existing home visiting programs so that families were engaged and able to access needed services, expand the capacity to serve more families, reduce wait lists, and strengthen systems coordination. In Year 3-5 of the grant, Boone County Project LAUNCH supported the implementation of the PAT program. Parents as Teachers, an evidence-based program, focused on providing information, support, and encouragement to parents to help children develop during early childhood. Centralia, Missouri, was selected and the implementation of the project began in early September 2013. For Boone County, the enhancement pertained to the addition of reflective consultation and maternal depression

screening to the existing practice. For both Boone and Weld counties, this program was enhanced by early childhood mental health consultation to the PAT educators about PAT families with young child or family mental/behavioral health needs.

Project LAUNCH Cohort 3 grantees also supported or implemented other promising programs with early childhood or maternal mental health consultation. These programs may not yet meet the evidence-based practice criteria put forth by the Substance Abuse and Mental Health Services Administration (SAMHSA; Center for Substance Abuse Prevention, 2009), but they are regarded as strategies that hold promise of positive outcomes and have yielded local evidence of positive impacts through LAUNCH:

- **Healthy Babies-Healthy Families:** An in-home parent education program that helps guide new parents through the first three years of their baby’s life and supports the development of nurturing relationships between parents and children, and provides home safety checks, screenings, referrals, and linkages to family services (El Paso, TX). One grantee developed and implemented this program model from scratch using promotoras also known as community health workers. The program included the development of a reflective supervision system and successfully aligned the home visitors (promotoras) with early childhood mental health consultants for support.
- **Promoting Maternal Mental Health During Pregnancy:** A maternal mental health home visiting program developed by Nursing Child Assessment Satellite Training (NCAST), which includes professional training of screening, assessment, and observation competencies for certification in infant mental health (Weld County, CO). In addition to implementing this service for mothers, maternal depression screening and consultations were provided upon request to other agency partners such as a behavioral health center, primary care clinics and teen mothers at a school site.

The Cohort 3 grantees experienced many successes with enhanced home visiting programs and strategies as well as challenges and opportunities to improve home visiting services (Exhibit 5-1).

**Exhibit 5-1: Cohort 3 Successes, Challenges, and Opportunities**

Cohort 3 Successes	Cohort 3 Challenges and Opportunities
<ul style="list-style-type: none"> <li>● Mental health consultation with reflective supervision enhanced home visiting services.</li> <li>● Home visitors gained positive changes in mental health knowledge and practice.</li> <li>● Referrals to mental health services increased.</li> <li>● Connecticut and Weld County (Colorado) documented strong fidelity to the home visiting models.</li> <li>● Parents reported high satisfaction with services.</li> </ul>	<ul style="list-style-type: none"> <li>● Some geographic areas lacked access to home visiting services.</li> <li>● Data sharing among collaborating partner organizations was limited in some cases due to privacy mandates.</li> <li>● Staff turnover in some home visiting programs resulted in the need for continuous training.</li> <li>● Assessment tools for non-English speaking families in home visiting programs were limited.</li> </ul>

## Grantee Spotlight: Project LAUNCH—Weld Systems Navigation Project

**Project LAUNCH—Weld Systems Navigation Project** is an early childhood capacity-building project in Weld County, Colorado, one of the fastest-growing counties in the country, partly because of a recent increase in refugees who have settled in the area. Project goals are aligned with the Colorado Early Childhood Framework and include the following: (1) ACCESS to and the availability of evidenced-based resources to families with young children across systems; (2) the QUALITY of workforce development to enhance service provision to families with young children; (3) EQUITY, to ensure that families with young children have equitable opportunities for available resources; and (4) SYSTEMS DEVELOPMENT, to create an integrated open-access system of care and family support for children ages 0–8 and their families.

**Overview:** The Weld Systems Navigation Project home visitation programs that were enhanced with early childhood or maternal mental health consultation included Parents as Teachers (PAT), a nationally recognized evidence-based program, and the Maternal Mental Health Home Visiting Program (MMHHVP). The latter program is based on the Promoting Maternal Mental Health During Pregnancy Program developed by NCAST at the University of Washington School of Nursing. MMHHVP supports the development of the early mother-child relationship by emphasizing the role that parent-child bonding, child attachment to the parent, the importance of early brain development, and caregiving plays in the child's emotional and cognitive development.

For both PAT and the MMHHVP, mental health consultation enhancements included consultation to (1) providers for their practice in general as it relates to mental health topics, (2) providers about individual family mental-health related issues or child concerns such as behavioral issues, or to (3) individuals or families about mental-health related issues.

For PAT enhancements, LAUNCH early childhood mental health consultants made provider consultations, went on home visits with PAT Educators for family consultations or met with individual families. PAT provider consultation topics focused on child behavioral issues, family mental health-related concerns such as relational issues, or mental health topics such as child developmental milestones for social-emotional or behavioral health. These enhancements allowed the PAT staff and LAUNCH consultants to address any child or family mental health issues or make referrals to appropriate community resources.

For MMHHVP enhancements, trained Project LAUNCH maternal mental health consultants provided consultations to providers about their practice or about family-related issues or to individual families. In the Nurse Family Partnership (NFP) Program, monthly case conferencing was provided as an enhancement by LAUNCH maternal mental health consultants. Consultation topics for providers focused on how to work with families to support healthy child development, strategies for family engagement, developmental milestones for socioemotional and behavioral health, appropriate referral and treatment options, maternal stress, attachment/bonding, depression or trauma-related issues, community mental health resources and other issues. The LAUNCH maternal



mental health consultants also accompanied providers on family home visits or met with individual mothers for maternal mental health consultations. Annual provider surveys with self-reported reflections indicated that a large benefit of the consultations was reduced NFP staff stress. Additional expertise, resources or support were provided by the consultants for addressing client-related concerns. The NFP coordinator reported that the consultation “increased support for home visitors working with mothers and their infants and toddlers who have mental health issues that takes pressure off the nurse home visitors.”

In the MMHHVP, maternal depression screenings were conducted. Maternal depression is a risk factor for socioemotional and cognitive development of children (Canadian Paediatric Society, 2004) and can impact the health of both mothers and their children. In the MMHHVP, the Edinburgh Postnatal Depression Scale (EPDS) was used to assess maternal depression and was administered by a maternal mental health consultant or trained early childhood mental health consultant to 71 women enrolled in the Weld Systems Navigation Project. EPDS scores can range from 0 to 30 across 10 items. An EPDS score of 10 or higher indicates possible depression, and a score of 14 or higher indicates likely depressive illness (Cox, Holden, & Sagovsky, 1987; Wisner, Parry, & Piontek, 2002).

**Results:** By the end of Year 5 of the project, 88 children and parents had participated in the two-year PAT program and had received monthly home visits. Parents’ self-reported outcomes (Years 4 and 5) included: (1) high confidence in parenting practices, (2) healthy parenting practices, (3) high reading activities, and 4) their perception that the PAT educators were very knowledgeable and performed well in their role. On the annual provider survey each year, PAT educators consistently self-reported improvement in four domains, including increased: (1) knowledge of children’s socioemotional and behavioral health and development, (2) knowledge of the available options for follow-up services for children with mental or behavioral health issues, (3) use of mental health consultation for children with mental or behavioral health issues, and (4) use of screening and/or assessment of children in the work setting.

#### PAT Educator Feedback

*“My knowledge in child development has increased, and the training/supervision that I received better prepared me for the position I am in now.”*

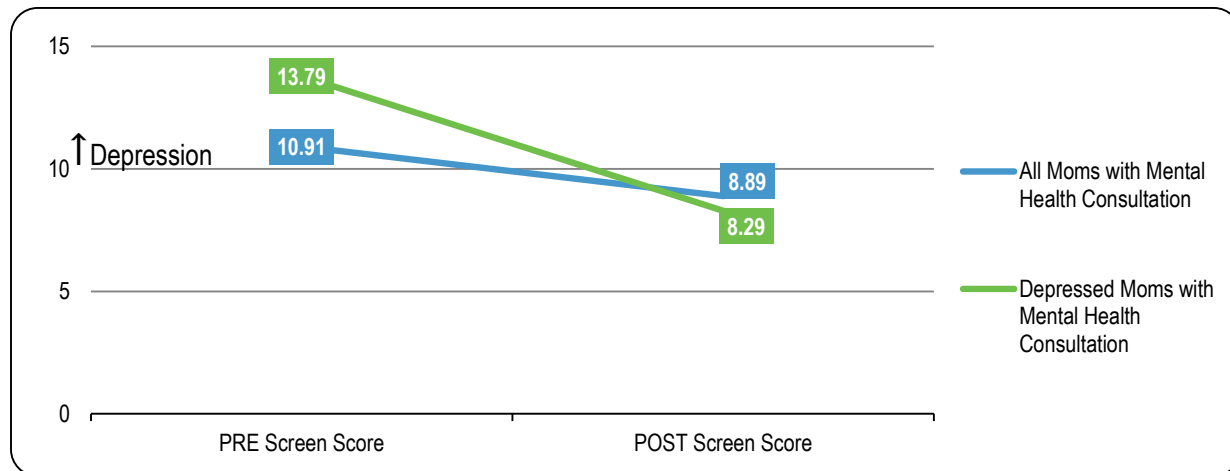
*“I am able to provide better quality information for families that have children under the age of 3.”*

*“I understand that families who have higher ACE (Adverse Childhood Experiences) scores are in need of more frequent Parent as Teacher home visits. It takes more direct contact to reach the goals of those families with lower scores.”*

Results from mothers in the MMHHVP who completed the EPDS prescale and postscale measure ( $N = 22$ ) and participated in maternal mental health consultation during the five-year project indicated a significant decrease in depression scale scores from a mean baseline value of 10.91 (possible depression) to a mean post value of 8.89 ( $t = 1.22$ ,  $df = 21$ ,  $p = 0.236$ ) as shown in Exhibit

5-2. Furthermore, 14 mothers who had initial EPDS scores indicative of clinical depression had EPDS scores that significantly declined from a baseline of 13.79 to a postmean value of 8.29 ( $t = 3.614, df = 13, p = .003$ ; Weld Project Maternal Mental Health Home Visiting Program, 2015).

**Exhibit 5-2: Project LAUNCH—Weld County Systems Navigation Project Maternal Mental Health Consultation: Maternal Depression Score Changes ( $N = 22$  All Mothers,  $N = 14$  Mothers With Clinically Depressed Scores)**



On the annual provider survey, LAUNCH maternal mental health consultants consistently self-reported increased: (1) knowledge of children’s socioemotional and behavioral health and development; (2) knowledge of the available options for follow-up services for children with mental or behavioral health issues; (3) use of mental health consultation for children with mental or behavioral health issues; and (4) use of screening and/or assessment of children in the work setting. They also reported positive changes in practice, such as increased family engagement and greater focus on the parent-child relationship, due to staff training and reflective supervision.

**Maternal Mental Health Consultant Reflection**

A maternal mental health consultant stated she had learned the importance of:  
*“Increased focus on the parent-child relationship. Confidence in home visitation and consultations with parents and infants.”*

## Grantee Spotlight: Multnomah Project LAUNCH Mental Health Consultation and EC PBIS in Home Visiting

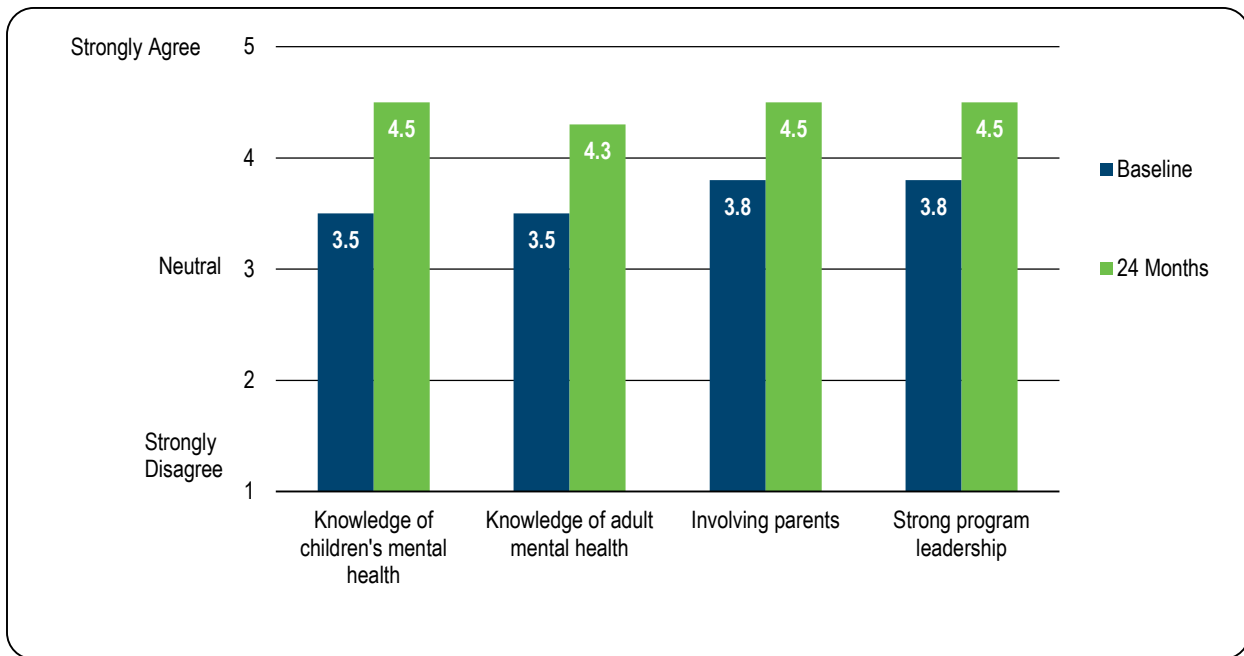
Multnomah Project LAUNCH is an early childhood wellness promotion and prevention project located in Multnomah County, Oregon, and encompasses the state’s largest city, Portland. Multnomah County is Oregon’s most diverse county, with 20% of the state’s population, 25% of the state’s persons of color, and 27% of the state’s immigrants and refugees (U.S. Census Bureau, 2014). Of families who completed risk surveys and participated in Healthy Families Oregon, a Healthy Families America (HFA)-accredited, home visiting program in Multnomah County, 71% were assessed as experiencing high stress, 32% reported substance abuse, and 29% reported mental illness (Green, Tarte, Aborn, & Croome, 2015).

**Overview:** Multnomah Project LAUNCH brought early childhood mental health consultation and EC PBIS to an HFA-accredited, evidence-based home visiting program for families with infants and young children at risk for child maltreatment and other adverse childhood experiences. The goals of bringing early childhood mental health consultation and EC PBIS to the home visiting team were to strengthen the home visiting program and staff capacity to work with high-risk families; increase home visitors’ job satisfaction and reduce job stress; and, ultimately, to improve the quality and strength of parent-child relationships.

Each mental health consultant, working an average of 16 hours per week, served a team of two supervisors and 12 home visitors. Each home visitor carried a caseload of approximately 15 families and served 490 families overall in the first 3.5 years of the project (October 2011–February 2015). The mental health consultant provided individual and group consultation and training; offered EC PBIS and other materials, resources, and tools; observed families on home visits; coached home visitors and supervisors; provided time-limited direct services with families; facilitated parenting groups; and participated in her own ongoing reflective group and individual supervision with mental health consultant colleagues and her supervisor.

**Results:** Home visitors completed surveys at baseline, 6 months, 12 months, and annually thereafter. A total of 12 home visitors had a 24-month follow-up post baseline. At the 24-month follow-up, home visitors reported significant increases in four domains: (1) feeling knowledgeable about children’s mental health; (2) feeling knowledgeable about adult mental health; (3) being able to involve parents as partners; and (4) experiencing strong program leadership. Similar results were seen after a year of consultation as well. These results are presented in Exhibit 5-3.

**Exhibit 5-3: Multnomah Project LAUNCH: Home Visitor Staff Survey Change in Selected Domains at 24 months (N = 12)**



Although home visitors did not report a significant difference in average ratings of work-related stress over this time period, home visitors shared feedback in focus groups suggesting that the mental health consultant has supported them in this area, resulting in decreases in both job-related stress and overall stress.

**Home Visitor Feedback on Reflective Group Supervision**

*"[Reflective group supervision] is a safe place to get feelings out. We establish ground rules with each other.... When I feel stuck with a family, it helps me feel less isolated. The team adds to my professional development and I feel rejuvenated to continue services with a family. And the self-care techniques—we get to practice them ourselves and then model them for families."*

Home visitors also described the value of mental health consultation and early childhood positive behavior interventions and supports in their work with families.

**Home Visitor Feedback on EC PBIS**

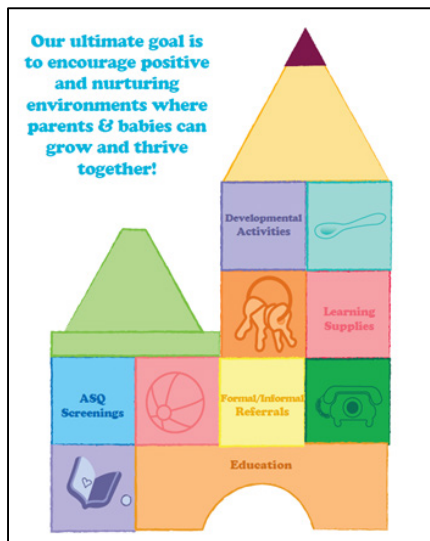
*"If I get the sense that a family is working hard at developing care routines or being consistent, EC PBIS really breaks down the steps for options families can try, like with a sleep routine. It's like another ingredient to our work."*

## Grantee Spotlight: El Paso Project LAUNCH

El Paso Project LAUNCH serves children and families living in the El Paso, Texas, neighborhoods of South Central and Chihuahuita, located directly on the United States–Mexico border. The target neighborhoods are considered to be medically underserved and are designated as mental health shortage areas. As with most border communities, the area faces challenges not present in other U.S. communities, including higher rates of poverty; lower educational attainment; higher rates of migration; higher uninsured rates; and lower ratio of health workers per capita. Additionally, families living in these areas face unique challenges that contribute to the unmet emotional and behavioral needs of children and young adults, including the influx of immigrants that have fled the cartel violence in neighboring Juarez, Mexico. Many of these immigrants have experienced violence and trauma that have not been adequately addressed.

**Overview:** To address the lack of culturally responsive home visiting programs in the community, El Paso Project LAUNCH developed and piloted a home visiting program, Healthy Babies-Healthy Families (Exhibit 5-4), using a community health worker, also known as a promotora. The Healthy Babies-Healthy Families program is an in-home parent education program that guides new parents through the first three years of their baby’s life. The program educates and supports parents to develop nurturing relationships with their children to support physical and emotional health and developmental growth. The program offers home safety checks, screenings for children and parents, and referrals and linkages to a wide range of family services. The program enrolled 23 families with children of up to 3 years of age in long-term services.

### Exhibit 5-4: Healthy Babies-Healthy Families Program Image



Parent outcomes for the home visiting strategy were measured using a pre/post design and the parent Protective Factor Scale (Institute for Educational Research and Public Service, 2008). The parent presurvey was administered during the second home visit, and the postsurvey was administered annually after enrollment. Data collected on the Protective Factor Survey was analyzed using both frequency and descriptive analysis. Percent change between presurveys and postsurveys and effect sizes were calculated on the primary risk and protective factors.

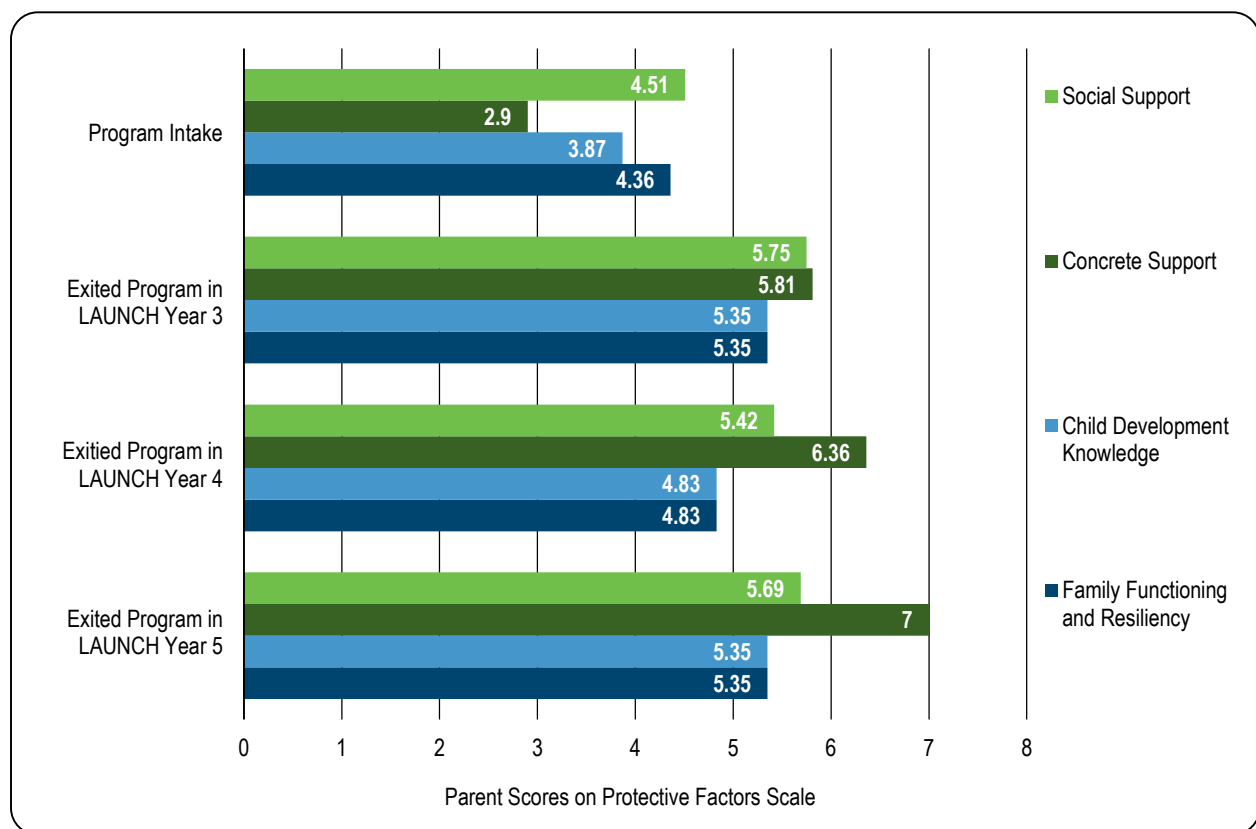
**Results:** The use of the Protective Factors Scale identified increases for parents enrolled in long-term services in the areas described below (Exhibit 5-5):

- 1) Family functioning and resiliency: 23% mean increase, from intake to program exit year, of the number of adaptive skills and strategies present that allow an individual to persevere in times of crisis.



- 2) Social-emotional support: 26% mean increase, from intake to program exit, of the amount of perceived informal support (from family, friends, and neighbors) to provide for emotional needs.
- 3) Concrete support: 141% mean increase, from intake to program exit, of perceived access to tangible goods and services that are needed for families to cope with stress, particularly in times of crisis or intensified need.
- 4) Child development/knowledge of parenting: 38% mean increase, from intake to program exit, in parent understanding and use of effective child management techniques and ability to have age-appropriate expectations for children’s abilities.
- 5) Nurturing and attachment: 7% mean increase, from intake to program exit, in the degree of parent understanding of the importance of emotional ties between parent and child and frequency of positive interactions between the parent and child over time.
- 6) Additionally, approximately 38% of parents in the program who were not previously in school, enrolled in school, GED, and/or vocational training during the course of receiving home visitation services.

**Exhibit 5-5: El Paso Project LAUNCH: Parent Protective Factors Scale Mean Ratings (N = 23)**



### A Parent's Perspective

*“Do you believe in destiny? Well I do because I think it was destiny that allow[ed] me to meet [home visitor]. The visits [we had] every week—at the beginning I felt a little shy—but little by little I started to feel more comfortable, to the point that [home visitor] started helping me not only to create a better relationship with [my son], my baby, and [the target child in the program], but with the whole family.... Her presentations have been always pleasant and dynamic and little by little, I have learned a lot of things about my children, things such as their feelings.... Learning about my family had help[ed] me to learn about myself.”*

## Lessons Learned, Opportunities, and Conclusions

Cohort 3 grantees implemented a range of enhancements to home visiting programs resulting in positive changes in home visitor and parent educator knowledge and practice, increases in child and family referrals, increases in parent protective factors, and high parent service satisfaction.

Several key lessons were learned through the implementation process. These included the need to devote significant time for building relationships among mental health consultants, home visitors, and families in order to establish trust to work together. Secondly, there is a need for devoting time to clarify the role of the mental health consultant and to identify the additional benefits that mental health consultation can bring to staff and families within home visiting programs. Finally, the importance of working with communities to develop culturally and linguistically responsive home visiting programs is essential.

Based on the experiences of Cohort 3 LAUNCH grantees regarding the use of enhanced home visiting strategies, it is recommended that communities striving to build or strengthen home visiting programs or systems continue to identify gaps in early childhood services to increase families’ access to culturally responsive home visiting programs; work across initiatives and funding sources to bring additional mental health consultation services to augment existing home visiting programs; and continue to build the evidence base of the impact of mental health consultation across a range of home visiting programs on child, family, provider, and program outcomes.

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## 6. Early Childhood Mental Health Consultation

There is mounting evidence that early childhood mental health consultation (ECMHC) is effective in promoting healthy social-emotional development and in preventing the onset of behavioral issues in children ages birth to 6 (Duran, Hepburn, Kaufmann, & Le, n.d.). Research studies support a direct correlation between ECMHC and positive social, emotional, and behavioral outcomes for children; a decrease in preschool expulsions; and improved readiness for kindergarten (Perry & Kaufmann, 2009). In addition, ECMHC has been shown to decrease early care and education (ECE) staff turnover, decrease job stress, and improve quality of care. Thus, ECMHC holds promise for addressing the increasing rates of problem behaviors and associated expulsions in ECE settings.

At its core, ECMHC is designed to prevent, identify, treat, and reduce the impact of childhood behavioral health issues by building collaborative relationships between consultants (or coaches) and caregivers in the child’s natural environment. The spectrum of ECMHC services ranging from promotion to intervention can be either child-centered (individualized) or program-centered (systemic), or both. Child-centered consultation can include observation, modeling, caregiver support, and referral to community resources. Programmatic consultation is typically focused on improving overall quality of care and can include staff training and support, team building, and creating supportive environments.

Several key characteristics distinguish ECMHC from other mental health models or services: a focus on ECE settings; an emphasis on collaboration and relationships; an indirect, capacity-building approach; and an evidence-based framework. Typically, ECMHC does not include therapeutic or diagnostic services, and any direct consultation provided is intended to enhance the skills and knowledge of the caregiver. It is important to note that unlike other models, ECMHC is based on a set of core principles rather than a prescribed curriculum and, as such, can be individualized according to the needs of programs, children, and families.

All Project LAUNCH Cohort 3 grantees worked with ECE providers in slightly different ways to implement ECMHC. Collectively, the grantees experienced several successes and challenges (Exhibit 6-1).

### Exhibit 6-1: Cohort 3 Successes, Challenges, and Opportunities in Early Childhood Mental Health Consultation

Cohort 3 Successes	Cohort 3 Challenges and Opportunities
<ul style="list-style-type: none"> <li>• Increased provider knowledge and competence</li> <li>• Early identification through screening and referral</li> <li>• Promotion of social-emotional wellness</li> <li>• Promotion of kindergarten readiness</li> <li>• Consultation extended to multiple sites</li> </ul>	<ul style="list-style-type: none"> <li>• Staff turnover rates negatively affect services</li> <li>• Scheduling conflicts on training dates</li> <li>• Data collection issues with timing and response rates</li> </ul>

New York City and Boone County (Missouri), in particular, chose different approaches to ECMHC in response to their widely diverse environments, both geographically and culturally. Exhibit 6-2 below compares and contrasts the main features of each project with detailed profiles that follow.

### Exhibit 6-2: Comparison of Early Childhood Mental Health Consultation Models: New York City and Boone County, Missouri

Grantee	Type of ECMHC	Target Population	Primary Intervention	Expected Outcomes
<b>Boone County</b>	Mostly programmatic	Rural child care providers; home-based providers	Coaching and training based on Pyramid Model	<p><i>Provider outcomes:</i> increased knowledge and competence; decreased stress</p> <p><i>Child outcomes:</i> increased social-emotional health</p>
<b>New York City</b>	Case-specific and programmatic	Urban; center-based Head Start and Child Care, children, and prekindergarten	Incredible Years Teacher training	<p><i>Teacher outcomes:</i> increased knowledge and use of effective practices for promoting social-emotional growth;</p> <p><i>Child outcomes:</i> improved social-emotional competencies and reduced problem behavior</p>

### Grantee Spotlight: Boone County Project LAUNCH

Boone County Project LAUNCH: Our mission is to develop an accessible, seamless early childhood system for all children, birth to age 8, in Boone County, Missouri. Our strategic goals include: promote the integration of ASQ® screening in primary and early care settings; promote timely and coordinated referral for early intervention services; promote knowledge of behavioral health integrations models in pediatric care; increase competence of early care professionals and decrease challenging behaviors in ECE settings; increase access to evidence-based home visitation services (Parents as Teachers); and increase access to evidence-based parent education programs such as Incredible Years.



**Overview:** Early Childhood Positive Behavior Support (EC-PBS) was collaboratively developed by local agencies in response to an identified need for supporting Boone County early childhood professionals in addressing and reducing challenging behaviors and developmental concerns in children ages 0–5. This need was especially evident in resource-constrained, isolated rural school districts and in home-based settings serving very young children where access to effective early intervention and prevention strategies is limited and expulsion rates remain high. EC-PBS offers a unique systems approach for implementing the research-based Positive Behavior Support (PBS; Dunlap et al., 2006) framework within a social-emotional context through program-wide training and behavioral consultation/coaching. Given the strong presence PBS has in school districts throughout Boone County, EC-PBS strengthens the preschool environment and promotes school readiness and successful transition to kindergarten.

EC-PBS coaching and training were designed to promote the use of problem-solving interventions to improve the ability of providers and others in the child’s natural environment to prevent and reduce challenging behaviors. EC-PBS also promotes early identification of developmental delays through standardized screening using the [Ages & Stages Questionnaires,® Third Edition](#) (ASQ-3™) and [Ages & Stages Questionnaires®: Social-Emotional](#) (ASQ:SE™). The benefits of regular and periodic screening in ECE settings are myriad: early detection of delays allows for timely intervention, ideally well before kindergarten; caregivers can use activities that strengthen a child’s skills; information/activities can be shared with parents to support development in the home environment; and screening data provide a common reference for parents, educators, primary care providers, and others (Developmental Screening in Early Childhood Systems, 2009).

Using EC-PBS, Boone County LAUNCH has worked with early childhood professionals in center, preschool, and home-based settings for nearly four years, refining and enhancing the model with each subsequent group of participants or cohorts. The current Cohort 4 consists of 12 geographically dispersed small- to medium-sized sites, six urban and six rural, receiving a minimum of two hours of classroom-based coaching per week from an assigned coach and technical assistance via phone or e-mail as needed. Coaching practice is supported through frequent communication among coaching staff and monthly reflective supervision. A coaching log is used to document the intervention and serves to standardize practice and methods across coaches. In addition to coaching, sites receive two to three EC-PBS training modules over the year-long project and training sessions on the standardized screening tools, ASQ-3™ and ASQ:SE™. To promote integration of screening into practice, sites receive ASQ® kits and ongoing support from a screening consultant.

The role of the EC-PBS coach is to create environments that support positive behaviors and to help implement strategies and practices that foster social-emotional wellness. The coach works with staff to build positive relationships with children, families, and peers while promoting collaboration. As shown in Exhibit 6-3, the majority of coaching time is spent teaching social-emotional strategies

followed by creating supportive environments and building relationships between staff and coach, as expected. Coaches most frequently use problem solving followed by observation and planning to teach strategies (Exhibit 6-4). The training method listed in Exhibit 6-4 refers to on-site activities only; day-long training modules are offered separately two to three times per year. Experience with EC-PBS has demonstrated that coaching frequency and duration (i.e., minimum of two contact hours per site per week) are important factors in maintaining program effectiveness.

**Exhibit 6-3: EC-PBS Coaching Practices, October 2013–August 2014**

Coaching Practice	Frequency (hrs.)	Percent
Social-Emotional Behavioral Strategies	282	70.0
Supportive Environments	259	64.3
Administrative Support	149	37.0
Collaborations/Teaming (staff, family, others)	31	7.7
Data Management	86	21.3
Quality Improvement	59	14.6
Building Relationships: Staff-Child	105	26.1
Building Relationships: Staff-Family	80	19.9
Building Relationships: Staff-Staff	78	19.4
Building Relationships: Staff-Coach	240	59.6

**Exhibit 6-4: EC-PBS Coaching Methods, October 2013–August 2014**

Coaching Method	Frequency (hrs.)	Percent
Teaching/Modeling/ Role Play	180	44.7
Observation	208	51.6
Problem Solving Discussion	268	66.5
Planning/Goal Setting	203	50.4
Providing Resources/Materials	103	25.6
Reflective Consultation	57	14.1
Data Collection/ Evaluation	88	21.8
Training	4	1.0
Team Meeting	25	6.2

**Results<sup>1</sup>:** Evaluating EC-PBS entailed defining systems-level outcomes such as the implementation of program-wide PBS principles and the promotion of early identification of developmental delays through ASQ<sup>®</sup> screening and referral. The Preschool-Wide Evaluation Tool (Pre-SET; Horner, Benedict, & Todd, 2005), specifically developed for ECE settings, was used to measure implementation. Early identification rates were assessed by collecting numbers of screens and referrals by provider and comparing results with prior years. At the provider level, the objectives were to increase knowledge of social-emotional health and development, increase job satisfaction and retention, and reduce job stress. The instrument used was the Teacher/Provider Survey. Social-emotional health in children ages 3 to 5 was measured using the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). In addition, numbers of expulsions were tracked for comparison with previous results and state and national rates.

Using the Pre-SET, 50% of sites were at or near full implementation of PBS principles postintervention in the fall of 2014. At least 75% of sites were expected to achieve full implementation by the fall of 2015. Regarding early identification of developmental delays, there has been an increase in numbers of ASQ<sup>TM</sup>-trained ECE staff and (anecdotally) in numbers of completed screens with the recent addition of an EC-PBS screening coach. Teacher and staff knowledge significantly increased by the fall of 2014, as measured by pre/post surveys, but no significant change in satisfaction, retention, or stress levels was noted. Fall 2015 analyses are expected to show positive changes in these areas. Likewise, no significant changes in social-emotional health were noted as measured by SDQ. Data analyses for fall of 2015 were expected to show positive changes in this area with implications for school readiness. From 2013–2014, approximately nine children were discharged from EC-PBS sites due to problem behaviors; this is roughly equivalent to a 3% expulsion rate, which compares favorably with prior EC-PBS and state-level tables.

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<sup>1</sup> 2015 follow-up data not finalized at time of publication; findings based on 2014 analyses.

## Grantee Spotlight: New York City Project LAUNCH

Through the New York City Department of Health and Mental Hygiene, New York City (NYC) Project LAUNCH works to expand and strengthen programs and services for children and their families city-wide, with a particular focus in two of New York’s highest need communities: Hunts Point (Bronx) and East Harlem (Manhattan). NYC Project LAUNCH promotes the social and emotional well-being of children ages birth to 8 by improving collaboration between young child wellness systems; developing the workforce to increase their understanding of child development; providing support, education, and training to increase the use of positive parenting practices and to improve parent-child relationships; and guiding the transformation of public policy and funding.

**Overview:** In Harlem and the South Bronx, NYC Project LAUNCH implemented two early care and education strategies at select sites over the course of each academic year: (1) training for teachers with the Incredible Years model (Webster-Stratton, Reid, & Stoolmiller, 2008), delivered in six day-long sessions spread out across the fall and spring, and (2) early childhood mental health consultation to teachers one day per week at each site to implement programmatic and case-specific Incredible Years strategies. Incredible Years teacher training aimed to build teachers’ skills in using practices that promote positive social-emotional growth and address children’s challenging behavior. During weekly classroom visits, the early childhood mental health consultants helped teachers use these practices by providing observation and feedback, modeling, and guidance on addressing the needs of individual children. In addition, mental health consultants conducted parent workshops at ECE sites receiving their consultation services.

By the end of the 2014–2015 academic year, 10 sites—3 in the South Bronx and 7 in Harlem—had implemented the early care and education strategies. One site was located within a public school and the others in community settings. A limited number of sites received two years of support, with different classrooms and teachers participating each year. All sites were publically funded and included Head Start, prekindergarten, and child care programs. Across the sites, 80 teachers and teaching assistants in 33 classrooms with 457 4-year-olds received the intervention.

**Results:** NYC Project LAUNCH evaluation of Incredible Years and mental health consultation in early care and education examined teacher outcomes and child outcomes for 61 teachers and teaching aides and 395 children whose parents consented and participated in fall and spring data collection of each academic year between 2011 and 2015. The evaluation data included evaluators’ classroom observation (*Supports for Social-Emotional Growth Assessment: SSEGA; Smith, 2007*), in-person interviews with teachers, self-administered surveys of teachers on changes in knowledge and practices, and teachers’ assessments of children using the Devereux Early Childhood Assessment (DECA; Naglieri, LeBuffe, & Pfeiffer, 1995).

Teachers showed an increase in their knowledge of effective practices for promoting children’s social and emotional growth and an increase in their use of these practices in classrooms. From the

fall to the spring, teachers became better able to identify effective strategies for addressing children’s challenging behavior and promoting social-emotional growth in children. Teachers were also less likely to identify negative strategies such as threats or punishment. Teachers were interviewed in the fall and spring regarding how they would respond with effective strategies for common classroom scenarios in vignettes. Responses were coded to evaluate positive and negative strategies, and improvement from fall to spring was evident. Compared to their fall responses, teachers’ spring responses showed more “mostly or all positive strategies” (such as help child understand others’ intentions, labels, and talks about feelings) and a complete elimination of “negative strategies” (such as criticism of child and threat of punishment).

Teachers self-reported improvements in their knowledge and practice based on the SAMHSA Multisite Survey.

**Teacher Feedback on Change of Knowledge and Practice**

*“[I have an] improved technique working with children. [I] learned how to be patient and calm.”*

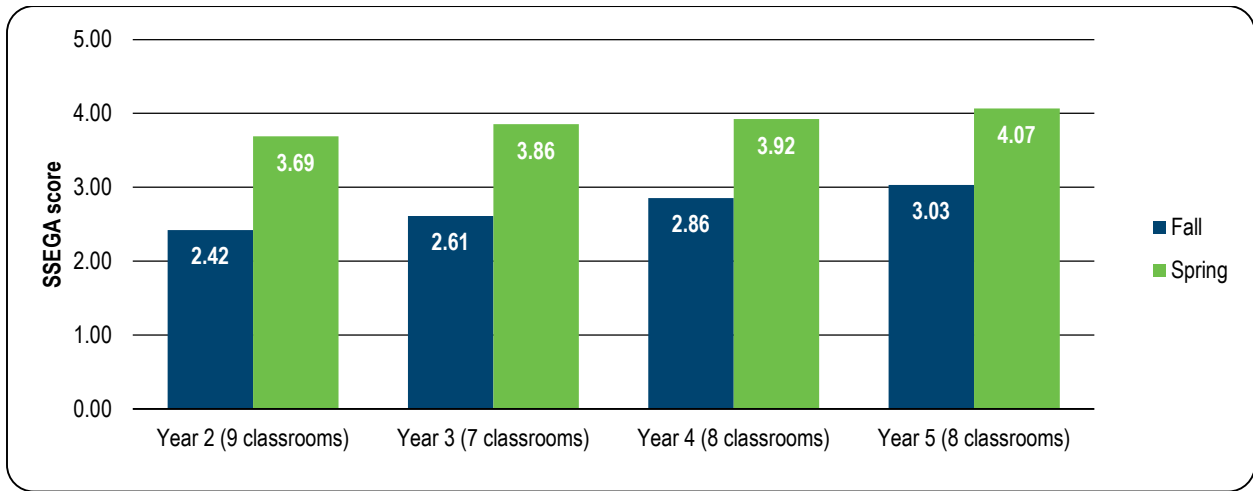
*“[I] gained more knowledge in managing children more carefully, evaluating children, identify[ing] the issues, and services to provide.”*

From the fall to the spring, teachers increased their use of classroom practices that promote a supportive teacher-child relationship and social-emotional competencies. This improvement was demonstrated in improved ratings on the observation-based *Supports for Social-Emotional Growth Assessment* (SSEGA; Smith, 2007), administered in each classroom in the fall and spring (Exhibit 6-5). The SSEGA documents the extent to which teachers use effective social-emotional teaching strategies such as modeling positive social behavior, helping children understand and manage their emotions, and supporting children’s positive interactions with peers.

Children showed improved social-emotional competencies and reduced problem behavior. In the analysis of cumulative fall to spring results for Years 2–5, the percent of children who showed strong social-emotional skills increased (Exhibit 6-6). This positive improvement was seen in total scores and subscale scores of the DECA, which was completed by teachers in the fall and spring (Naglieri et al., 1995). There was significant improvement in subscale scores assessing children’s attachment to adults, initiative, and self-control. There was a slight increase in the percent of children with low DECA scores indicating that developmental risk was found. In East Harlem only, there was a significant decrease in the percent of children showing behavior problems on DECA assessments.

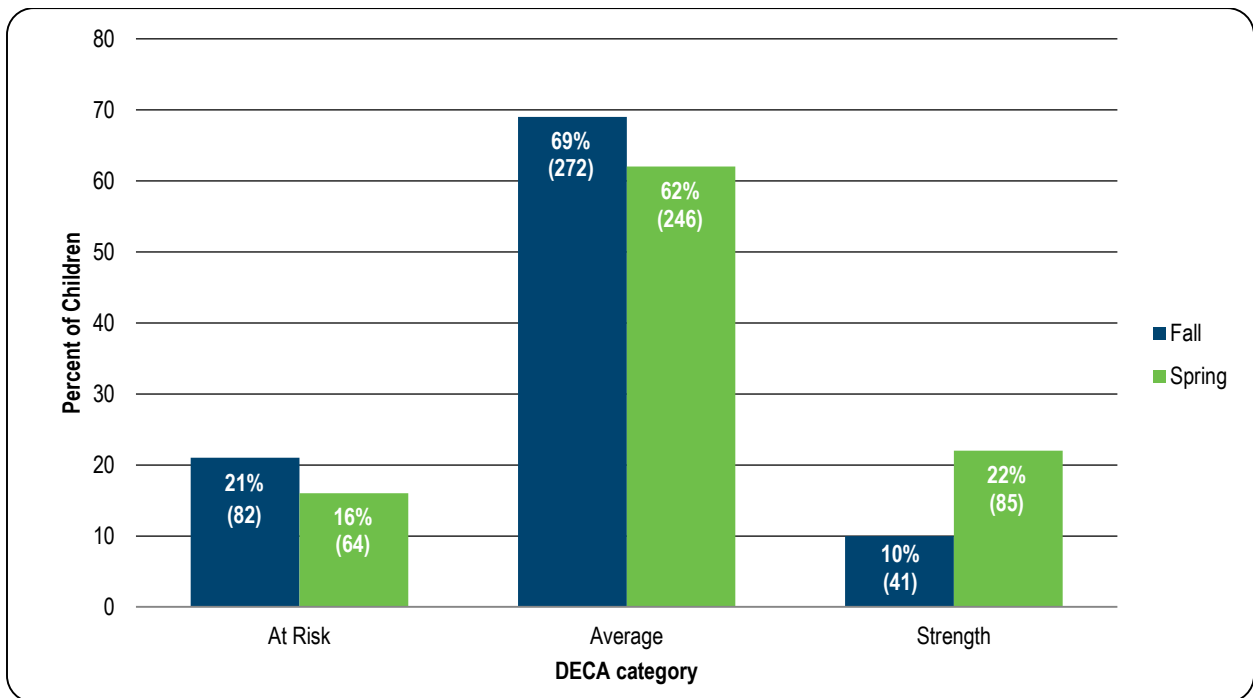


**Exhibit 6-5: Teachers’ Supports for Social-Emotional Growth in the Classroom From Fall to Spring (N = 32), Years 2–5**



Note: All changes are statistically significant at  $p < .05$ .

**Exhibit 6-6: Changes in Protective Factors Among Children (DECA) from Fall to Spring (N = 395), Years 2–5**



Note: All changes are statistically significant at  $p < .05$ .

Children and teachers benefitted from the delivery of Incredible Years teacher training and ECMH consultation to preschool programs in the South Bronx and Harlem. A major strength of the intervention was the high-quality delivery of an evidence-based teacher training model in combination with ongoing consultation that supported teachers’ use of the training they received. In

the survey, teachers reported that they valued and enjoyed both the group training and consultation. Implementation of the Incredible Years model and consultation also posed challenges, including coordination of training schedules and teacher turnover, with the potential to impact consistency of strategy use in the classroom and, therefore, children’s social-emotional learning. Finally, the model is costly, making it challenging to expand or sustain.

The NYC Project LAUNCH strategy for early care and education programs demonstrated promise as a model that should be implemented on a wider scale. With certain enhancements, such as an increase in available training days and expanded supports for helping children with challenging behavior, this intervention could promote the school readiness and social-emotional well-being of the city’s most vulnerable children.

## Lessons Learned, Opportunities, and Conclusions

There is promising evidence that ECMHC programs such as EC-PBS promote social-emotional wellness in young children as well as enhance the skills and knowledge base of the ECE workforce. These programs are by nature long-term investments and must be implemented with a high degree of fidelity. Consequently, they are resource intensive, requiring both a pool of well-trained early childhood mental health professionals to serve as coaches and adequate funding to sustain services over time. Boone County Project LAUNCH has been fortunate enough to secure local funding to continue EC-PBS over the next few years, but its long-term future remains uncertain. It is critically important for legislators to understand the social and economic benefits that can accrue from creating public funding structures that support ECMHC services in all communities.

Additional recommendations for early childhood programs interested in expanding and strengthening ECMHC in ECE settings include:

- 1) Identify sources of public funding for an expansion of Incredible Years teacher training and ECMH consultation in early care and education programs in high-needs communities; possible sources include quality set-aside funds in the federal Child Care Development Block Grant; Mental Health Block Grant, Title 1 Funds; and other local and state funds;
- 2) Design and fund a plan for wide-scale implementation to allow teacher training for each Incredible Years session on multiple days and make-up trainings to ensure high levels of teacher participation in training;
- 3) Develop formal guidelines and standardized training for early childhood mental health consultants that incorporate research-based methods for addressing children’s challenging behavior and assessing progress on a regular basis;



- 4) Ensure that early childhood mental health consultants have sufficient time and resources to provide parents with guidance on providing supports for children's social-emotional growth in the home setting;
- 5) Incorporate funding for teacher release time from the classroom into project budgets; this funding is critical to ensure teacher attendance in networking and education opportunities; and
- 6) Implement strategies to encourage participation of other organizations, such as public school districts, which are sensitive to the challenges and limitations of partner organizations; coordination across systems requires working in partnership and long-term commitment to building quality relationships.

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## 7. Family Strengthening and Parent Skills Training

Families matter. Investment in parents and young children through evidence-based and promising family strengthening programs and practices yields impressive short- and long-term dividends for families (O’Neill, McGilloway, & Donnelly, 2010). When implemented with fidelity to the training model, the family strengthening or parent skills approach can help:

- enhance the relationship between the parent and the child (Hoffman, Marvin, Cooper, & Powell, 2006);
- improve parenting skills (O’Neill et al., 2010);
- enhance school readiness (O’Neill et al., 2010);
- reduce parental, maternal, or family stress (Lavi, Gard, Hagan, Van Horn, & Lieberman, 2015; Thomas & Zimmer-Gembeck, 2012);
- reduce child challenging behaviors (O’Neill et al., 2010); and
- provide supports to families (Thomas & Zimmer-Gembeck, 2012).

Family strengthening and parent skills training is one of the core strategies of Project LAUNCH. The goal of this strategy is to help families create healthy environments for their children. This strategy includes an array of evidence-based and promising programs and approaches that support the socioemotional health of young children. Programs and strategies utilized in the Project LAUNCH Cohort 3 included:

- 211info Family, Multnomah Project LAUNCH;
- Child-Parent Psychotherapy— Project LAUNCH Weld Systems Navigation Project (Lavi et al., 2015; Lieberman, Van Horn, & Ghosh Ippen, 2005; Substance Abuse and Mental Health Services Administration, 2010);
- Circle of Security Parenting Program, Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH and New York City Project LAUNCH ([Circle of Security International™](#), n.d.; Cooper, Hoffman, Powell, & Marvin, 2005; Hoffman et al., 2006);
- [Incredible Years® Series and Children’s Small Group \(Dina Dinosaur\) Therapy Program](#), Multnomah Project LAUNCH; Project LAUNCH—Weld Systems Navigation Project;
- [Parent-Child Interaction Therapy \(PCIT\)](#), Project LAUNCH —Weld Systems Navigation Project (Troutman, Moran, Pelzel, Luze, & Lindgren, 2011);



- [Positive Solutions Groups \(The Pyramid Model for supporting social-emotional competence in infants and young children\)](#), Project LAUNCH—Weld Systems Navigation Project;
- [Trauma-Focused Cognitive Behavior Therapy \(TF-CBT\)](#), Project LAUNCH —Weld Systems Navigation Project; and
- System Navigation Services, Project LAUNCH—Weld Systems Navigation Project.

Every Cohort 3 grantee experienced success in strengthening families. Outcomes included implementation of models that were culturally and linguistically appropriate, high family participation in evidence-based family strengthening and parenting skills practices, and increased family protective factors. The grantees embraced challenges such as program logistics as opportunities to provide services that promoted family involvement. Examples of evidence-based and promising approaches for family strengthening and parent skills training are presented below for Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH (Circle of Security Parenting Program [COS-P]), the Project LAUNCH —Weld Systems Navigation Project (PCIT and System Navigation Service) and Multnomah Project LAUNCH (211info Family). Cohort 3 successes and challenges and opportunities are documented in Exhibit 7-1.

**Exhibit 7-1: Cohort 3 Successes, Challenges, and Opportunities in Family Strengthening & Parent Skills Training**

Cohort 3 Successes	Cohort 3 Challenges and Opportunities
<ul style="list-style-type: none"> <li>● Culturally and linguistically appropriate evidence-based models</li> <li>● High family participation</li> <li>● Increased parenting and/or child development knowledge for families</li> <li>● Reduced parental stress</li> <li>● Families empowered by system navigation services (intense case management) for families with multiple needs across systems</li> <li>● Decreased family risk factors and increased family protective factors</li> <li>● Obtained private funding for evidence-based practices</li> </ul>	<ul style="list-style-type: none"> <li>● Meeting logistics challenges (e.g., meeting space, scheduling classes for parents who missed sessions, separate classes for foster parents or with Department of Family Corrections) can promote targeted services for families</li> <li>● Funding for nonreimbursable prevention services</li> <li>● Need for trained male facilitators</li> <li>● Program sustainability must include administrative and program implementation costs</li> </ul>

## Grantee Spotlight: Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH

Wheeler Clinic’s program strives to improve and expand services and systems for children ages 0–8 in New Britain, Connecticut. New Britain is a diverse, midsized city with a population of 73,000. In New Britain, 31.6% of children live in poverty, more than 50% of children entering kindergarten are overweight or obese, 41.7% of mothers receive inadequate prenatal care, and a significant number of children are substantiated for abuse and neglect (The Connecticut Home Visiting Needs Assessment Group, 2010).



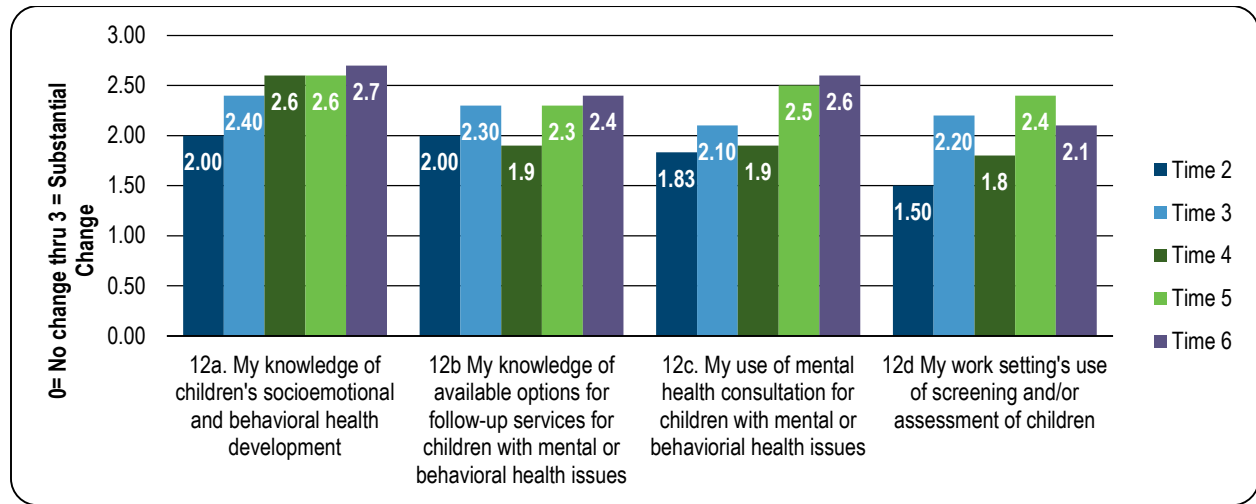
**Overview:** Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH implemented the Circle of Security-Parenting (COS-P) early intervention program to promote family strengthening. COS-P is a research-informed model to enhance secure attachment between parents (caregivers of) and children from birth to 5 years (Powell et al., 2014; Zeanah, Berlin, & Boris, 2011). Research shows parent depression can increase risk for adverse social-emotional development and lower rates of secure attachment (Goodman & Brand, 2009). COS-P uses video technology to improve parenting skills and promote infant-parent attachment through facilitated groups or with individual families in the context of home visiting services. Of the 75 providers who participated in an overview training on the COS-P model, more than 50 went on to become trained facilitators of COS-P groups. More than 230 parents/caregivers participated in the intervention during the 5-year grant period. Minor modifications to the COS-P model in New Britain included decreasing the number of sessions from eight weeks to six by combining chapters and adapting the model for use in home visiting sessions with Spanish-speaking families using simultaneous translation by a bilingual family member.

**Results:** Data from the preassessments and postassessments collected through Year 5 consistently show that providers (Exhibit 7-2) and parents (Exhibit 7-3) increased in knowledge and gained experience in key early childhood competencies after exposure to COS-P training and practices.

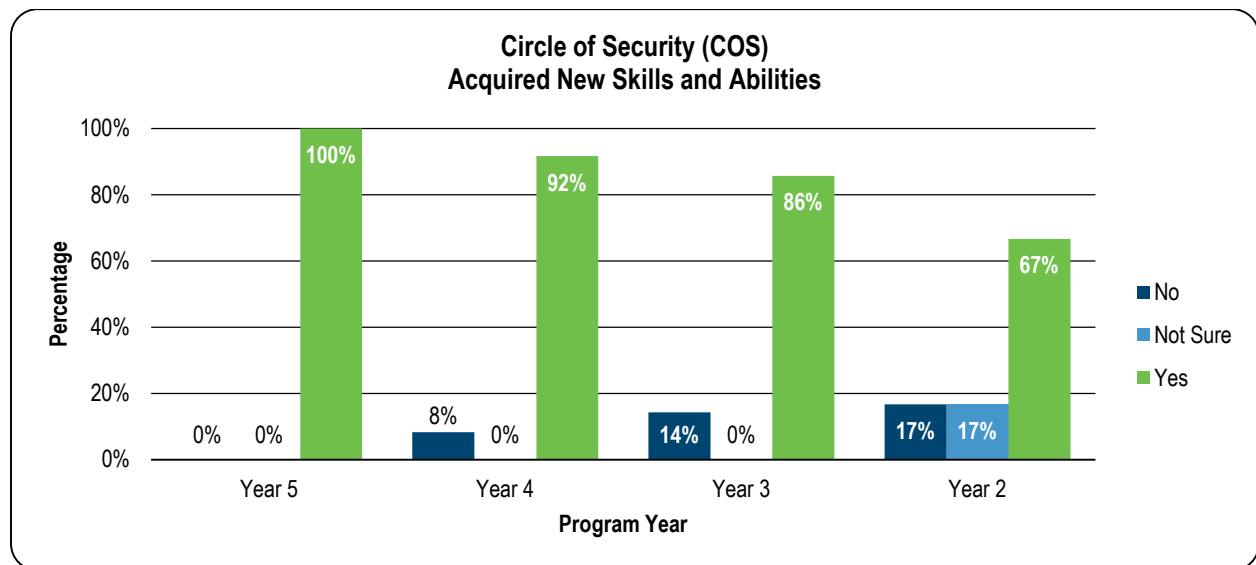
### Parent Participant Feedback

*“I didn’t know how to be a parent until I looked at this road map for how to be emotionally available for my child and how to read my child’s emotional cues.”*

**Exhibit 7-2: Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH: Provider Change as a Result of COS-P Training**



**Exhibit 7-3: Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH: Parent Change as a Result of COS-P Intervention**



New York City Project LAUNCH evaluators developed a Circle of Security fidelity measure that was implemented by Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH in Year 3 to track fidelity to the model among trained providers. Results indicate that facilitators maintained high fidelity ( $M = 4.36$  and  $4.14/5.0$ ) to the intervention model while practicing the specific itemized activities related to group facilitation, even with stated adaptations. Program staff maintained close contact with model developers to monitor fidelity of implementation and foster sustainability throughout the grant period. Through these various activities and efforts, COS-P training will be sustained and the program is expected to continue to expand throughout the state of Connecticut.

## Grantee Spotlight: New York City Project LAUNCH

Through the New York City Department of Health and Mental Hygiene (Health Department), New York City (NYC) Project LAUNCH works to expand and strengthen programs and services for children and their families citywide, with a particular focus in two of New York’s highest need communities: Hunts Point (Bronx) and East Harlem (Manhattan). NYC Project LAUNCH promotes the social and emotional well-being of children from birth to 8 years of age by improving collaboration between young child wellness systems; developing the workforce to increase their understanding of child development; providing support, education, and training to increase the use of positive parenting practices and to improve parent-child relationships; and guiding the transformation of public policy and funding.

**Overview:** Through NYC Project LAUNCH, family advocates from the New York City Health Department funded Family Resources Centers (FRCs) that implemented the evidence-informed relationship-based early childhood parenting program, Circle of Security-Parenting (COS-P), in Harlem and the South Bronx. NYC Project LAUNCH led citywide workforce development in the COS-P model and successfully secured funding for expanded training and implementation.

In 2013, NYC Project LAUNCH held a workforce training lead by Circle of Security International for family advocates from FRCs to become registered parent educators (RPEs) in the COS-P model. The training was initiated for LAUNCH communities, but in an effort to leverage the opportunity and expand COS-P beyond grant communities, 50 family advocates, supervising staff, and support staff from all nine FRCs in New York City were also trained. As a result of NYC Project LAUNCH successes with COS-P and increased interest from leadership, the Health Department supported additional workforce development, as shown in Exhibit 7-4, to further expand capacity for COS-P beyond LAUNCH communities to reach families across the city.

**Exhibit 7-4: Circle of Security Parenting Program Workforce Development in NYC, April 2013–March 2015**

Training Date	April/May 2013	June 2014	March 2015
<b>RPEs</b>	50 Trained	63 Trained <sup>a</sup>	25 Trained
<b>Funding</b>	LAUNCH	Health Department	Health Department
<b>Workforce Trained</b>	LAUNCH and FRC family advocates and supporting staff	FRCs, Administration for Children’s Services Preventive Services, and other providers	Parent coaches from District Public Health Office neighborhoods in Harlem and Brooklyn

<sup>a</sup> Plus 22 additional participants registered from public and paid own tuition

From the initial training through 2015, NYC Project LAUNCH implemented 34 cycles of COS-P in the South Bronx and Harlem, with graduation rates increasing from 65% in Year 4 to 77% in Year 5 as engagement strategies were refined. During each quarter, family advocates in each neighborhood provided sessions in both English and Spanish. The project also developed a COS-P implementation

toolkit—including outreach and engagement logs—and provided family-friendly incentives such as child care, Metrocards for transportation, food, and children’s books to support family engagement. Family advocates conducted outreach directly to parents at community events, as well as through community partners, and held classes in community settings such as WIC and Head Start programs.

**Results:** NYC Project LAUNCH evaluation examined the impact of the COS-P parenting program on parent depression, parent-child relationships, and family well-being. During the evaluation period (July 2013 to May 2015), 269 parents/caregivers enrolled in LAUNCH-supported COS-P classes and 189 graduated by attending six or more classes. Of the enrolled parents/caregivers, 170 consented to participate in this study; 117 completed measures of study outcomes at two time points, the beginning and end of the 8-session COS-P; and 110 participants with two data points graduated from the classes, indicating that they received a sufficient dosage of the intervention. Since COS-P was created specifically for parents with children between 0 and 5 years, analysis and results include only the 93 parent graduates who reported at least one child in this age range. Outcomes included self-reported measures looking at the impact of the program on parent and caregiver depression using the Patient Health Questionnaire-9 (PHQ-9; Kroenke & Spitzer, 2002), parent-child relationship quality using the Child-Parent Relationship Scale (Pianta, 1992), and parent knowledge of parenting/child development and nurturing and attachment using the Protective Factors Survey (Counts, Buffington, Chang-Rios, Rasmussen, & Preacher, 2010) at the beginning and end of the program. T-tests with paired samples assessed statistically significant changes in outcomes over time.

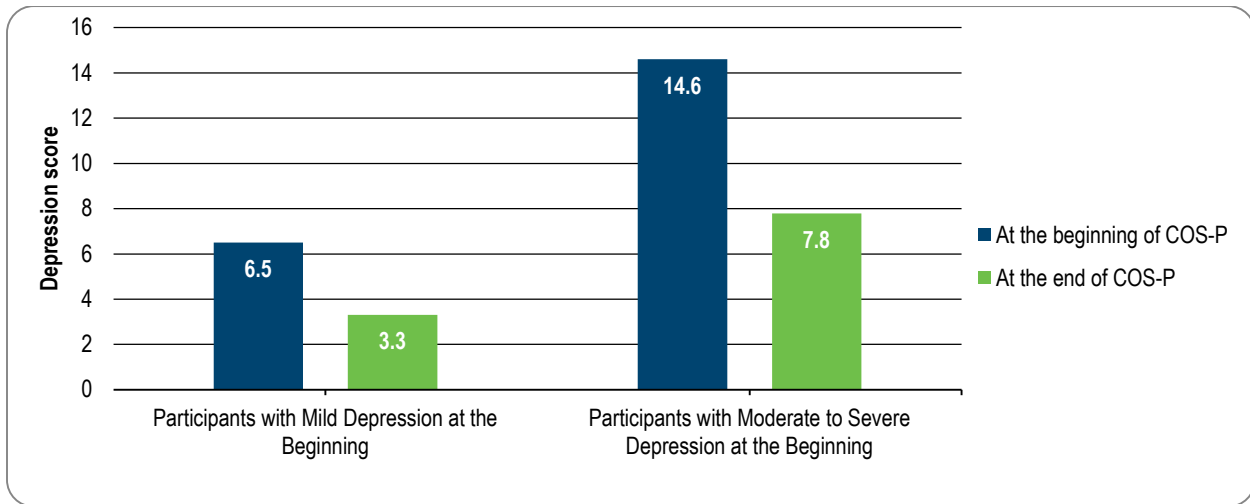
Among the diverse group of families in the evaluation, high percentages had limited income and education. The evaluation participants were predominantly female (79%), Latino (68%) or African American (19%), and low income (50% with annual household income below \$10,000 and 68% below \$20,000). In addition, 38% had not graduated from high school and 20% had high school diploma or equivalent as their highest level of education.

At the beginning and the end of the cycle, parents in COS-P were screened for depression using the PHQ-9 to understand baseline depression and to see if there were any changes in depression at the end of the program.<sup>2</sup> Among parents and caregivers with depression scores in the mild category at the beginning of COS-P (average mild depression: 6.5), there was a significant decrease in PHQ-9 score by 50%, reflecting less depression (average minimal depression: 3.3), by the end of COS-P. Furthermore, for participants with clinical depression at the beginning (PHQ-9 scores in moderate to severe categories; average moderate depression: 14.6), there was a significant decrease in depression scores by 47%, reflecting scores moving below clinical depression range (average mild depression: 7.8) at the end of COS-P (Exhibit 7-5).

<sup>2</sup> Each of the 10 items in the parent self-reported PHQ-9 questionnaire is rated from 0 to 3, and the total score ranges from 0 to 27 with “no to minimal depression (scored 0–4),” “mild depression (scored 5–9),” “moderate depression (10–14),” “moderately severe depression (scored 15–19),” and “severe depression (scored 20–27).”



**Exhibit 7-5: Change in Average Depression Score Among Participants With Mild ( $N = 16$ ) and Moderate to Severe ( $N = 14$ ) Scores From the Beginning and to the End of COS-P, May 2013–May 2015**



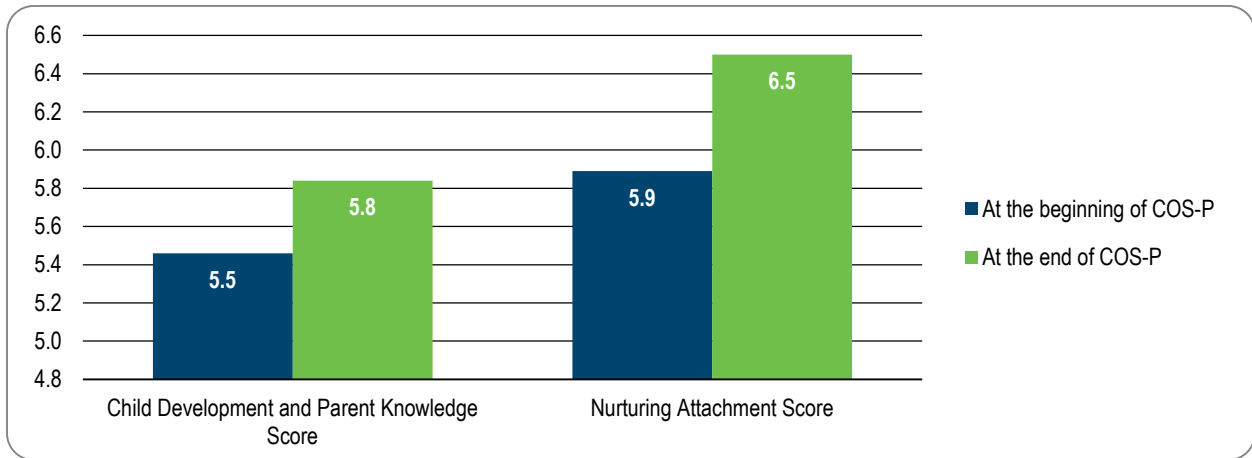
Note: Statistically significant at  $p < 0.01$ .

In addition to reporting severity of symptoms, parents reported difficulty managing symptoms at home, at work, and with other people, with an overall decrease by 26% (from 19 to 14) in parents reporting difficulty from the beginning to the end of COS-P.

Changes in child-parent conflict and closeness were measured by subscales of the Child-Parent Relationship Scale. Although there was no statistically significant change in the conflict or closeness among all parents, there was significant improvement in the closeness subscale at the end of the classes when excluding parents with the maximum score (35 out of 35) and significant improvement on the conflict subscale when excluding parents with the minimum scores (0–7 out of 40).

At the end of COS-P, there was a significant increase in the child development knowledge and use of effective child-parenting skills subscale of the Protective Factors Survey among all parents, particularly for subgroups enrolled in classes in East Harlem and in classes in Spanish in either neighborhood. There was also significant improvement of nurturing attachment among a subgroup of parents with low scores (below sample average) by the end of COS-P, as shown in Exhibit 7-6.

**Exhibit 7-6: Parent/Caregiver Improvement in Parenting Knowledge (N = 74) and Nurturing Attachment (N = 51) for Participants With Low Scores<sup>a</sup> at Beginning of COS-P, May 2013–May 2015**



<sup>a</sup> Below group average when maximum scores are excluded in each Protective Factors Survey subscale.

Note: Statistically significant at  $p < 0.01$ .

NYC Project LAUNCH successfully engaged a diverse group of parents in COS-P with a strong parenting class graduation rate among a population facing socioeconomic disadvantage. Within this high-need group, parents with mild to severe depression scores at the start of COS-P experienced reductions in depression by the end of the program. Similarly, on two measures of parenting—for subgroups of parents with lower child development knowledge, closeness, or nurturing attachment with their child at the beginning of COS-P—there were significant improvements by the end. These gains were evident in scores reflecting increased knowledge of child development, lower parent-child conflict, a closer parent-child relationship, and more nurturing parent behavior.

NYC Project LAUNCH implementation and evaluation of COS-P shows promise as an effective strategy for enhancing the capacity for nurturing parenting in vulnerable families. Positive changes in a subset of parents’ depression and parenting found in the evaluation suggest that COS-P may benefit the parent-child relationship and young children’s social-emotional development. Building wider system capacity and parent/caregiver access for COS-P has the potential to help large numbers of parents strengthen nurturing, responsive relationships; promote their early development; and build a stable foundation for success in school and beyond.

## Grantee Spotlight: Project LAUNCH—Weld Systems Navigation Project

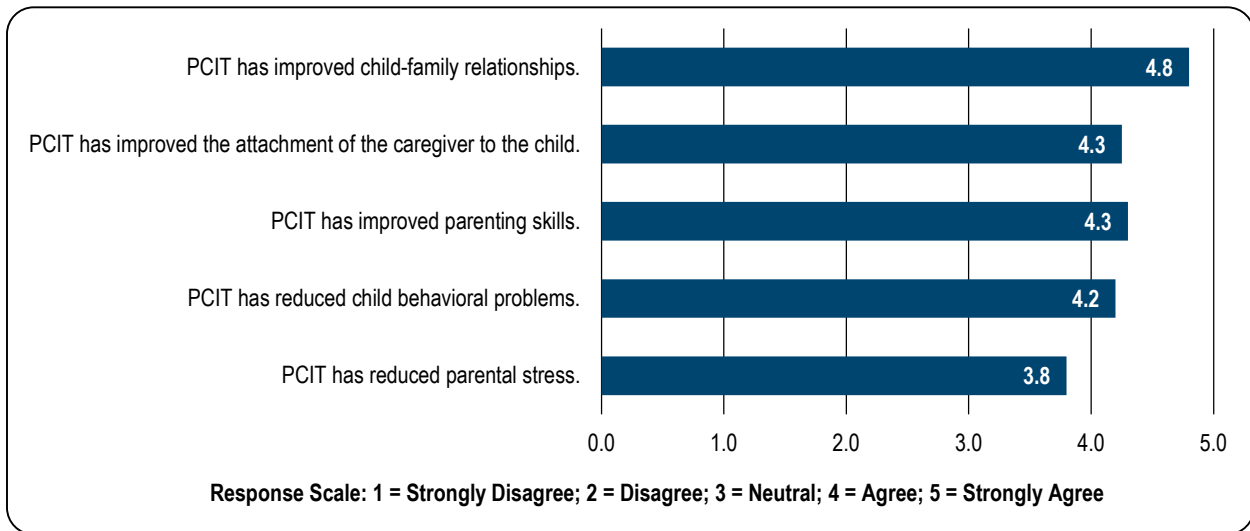
Project LAUNCH—Weld Systems Navigation Project is an early childhood capacity-building project in Weld County, Colorado, one of the fastest-growing counties in the country, partly because of a recent increase in refugees who have settled in the area. Goals of the project are aligned with the Colorado Early Childhood Framework and include the following: (1) ACCESS and availability of evidenced-based resources to families with young children, across systems; (2) QUALITY of workforce development to enhance service provision to families with young children; (3) EQUITY to ensure that families with young children have equitable opportunities for available resources; and (4) SYSTEMS DEVELOPMENT to create an integrated, open-access system of care and family support for children ages 0–8 and their families.

**Overview:** Evidence-based and promising family strengthening practices implemented or enhanced by the Weld Project include Child-Parent Psychotherapy, the Incredible Years young children’s small therapy group, parent-child interaction therapy (PCIT), Positive Solution Groups, and trauma-focused cognitive behavioral therapy (TF-CBT). With LAUNCH support, 81 providers were trained in these family-strengthening practices. Trainer consultation enhanced fidelity to each practice. The project also created system navigation services for families with multiple needs. Workforce development with certified trainers was a key to the success of this strategy.

**Results:** Provider survey results indicate that most of the training participants reported increases in their (1) knowledge of children’s socioemotional and behavioral health and development, (2) knowledge of the available options for follow-up services for children with mental/behavioral health issues, (3) use of early childhood mental health consultation, and (4) use of screening and/or assessment of children in the work setting. Clinicians self-reported greater confidence in their work with families and supports for families with children with behavioral challenges. Clinicians also reported positive family changes such as improved parent-child relationships, decreased parental stress, and happier children.

Weld Systems Navigation Project results for PCIT showed significant increases in parental praise, greater caregiver attachment to the child, improved parenting skills, reduced child behavioral problems, and reduced parental stress. All providers indicated that PCIT was implemented with fidelity exactly or with minor adjustments. During the child-directed interaction phase, matched *t*-tests indicated significant increases in parental labeled praise ( $t = -3.319$ ,  $df = 12$ ,  $p = 0.006$ ) and decreased questions to children ( $t = 3.31$ ;  $df = 12$ ,  $p = 0.006$ ). Also, negative talk by parents to children decreased. Six North Range Behavioral Health (NRBH) therapists and Weld Project LAUNCH mental health consultants reported that PCIT improved (1) child-family relationships, (2) the attachment of the caregiver to the child, (3) parenting skills, and (4) reduced child-behavioral problems and parental stress (Exhibit 7-7).

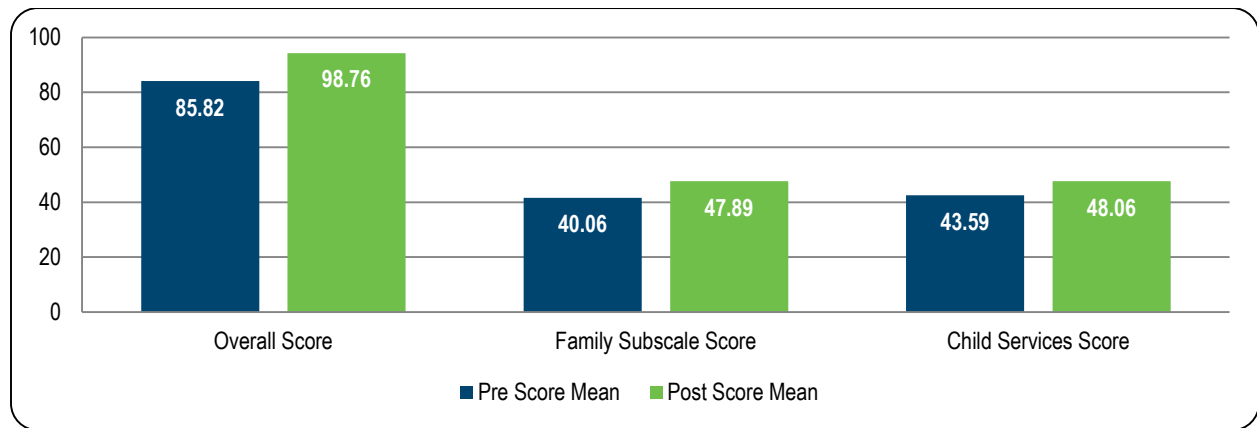
**Exhibit 7-7: Family Outcomes Reported by NRBH/Weld Project LAUNCH Therapists, 2013 (N = 6)**



In the Weld Project, system navigators educated families with multiple needs about support services, motivated families to navigate through various systems (e.g., primary care, education, integrated health, human services), and guided families to advocate for their young children. Families accessed services such as early childhood mental health consultation, child screens and referrals, Child FIND, Part C developmental services, Head Start, local play groups, locating legal documents, a behavioral health treatment, pediatric providers, employment assistance, maternal mental health consultation, utility assistance, child care, and housing. Survey results from 18 families indicate significant positive changes in the Family Empowerment Scale (FES), including the overall FES score ( $t = 2.71, df = 16, p < .05$ ), the Family Subscale Score ( $t = 2.74, df = 17, p < .05$ ) and the Child Services Subscale Score ( $t = 2.27, df = 16, p < .05$ ) using matched  $t$ -tests.<sup>3</sup> These results indicate that the families perceived themselves as more empowered to help themselves and their children (Exhibit 7-8). No significant changes from the preassessment to postassessment scores resulted on the Family Protective Factor Survey.

<sup>3</sup> The Family Empowerment Scale is reproduced with permission from Nancy Ferber, Publication Coordinator, Research and Training Center for Pathways to Positive Futures, Regional Research Institute, Portland State University, P.O. Box 751, Portland, OR 97207-0751 (503) 725-9679 [rtcpubs@pdx.edu](mailto:rtcpubs@pdx.edu).

**Exhibit 7-8: Project LAUNCH—Weld Systems Navigation Project: Family Empowerment Scale Results, Years 2–5 (N = 18 Families)**



Results from a six-item, locally developed parent motivation survey using a matched *t*-test indicated a significant increase in parental motivation among families to seek services for their children or families ( $t = 2.345, df = 18, p = .031$ ). Parent satisfaction survey results indicated that 100% of the parents were “very satisfied” or “satisfied” with the system navigation services, were “very likely” or “likely” to make an appointment if a referral was made, were given the resources they needed, found the services helpful, and were “very likely” or “likely” to recommend the system navigation program to other families.

### Grantee Spotlight: Multnomah Project LAUNCH

Multnomah Project LAUNCH serves children and families in Multnomah County, Oregon. Multnomah is the state’s most populous and diverse county, encompassing Oregon’s largest city, Portland, and it is surrounding suburban and rural areas. Multnomah Project LAUNCH strives to expand and connect community resources to improve the wellness of young children. To promote young child wellness, the project partners with statewide and local organizations for professional and system development, provides services that promote behavioral health, and connects parents and professionals to the best resources for children.

**Overview:** Multnomah Project LAUNCH addressed family strengthening and parent skills training by using two approaches: (1) Incredible Years trainings for parents in three child care centers and one home visiting team receiving LAUNCH mental health consultation; and (2) on-the-spot parenting skills support, information, and referral through 211info Family.

For the Incredible Years parenting series, mental health consultants delivered five Incredible Years series programs between 2011 and 2015. The series was offered to parents of preschoolers and infants/toddlers. Through the life of the grant, 46 parents from early care and education settings and 48 parents served by a Healthy Families home visiting team participated in Incredible Years parent training. The 12- to 14-week programs focus on strengthening parent-child interactions, helping



parents promote social and emotional development in their children, and reducing harsh discipline. A 6-week attentive parenting series was offered to parents of infants/toddlers to complement and build on Incredible Years parenting skills. In addition, a 6-week Balancing Lessons series was provided prior to the Incredible Years series to address home visiting family needs concerning stress management and self-care. Project staff identified the provision of Balancing Lessons before Incredible Years as contributing to strong recruitment and retention. Overall, retention was high (71% of enrolled participants completed the series, attending 50% or more sessions) and was encouraged with additional strategies, including providing dinner and on-site child care. Staff described the increased ability of parents to better manage daily stress as leading to increased willingness and ability to participate in the Incredible Years series focused on strengthening parenting skills.

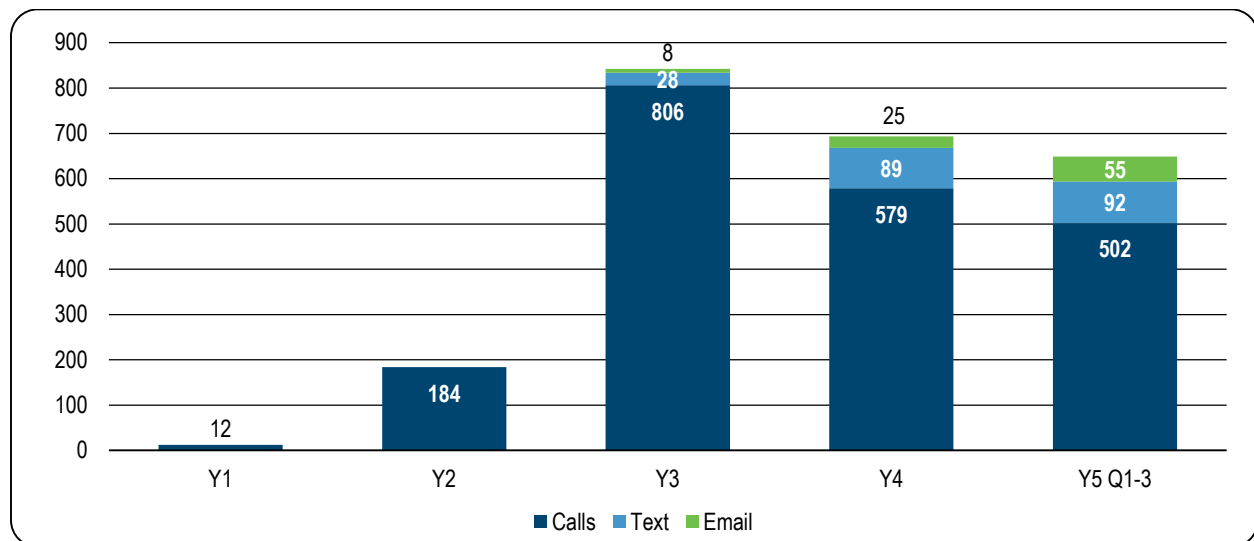
In addition to the parenting series, Multnomah Project LAUNCH implemented family strengthening and parenting skills by enhancing its 211info system to embed information on all early childhood resources and supports in Multnomah County within the 211info database. With LAUNCH funding, 211info hired an experienced parent educator to respond to calls, texts, and e-mails in order to provide advice and make relevant referrals. The goal of 211info Family is to serve families on a broad continuum of need, ranging from on-the-spot parenting advice to connecting families to more concentrated supports.

Three distinct activity areas within 211info Family—parent support, education, and outreach/marketing—promote the parenting support specialty phone line. These activities are summarized below:

- **Gather and input parenting support and child behavior and development services data.** Data were gathered during the first three years of the grant and incorporated into the 211info database. Subsequently, the database was updated annually, keeping it current. As new resources become available, they are added to the database. The database is accessible to the public at 211info.org.
- **Provide parent education.** The parent educator responds to calls, texts, and e-mails from parents and professionals and provides quick consultation to 211info call center staff using an instant messaging “chat” feature. The parent educator also e-mails information to parents and responds to questions for Multnomah and Clackamas county parents who use the ASQ®-online.
- **Perform outreach and promotion.** 211info hired staff to be the face of 211info Family, to share the program with other organizations, demonstrate the capabilities of the database, and answer questions about the program. This activity is supported by the organization’s in-house graphic designer who creates marketing materials and a contract with a public relations firm to support planning, advertising, and earned media.

**Results:** Overall, Exhibit 7-9 shows the dramatic increase in 211 call volume between Year 2 and Year 3 of the LAUNCH grant. The slight drop in total volume of calls, texts, and e-mails between Year 3 and Year 4 resulted from a revision of the internal call routing process conducted by 211infoFamily. This revision improved matching of calls to the intended service and a corresponding drop in calls that were not connected to families with children ages 0–8 or were not specific to parenting, family support, and child development advice, information, and referrals. Exhibit 7-9 summarizes results including three out of four quarters for Year 5. It is expected that call, text, and e-mail volume will remain high and continue to increase gradually over time.

**Exhibit 7-9: 211info Family Call, Text, E-Mail Volume by Project Year**



Evaluation includes follow-up interviews with callers to gauge their satisfaction with the service. Among respondents, 83% replied that they “strongly agree” they would recommend 211info Family to a friend. All other respondents said they “somewhat agree.” These individuals attributed their lower satisfaction to an inability to access resources that were not available in the community.

As a result of the success during Year 1, the Oregon Community Foundation agreed to fund 211info in two additional counties. Other grant funding added two more counties, bringing the total coverage to five counties by the end of Year 3. Concurrently, the Oregon Maternal and Child Health (MCH) contract with 211info was revised to follow the 211info Family model. As a complementary service to 211info Family, MCH has a statewide specialty line that provides information on services such as WIC, immunizations, prenatal and postnatal resources, women’s healthcare, and contraceptive resources. 211 info Family and the MCH line each has a number to press in the hold message to be used for direct connection to the specialist with minimal hold time.

## Lessons Learned, Opportunities, and Conclusions

A variety of efforts to enhance sustainability in family strengthening and parenting skills training have been used by Cohort 3 grantees. These efforts include training clinicians to facilitate and supervise activities, outreach to support integration of evidence-based models into community-based support groups, supporting parents in sharing their success stories to engage others, and collaborating with other organizations utilizing similar evidence-based programs to expand a statewide network.

LAUNCH grantees identified the promotion of a public health approach for family strengthening as essential. This approach increases the ability of programs to identify and implement family strengthening approaches for targeted communities based on risk and/or involvement in the child protective services. Grantees also identified the use of relationship-based family strengthening prevention models and approaches as very successful, particularly if they are implemented with fidelity to the model. This success is also attributed to the grantee's ability to diversify an organization's parent education portfolio and to offer varied evidence-based and promising curricula/programs to reach a variety of targeted populations. Multiple outreach and publicity strategies boost promotion of the family strengthening approaches. A number of grantees such as Multnomah Project LAUNCH and Promising Starts—Wheeler Clinic's New Britain Project LAUNCH are experiencing rapid statewide expansion of the selected approach.

Challenges experienced by grantees included a need to build trust among service providers and families while working with the various strategies. The majority of grantees identified that it is essential to consistently meet the needs of parents and providers, develop and share a consistent message to stakeholders through a variety of venues, and to address issues experienced during implementation as rapidly and effectively as possible.

Experiences of LAUNCH Cohort 3 grantees indicate that workforce development and training on evidence-based and promising family strengthening and parenting programs—with ongoing supervision and coaching—can contribute to effective provider changes in practice, fidelity in implementation, and positive child and family outcomes. Evidence-based family strengthening and parenting programs are essential for early childhood development and family wellness.

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## 8. Substance Abuse Prevention: Healthy Alternatives for Little Ones (HALO)

Project LAUNCH promotes the health and well-being of children from birth to age 8 and strives to achieve school readiness and life success for all children. Achievement of this goal requires that all children arrive at school emotionally and physically healthy and ready to learn.

National research has documented a close link between the healthy development of very young children and children’s educational and overall life outcomes (Shonkoff & Phillips, 2000). Healthy People 2020 defines the five domains of healthy development as physical development, socioemotional development, approaches to learning, language, and cognitive development and has identified the need to “increase the proportion of children who are ready for school in all five domains” as a key objective (HHS, 2010).

Both social and emotional competence are required for healthy peer relationships and can predict a child’s success in school. Social competence supports the development of a positive attitude toward school, facilitates adjustment to school, increases academic achievement for kindergarten children, and decreases the risk of future challenges such as drug abuse or obesity (Denham et al., 2003). Social and emotional competence support the ability of children to become independent adults (Jolivette, Stichter, Sibilsy, Scott, & Ridgley, 2002) and provide a foundation for children’s later functioning across peer and school contexts (Blandon, Calkins, & Keane, 2010; Keane & Calkins, 2004).

Early childhood experiences impact the quality of brain architecture and affect the foundation for a child’s lifelong behavior, learning, and health (Center on the Developing Child at Harvard University, 2010). Interventions that occur early in life often have a greater impact than later intervention (Ialongo, Poduska, Werthamer, & Kellam, 2001).

The proportion of 3- to 6-year-old children who are not yet in kindergarten in the United States and attend center-based early childhood care and education programs increased from 55% in 2007 to 61% in 2012 (Child Trends Data Bank, 2014). Participation in high-quality early care and education has a positive impact on children’s cognitive, language, and social development (Shonkoff & Phillips, 2000), with many of these impacts being lifelong (Campbell, Pungello, Miller-Johnson, Burchinal, & Ramey, 2001).

Early care and education programs present an opportunity to positively impact the growth, development, and lifelong success of young children; support the transition to kindergarten; improve socioemotional competence; and minimize the risk of future long-term challenges such as drug abuse, obesity, and other high-risk behavior outcomes. Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH selected the evidence-based Healthy Alternatives for Little Ones (HALO) model to address existing needs in the area of health and substance abuse education for young children in New Britain (DHHS, SAMHSA, 2015).

## Grantee Spotlight: Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH

The Wheeler Clinic’s program strives to improve and expand services and systems for children ages 0-8 in New Britain, Connecticut. New Britain is a diverse, midsized city with a population of 73,000. In New Britain, 31.6% of children live in poverty, more than 50% of children entering kindergarten are overweight or obese, 41.7% of mothers receive inadequate prenatal care, and a significant number of children are substantiated for abuse and neglect (The Connecticut Home Visiting Needs Assessment Group, 2010).



**Overview:** The need for programming to address challenges in the areas of health and substance abuse education became apparent through the environmental scan process conducted in 2011 and conversations with early care and education (ECE) professionals. ECE partners stated they had no appropriate strategies for responding to children when presented with questions or concerns around substances and substance use. Additionally, the environmental scan identified a high number (58%) of children entering kindergarten who were overweight or obese.

HALO (Heartland Family Service, 2007) is a holistic health and substance abuse prevention curriculum designed for children ages 3–6 in child care settings. HALO addresses protective and risk factors for health behaviors, including substance abuse, by providing children with information on healthy choices.

HALO supports children to learn about "health" and "healthy choices" by putting these concepts into concrete, simple terms. The curriculum encourages healthy eating, exercise, and emotion recognition. HALO also educates children about the harmful effects of alcohol, tobacco, and other drugs. Learning opportunities for children are provided through developmentally appropriate and fun hands-on activities including books, educational songs, group activities, and videos (Exhibits 8-1 and 8-2). Parental involvement is facilitated through introductory and unit-specific letters that encourage at-home discussion and the practice of identifying and making healthy choices.

**HALO Activity—Unit 3**

Children are asked to draw a picture of the people in their family and discuss how all families are different.

**Exhibit 8-1: A Family-Based HALO Activity**

In 2012, Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH invested in HALO for New Britain preschoolers and purchased the program for all elementary schools and ECE settings. To engage and support ECE settings, Promising Starts provided HALO in willing classrooms through trained Wheeler Clinic interns who were provided regular, ongoing weekly supervision. Interns provided the program in classrooms with children between the ages of 3–5 over the grant period. In the second year of implementation, data from three groups of students were shared with the community collaborative as a best-practice strategy to facilitate communication and engagement among project partners.

**Exhibit 8-2: Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH: A Child’s Response to a Family-Based Halo Activity**

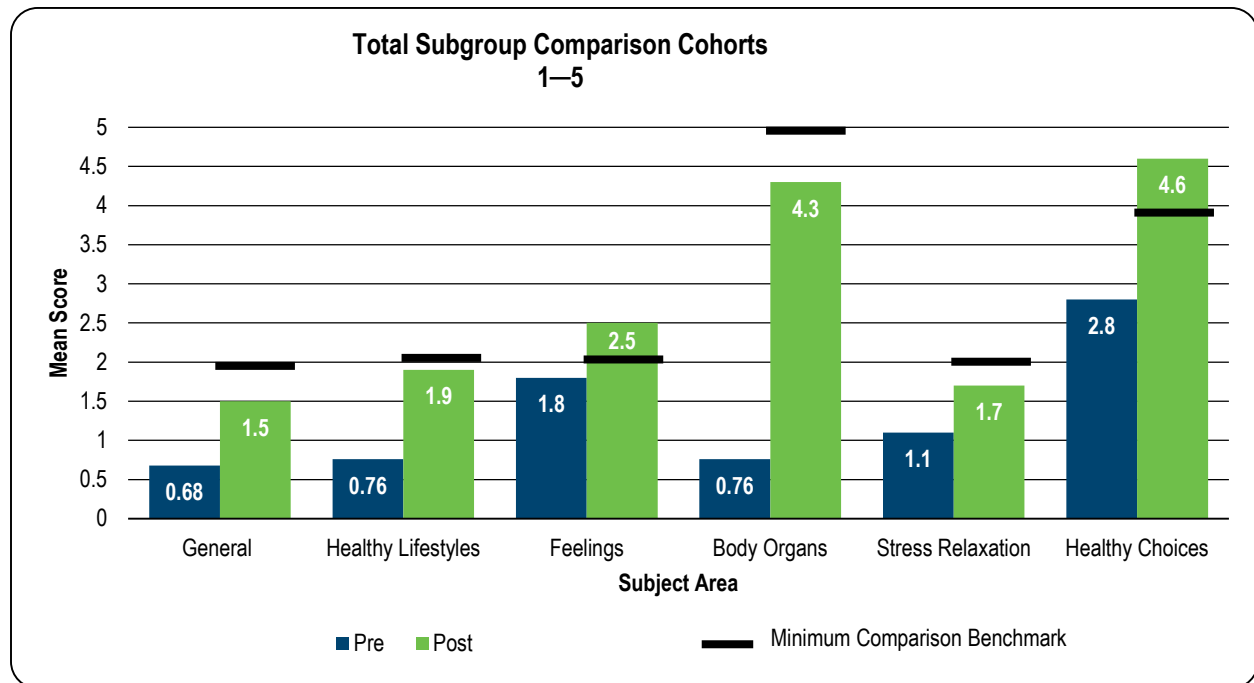


*“Our children really enjoyed their HALO lessons and it was amazing how quickly they learned the concepts. I was surprised that my 4 year olds could learn what the brain, lungs, and heart actually do!”*

– New Britain YWCA Preschool Teacher

**Results:** During the 5 years of LAUNCH funding, the HALO curriculum was administered by five trained staff members to 379 children in Head Start and School Readiness programs, exceeding the 5-year benchmark of 320 children. Seventy children received both the pre-assessment and post-assessment. Results are summarized in Exhibit 8-3, with black lines illustrating benchmarks set by the program developers.

**Exhibit 8-3: Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH: Change in Health Subscale Competencies for HALO Cohorts 1–5 Over Time (N = 70)**



Note: Four differences are significant at  $p < .05$ .

HALO pre-assessments identified areas of difficulty in general health, healthy lifestyles, and knowledge of body organs. At the posttest, children were able to successfully recite term definitions and to identify healthy and harmful food and lifestyle choices. Children demonstrated a significant improvement in four of the six areas at the posttest but failed to meet the minimum levels of competency in general health, healthy lifestyles, body organs, and stress and relaxation. The overall impact of HALO participation is summarized in Exhibit 8-4.

**Exhibit 8-4: Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH: Impact of HALO**

<p>Through HALO, children learned to:</p> <ul style="list-style-type: none"> <li>• strengthen their sense of self,</li> <li>• say “yes” to things that are healthy and “no” to things that are harmful,</li> <li>• recognize and express feelings appropriately,</li> <li>• practice communication skills,</li> </ul>	<ul style="list-style-type: none"> <li>• obtain information about the harmful impact of tobacco and drugs,</li> <li>• identify safety precautions for medicines,</li> <li>• understand the importance of nutrition and physical activity,</li> <li>• practice techniques to reduce stress, and</li> <li>• increase acceptance of cultural diversity.</li> </ul>
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Although the developer’s benchmarks were not met in three areas, progress was achieved as indicated by the significant improvements between the pretest and the posttest scores across

individual items and on four of six subscales, and anecdotal information from teachers and families. Based on these promising outcomes, the community has scaled-up curriculum delivery across school readiness programs and developed strategies for sustainability.

## Lessons Learned, Opportunities, and Conclusions

Five-year implementation results revealed that the HALO curriculum is an effective approach to educating young children on matters of health and safety. Project administrators recommend that early childhood programs with needs related to health and substance abuse prevention consider the use of the HALO curriculum to improve child knowledge about healthy choices. Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH is a model for other similar projects to emphasize the development and growth of partnerships with statewide efforts to promote the use of evidence-based practices in early childhood health and education.

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## 9. Promotion and Public Awareness

Promotion and public awareness of early childhood mental health is an important component of Project LAUNCH. Each grantee provides health education and anticipatory guidance for parents and caregivers in a variety of areas, with an additional focus on the impact of trauma and toxic stress on a child’s development.

These guidelines are in line with national research, which highlights the negative impact of toxic stress on children. The Adverse Childhood Experiences (ACE) Study, a collaborative effort between the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia, and Kaiser Permanente in San Diego, California, demonstrated that childhood trauma contributes to long-term health and social consequences (Centers for Disease Control and Prevention [CDC], 2015a; Health Presentations, 2015). Researchers reported that individuals who had experienced four or more types of adverse childhood experiences or exposures (e.g., psychological, physical, or sexual abuse; violence against the mother; living with household members who were substance abusers, mentally ill or suicidal, or had been or were imprisoned) were at risk for alcoholism, drug abuse, depression, suicide attempts, and other adverse health conditions at a rate 4 to 12 times greater than children with none of these experiences (Felitti et al., 1998).

The prevention of both child abuse and exposure to household dysfunction during childhood has been shown to improve the health and well-being of children and reduce risk factors for several leading causes of death in adults (CDC, 2015b). Project LAUNCH supports early childhood efforts that contribute to child and family wellness, including the promotion and public awareness of early childhood social-emotional and physical health.

The Cohort 3 grantees promoted a variety of important public health messages, including that child and family mental health is important, services are available for families, and toxic stress can be prevented or alleviated. Examples from the experiences of several grantees, including New York City (NYC) Project LAUNCH (New York, New York), the Project LAUNCH —Weld Systems Navigation Project (Weld County, Colorado), and Multnomah Project LAUNCH (Multnomah County, Oregon) are highlighted within this section.

## Grantee Spotlight: NYC Project LAUNCH

Through the New York City Department of Health and Mental Hygiene (Health Department), New York City (NYC) Project LAUNCH works to expand and strengthen programs and services for children and their families citywide, with a particular focus in two of New York’s highest need communities: Hunts Point (Bronx) and East Harlem (Manhattan). NYC Project LAUNCH promotes the social and emotional well-being of children ages birth to 8 by improving collaboration between young child wellness systems; developing the workforce to increase their understanding of child development; providing support, education, and training to increase the use of positive parenting practices and to strengthen parent-child relationships; and guiding the transformation of public policy and funding.

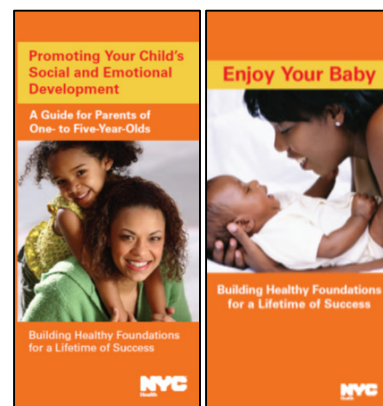
**Overview:** As part of NYC Project LAUNCH, the city health department designed and distributed almost one million public awareness materials related to the development and well-being of children ages 0–10 for parents and caregivers, the provider community, and project stakeholders. These materials highlight information regarding early childhood developmental milestones and social and emotional development for three different stages of childhood. NYC Project LAUNCH developed the materials, and based on widespread interest from more than 600 family-serving provider agencies ordering materials through 311, city funding supported additional translations and reprints. Materials for parents and caregivers included information on how to promote social and emotional development through healthy relationships, how to assess growth through developmental milestones, and the importance of developmental screening.

Materials were made available as PDFs online (New York City Department of Health and Mental Hygiene, 1998), individual and bulk hard copies through the New York City 311 telephone service, and were sent in direct mailings free of charge. Direct mailings and 311 orders of the materials were sent to after-school programs; child welfare (preventive programs, foster and adoptive); community-based organizations and multiservice centers; community health centers (pediatrics, women’s health, family medicine); early care and education (Head Start, Child Care, and universal prekindergarten); elementary schools; school-based health centers; counseling centers; faith-based organizations; family resource centers; home visiting programs (Nurse Family Partnership and Newborn Home Visiting); hospitals; mental health and substance use treatment clinics; public housing; community centers; public libraries; women, infant and children programs; private pediatric practices; city government offices; health insurance providers; block associations; and other organizations. Descriptions of materials and use are outlined below.

### *Three age-specific social-emotional pamphlets*

Exhibit 9-1 shows two examples of pamphlets from the Building Healthy Foundations for a Lifetime of Success series. A total of 770,500 of these pamphlets were printed

**Exhibit 9-1: New York City Social Emotional Pamphlets**



in 10 languages including English, Spanish, Chinese, Russian, Haitian Creole, Korean, French, Arabic, Bengali, and Urdu in 2012–2015. Providers ordered pamphlets through 311 from all boroughs and 150 zip codes. More information can be found at the following websites:

- [Social-emotional web page and pamphlet series](#)
- [Enjoy Your Baby](#)
- [Promoting Your Child’s Social and Emotional Development: A Guide for Parents of One- to Five-Year-Olds](#)
- [Promoting Your Child’s Social and Emotional Development: A Guide for Parents of Five- to Ten-Year-Olds](#)

**Ten age-specific developmental milestones checklists: *Your Child’s Growth is More Than Physical series***

Exhibit 9-2 shows one example of a developmental milestone checklist adapted from the CDC (CDC, 2015c), available for ages: 2, 4, 6, 9, and 18 months and 1, 2, 3, 4, and 5 years. A total of 155,000 were printed in English and Spanish in 2014–2015, and PDFs in eight additional languages are also available online: Chinese, Russian, Haitian Creole, Korean, French, Arabic, Bengali, and Urdu. NYC Project LAUNCH provided text for the translated pamphlets to CDC so the materials can be adapted for other communities in these languages. More information can be found at the following websites:

- [Child Development web page](#)
- [Age-Specific Developmental Milestone Checklists](#)

**Exhibit 9-3: NYC Developmental Screening Posters**



**Exhibit 9-2: NYC Developmental Milestone Checklists**



### Developmental Screening Posters: *Your Child's Growth is More Than Physical series*

Exhibit 9-3 shows two examples of pamphlets from the Building Healthy Foundations for a Lifetime of Success series. Posters are designed to raise awareness of early childhood development, including normalizing developmental screening and the importance of acting early when there may be a developmental concern. Providers are encouraged to post them in their offices or clinic waiting rooms. NYC Project LAUNCH printed 3,750 posters in English and Spanish in 2015, available at 311 and online. More information can be found at the following web link:

- [Developmental Screening Posters](#)



### Promotional Items: *Developmental Screening Matters*

To encourage developmental screening and spread the message of its importance, NYC Project LAUNCH created 25,000 promotional items in 2014. These items included pens, water bottles, tote bags, business card holders (Exhibit 9-4), and stress balls for use at community and provider events and in partner programs.

Exhibit 9-4: NYC Promotional Item

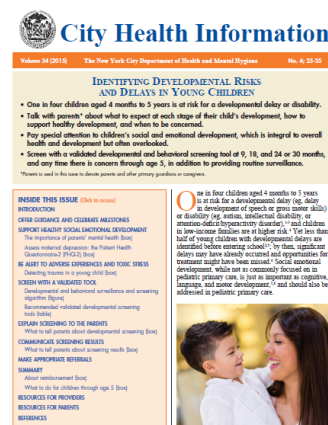


### City Health Information: *Identifying Developmental Risks and Delays in Young Children*

Through NYC Project LAUNCH, the Health Department released a City Health Information (CHI) publication to 27,000 health care providers in October 2015 on conducting routine early childhood developmental screenings in pediatric primary care (New York City Department of Health and Mental Hygiene, 2015). The publication highlights social-emotional development, maternal depression, and Adverse Childhood Experiences in pediatric settings (Exhibit 9-5). The CHI can be found at the following web link:

- [City Health Information: Identifying Developmental Risks and Delays in Young Children](#)

Exhibit 9-5: NYC City Health Information Bulletin





## Grantee Spotlight: Project LAUNCH—Weld Systems Navigation Project

Project LAUNCH—Weld Systems Navigation Project is an early childhood capacity-building project in Weld County, Colorado, one of the fastest-growing counties in the country, partly due to a recent increase in refugees who have settled in the area. The goals of the project are aligned with the Colorado Early Childhood Framework and include the following: (1) ACCESS and availability of evidenced-based resources to families with young children, across systems; (2) QUALITY of workforce development to enhance service provision to families with young children; (3) EQUITY to ensure that families with young children have equitable opportunities for available resources; and (4) SYSTEMS DEVELOPMENT to create an integrated open access system of care and family support for children ages 0–8 and their families.

**Overview:** The Weld Systems Navigation Project engaged the project administration, staff, and partners in several promotional and educational endeavors including the development of early childhood newsletters on selected topics. The project also involved partners in: (1) the proclamation of May as National Mental Health Awareness Month (Obama, 2014) and the National Children’s Mental Health Awareness Day (U.S. Department of Health and Human Services, Substance Abuse Mental Health Services Administration, 2014); (2) an all-day Toxic Stress summit attended by 174 participants from 10 counties; (3) showings of the public broadcast series, *Raising of America: A Documentary Series About Early Childhood and the Future of Our Nation* (California Newsreel, 2015), for local businesses and organizations; and (4) local trainings on toxic stress conducted by the Young Child Wellness Coordinator. Further descriptions of these events and the evaluation methods utilized are provided below.

### Exhibit 9-6: Weld County Mental Health Awareness Month and Children’s Mental Health Awareness Day Proclamation, 2014



(Left to right: County Commissioners Sean Conway, William Garcia, and Douglas Rademacher; North Range Behavioral Health Director Susan Stone; Project LAUNCH Young Child Wellness Coordinator Noelle Hause; Commissioners Barbara Kirkmeyer and Mike Freeman

- 1) **Proclamations:** To increase recognition of May as National Mental Health Awareness Month and National Children’s Mental Health Awareness Day in local communities, the project’s Young Child Wellness Coordinator and North Range Behavioral Health developed proclamations that were presented and received by the local county (Exhibit 9-6), a city council, and a local township involved in the project. The proclamations, which are official declaration documents that include statements for supporting mental health and call upon others to increase

awareness of the issue and support family mental health services, were a way to celebrate these national events and to bring greater awareness to the importance of mental health in general and children’s mental health specifically.

- 2) **Toxic Stress Summit:** An all-day summit: *Toxic Stress in the First Three Years: Understanding and Mitigating the Lifelong Impact*, was held on May 20, 2014 in Greeley, Colorado. The event was sponsored by the Weld, Morgan, and Larimer County Early Childhood Councils; North Colorado Health Alliance; the Early Childhood Colorado Partnership; and The Civic Canope. The event was patterned after the summit conducted by the Early Childhood Colorado Partnership in Aurora, Colorado in January 2014, a result of an Early Childhood Comprehensive Systems (ECCS) grant. The purpose of the summit was to help partners collectively understand: the critical importance of the period from before birth to age 3; what ACEs are; how the earliest experiences influence lifelong health, education, and success; and how to buffer the impact of toxic stress. A major goal was to have partners take collective responsibility to prevent childhood adversities and to buffer the impact of toxic stress. The summit included research on toxic stress, perspectives from the field, evidence-based prevention and intervention strategies, and the opportunity to build collective commitment. Activities included: (1) a keynote address by Associate Professor Dr. Sarah Watamura, University of Denver Department of Psychology; (2) an activity, “Think of a Child,” woven throughout the day and utilizing audience clicker response technology; (3) a presentation on ACEs; (4) a community panel including a county Department of Human Services program manager; a Home Instruction for Parents of Preschool Youngsters (HIPPPY) coordinator/Parent as Teachers (PAT) parent educator home visitor, a private pediatrician and advocate for early child/family wellness, and the director of the local Global Refugee Center; (5) an expert panel on developmentally sensitive interventions; and (6) the development of individual and collective commitments to prevent toxic stress or educate others, including next steps.

For individual and collective commitments, the Project LAUNCH Young Child Wellness Coordinator asked each participant to write down his or her response to the following questions or items:

Step 1. Individual Commitment:

“What next steps will you take to better understand and address toxic stress?”

To help immunize the children against toxic stress, I will: \_\_\_\_\_.

I want to learn more about: \_\_\_\_\_.

Step 2. Community—Establish Collective Responsibility:

Identify your community (e.g., agency, family, neighborhood, workplace, etc.)

How can you create an impact based on what you have learned today?

Electronic clickers were distributed to participants and were used to assess pre-knowledge and post-knowledge changes. Individual and collective actions were documented on handouts that were completed by individual participants and agency groups.

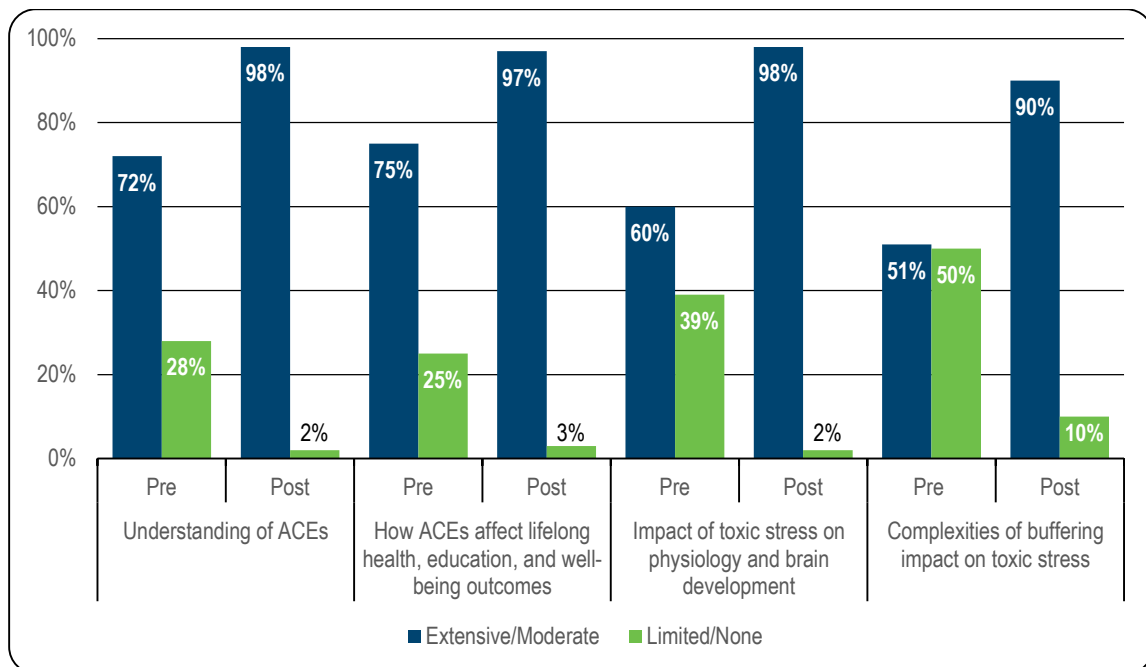
- 3) **Raising of America Premiere Showings:** *The Raising of America: A Documentary Series About Early Childhood and the Future of Our Nation* showings were sponsored by United Way of Weld County and Project LAUNCH —Weld Systems Navigation Project in partnership with Family Connects/Northeast Behavioral Health, the Early Childhood Colorado Partnership, North Colorado Health Alliance, North Range Behavioral Health, and Promises for Children of the Weld County Early Childhood Council, with a minigrant from the Early Childhood Colorado Partnership and Civic Canopy. The event was designed to increase understanding of (1) the issues facing young children in our community, (2) how to mitigate toxic stress in children’s lives, (3) why the Early Learning and Development Guidelines are important, and (4) what needs to be done to improve early childhood care. Two child-guided showings were held in a local theater on November 18, 2014, in Greeley, Colorado for 84 decision makers of local businesses and agencies representing 28 organizations. Every participant received a program booklet of information related to child care, toxic stress, and the early learning and development guidelines. A sealed envelope about the life of a fictitious child, birth certificate, and life story with a summary of risk and protective factors was also given to each invited guest at the beginning to enhance the experience. Two young children emceed the showings with their voices over an audio system that filled the theater and verbally walked participants through the event’s activities, which included a welcome and introduction to the documentary. After the movie, the children also guided each participant to open their envelope and silently read an anecdotal description of a child exposed to ACES as well as protective factors that may have buffered the child’s experience. Each participant received one of several case studies of children who either thrived or suffered negative life outcomes. These child case studies were written by infant mental health providers who used various aspects of actual children with adverse experiences or protective factors, but without any identifiable information. An observation of the event was documented and electronic clicker technology was utilized to determine pre-knowledge and post-knowledge gains and intentions regarding learning as a result of the event. A follow-up online survey was also conducted for those who provided emails.
  
- 4) **Toxic Stress Trainings.** The Weld Project’s Young Child Wellness Coordinator (Dr. Hause) developed and conducted *Mitigating Toxic Stress: You Can Make A Difference* two to four hour workshops for 82 early childcare (EC) providers in Weld County (e.g., Department of Human Services, Head Start, Envision-Early Intervention Part C, child care, and preschools). Each training focused on: (1) perceptions of children’s mental health, (2) toxic stress and trauma—effects on brain architecture, (3) the ACEs study, and (4) protective factors. Dr. Hause also engaged the audience in an activity, “Think of a Child,” with research

on the long-term effects of a number of risk factors. One workshop included the core competencies for effective practice for trauma-informed and developmentally sensitive services for children based on the work of the Health Federation of Philadelphia (Health Federation of Philadelphia, 2010).

**Results.** Participant changes in knowledge or actions taken for the Toxic Stress summit, Raising of America, and toxic stress trainings are summarized in this next section.

- 1) **Toxic Stress Summit.** The summit was attended by 174 participants representing more than 30 community or state systems from 10 counties and most served children ages 0–8 and/or their parents. Among these, 136 were engaged in evaluation clicker technology questions and responses. More than half of the participants indicated that this was their first time (25%) or that they had only some (31%) exposure to the topic of toxic stress in the first three years of a child’s life. In terms of the “Think of A Child” activity, more than three-fourths (76%) of the participants indicated that they knew a child with three or more risk factors (e.g., abuse, neglect, family dysfunction) and just over a third (35%) reported a child with six or more risk factors. With regard to changes in knowledge, 90% or more of the participants indicated they had achieved the summit objectives of: (1) an understanding of ACEs; (2) how ACEs affect lifelong health, education and wellbeing; (3) the impact of toxic stress on physiology and brain development; and (4) the complexities of buffering the impact of toxic stress (Exhibit 9-7).

**Exhibit 9-7: Toxic Stress Participant Changes in Knowledge, Weld County (N = 136)**



Sixty-four participants (37%) provided written individual commitments to help “immunize” children against toxic stress. Their commitments emphasized utilizing skills, providing family resources or family/child supports, child advocacy, referrals, safe places for children, child care, and promoting legislation as shown in Exhibit 9-8.

**Exhibit 9-8: Individual Commitment Areas and Examples (N = 64)**

Individual Commitment Areas	Examples from Participants
<b>Use Skills Learned</b>	<ul style="list-style-type: none"> <li>• Help parents develop skills to de-stress in their own lives to better care for their children.</li> <li>• Work with parent[s] to educate them on children’s bids for attention, nurturing, and bonding techniques.</li> <li>• Talk to the families that I work with about what I learned and also apply this information in my personal life.</li> <li>• Be a present and compassionate parent, clinician, and community advocate to help families and caregivers work and learn to understand and provide protective skills against toxic stress.</li> <li>• Speak calmly, patiently, and empathetically with children.</li> <li>• Help educate foster parents about toxic stress since they are directly working with our kids.</li> <li>• Listen beyond the words.</li> <li>• Work with the parents in my program on understanding toxic stress and how they can reduce it for the health of their children.</li> </ul>
<b>Provide Family Resources or Family/Child Supports</b>	<ul style="list-style-type: none"> <li>• Assist the parents with finding needed resources.</li> <li>• Get to know the families more and help them with resources because I believe reducing their stress level will help reduce the toxic environment kids live in.</li> <li>• Ensure that parents know the resources available to them in their community, including but not limited to home visitation programs.</li> </ul>
<b>Promote Child Advocacy</b>	<ul style="list-style-type: none"> <li>• Advocate for help and/or services for the family.</li> <li>• Advocacy on behalf of children, families, and effective strategies to mitigate toxic stress.</li> </ul>
<b>Create Toxic Stress Awareness</b>	<ul style="list-style-type: none"> <li>• Educate their teachers about effects of toxic stress and mitigating factors.</li> <li>• Talk about toxic stress in classes I teach. Listen to children with intentionality. Look at websites listed under other resources.</li> </ul>
<b>Other Commitments (Referrals, Safe Places for Children, Child Care, Legislation)</b>	<ul style="list-style-type: none"> <li>• Be available and create safe places for children to be comfortable.</li> <li>• Promote awareness building across Colorado. Connect partners and facilitate collective mobilization toward action.</li> <li>• Effective strategies to mitigate toxic stress. Develop resolution similar to Wisconsin for Colorado legislature.</li> </ul>



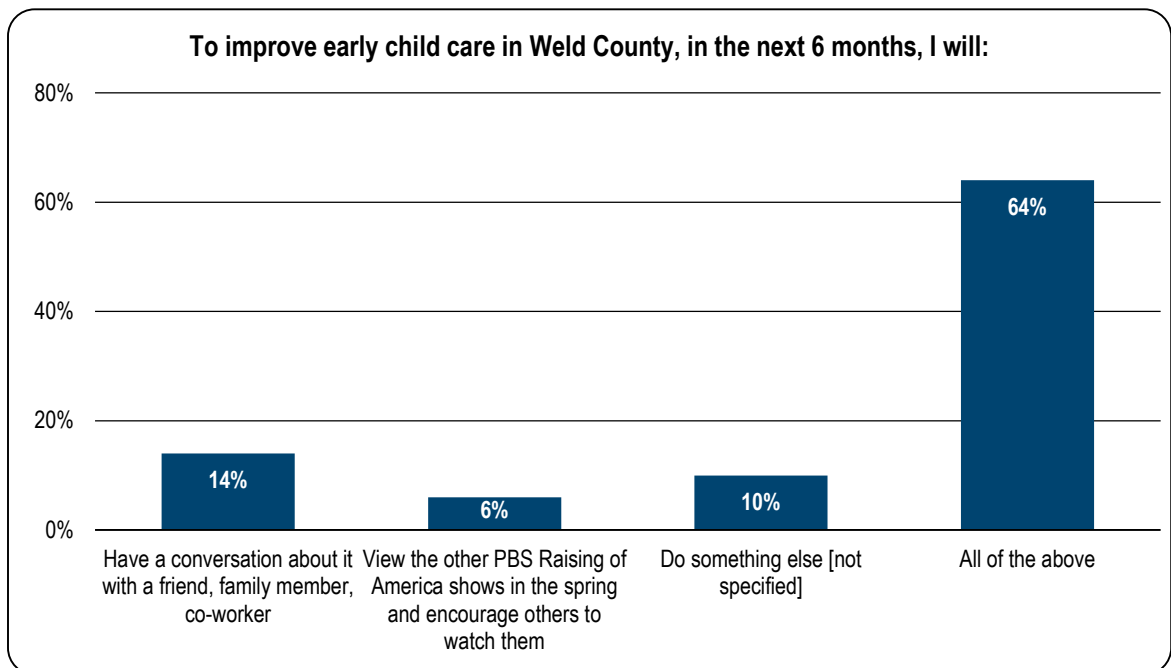
Twenty-four organizations indicated their commitment to the prevention or buffering of toxic stress among young children. Their commitments included educating their organizations or communities about the impact of toxic stress on children, staff training or education for evidence-based prevention or intervention strategies, and providing consultations.

- 2) **Raising of America.** Among the clicker technology participants for the *Raising of America* showings ( $N = 80$ ), 89% indicated that their understanding of young child issues had increased, 63% agreed that they had learned something new about early childhood toxic stress, and 92% indicated that their commitment to help young children had increased.

In terms of action (Exhibit 9-9), a total of 94% indicated that over the next 6 months, they would: (1) have a conversation about the series with a friend, family member, or coworker (14%); (2) view the other PBS Raising of America shows in the spring and encourage others to watch them (6%); (3) do something else (not specified) (10%); or (4) all of the above (64%).

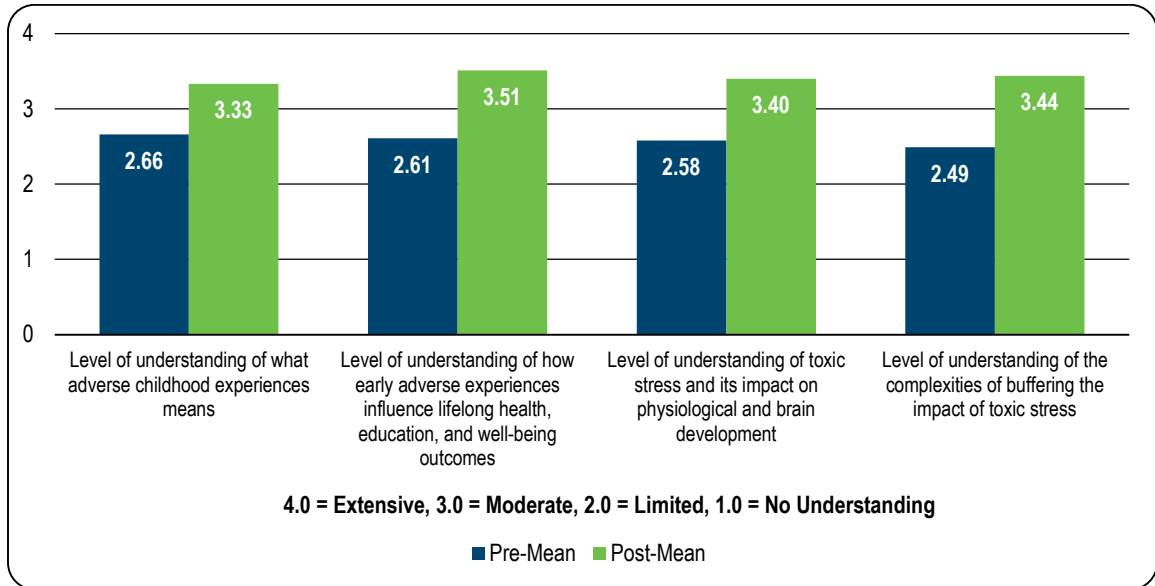
A follow-up e-mail survey completed by 34 participants revealed that three-fourths (77%) had a conversation with a friend, family member, or coworker about the problems facing young children or the importance of positive, quality early child care experiences. A third (35%) had told others about the upcoming Raising of America PBS Special. Just over half (59%) had made a commitment to help children in Weld County.

**Exhibit 9-9: Actions to Improve Early Child Care In Weld County ( $N = 80$ )**



- 3) **Toxic Stress Trainings:** For the majority (76%) of the 82 participants in local toxic stress trainings, this was the first exposure (49%) or some exposure (27%) to the topic. Results utilizing clicker technology showed that 85% had greatly (39%) or significantly (46%) enhanced their understanding of the critical importance of development during prenatal to age 3. Participants self-reported significant increases in their level of understanding of what adverse childhood experiences mean ( $t = 7.298, df = 80, p = 0.000$ ), how early adverse experiences influence lifelong health, education, and well-being ( $t = 11.358, df = 81, p = 0.000$ ), their understanding of toxic stress and its impact on physiological and brain development ( $t = 8.918, df = 81, p = 0.000$ ), and their level of understanding of the complexities of buffering the impact of toxic stress ( $t = 11.126, df = 80, p = 0.000$ ), as shown in Exhibit 9-10.

**Exhibit 9-10: Participant Understanding of Adverse Childhood Experiences and Impacts (N = 82)**



The workshop participants indicated that they wanted to learn more about ACEs and how to help support families with grief, loss, and trauma. Overall, the educators, child care providers, and other providers were very excited about the new information and wanted to learn more about how they can help families and children in the classroom, in their child care, and how to support families directly when children are experiencing development disabilities or delays.

**To Help Immunize Children Against Toxic Stress, Child Care Participants Said:**

*“Build a strong relationship with all parents and children.”*

*“Educate parents about available resources; encourage protective factors.”*

*“Have clear and consistent expectations of classroom behaviors and routines so children can have a stable routine.”*

## Grantee Spotlight: Multnomah Project LAUNCH

Multnomah Project LAUNCH serves children and families in Multnomah County, Oregon. Multnomah is the state’s most populous and diverse county, encompassing Oregon’s largest city, Portland, and its surrounding suburban and rural areas. Multnomah Project LAUNCH strives to expand and connect community resources to improve the wellness of young children. To promote young child wellness, the project partners with statewide and local organizations for professional and system development, provides services that promote behavioral health, and connects parents and professionals to the best resources for children.

Multnomah Project LAUNCH supported young child wellness by promoting the use of 211info Family for advice, information, and/or connection to resources. The outreach specialist ensured that these posters were placed in a variety of settings. Oregon Pediatric Society delivered posters and cards to all pediatric practices in the county (Exhibit 9-11).

### Exhibit 9-11: Multnomah Project LAUNCH 211 Family Info Publicity



Multnomah Project LAUNCH also supported 211info through engaging a public relations firm (Weinstein PR) to promote 211info Family. Their work included developing Facebook advertisements, ads on buses and light rail, articles in local parenting magazines, other print coverage (Exhibit 9-11), and appearances on morning television shows (Exhibits 9-12 and 9-13). They also created a short promo that preceded the previews in a few movie theaters.

Print Coverage included:

- Portland Family: [\*Three numbers for help: 211\*](#)
- Metro Parent: [\*Angels Among Us: 211 Family Info\*](#)
- *The Oregonian*: *Don't worry about late potty training* (Exhibit 9-12)

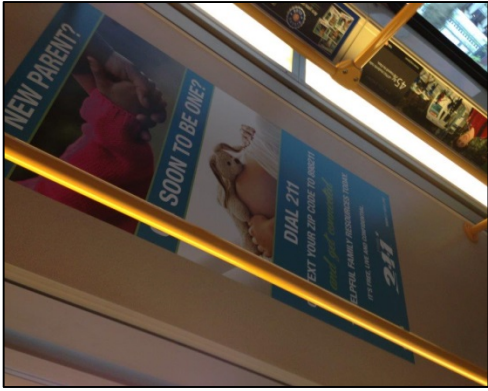
**Exhibit 9-12: The Oregonian Newspaper Article on Potty Training**



**Exhibit 9-13: Television Coverage on AM Northwest: [Part 1](#) and [Part 2](#) and KPTV 12: Good Day Oregon**



**Exhibit 9-14: Multnomah Project LAUNCH Advertising on TriMet Bus Ad**



NCM Media Networks: A [movie ad](#) was shown in 12 first-run theaters across 153 screens in the tricounty area. Print ads have run in publications including: *Willamette Week*, *El Latino*, *Portland Family*, *Metro Parent*, *The Examiner*, *Mid-County Memo*, *Parenting Now*, *SW Community Connection* *The Bee*, and *Hollywood Star*.



## Lessons Learned, Opportunities, and Conclusions

Promoting public awareness of early childhood mental health, family wellness, and the importance of preventing toxic stress and trauma is essential for educating families and providers who serve parents and caregivers of young children. Cohort 3 grantees successfully achieved public education goals using a variety of media, printed materials, trainings, and venues in culturally appropriate languages and graphics. Grantee experiences document the importance of collaboration with other child-serving organizations to effectively reach providers and families and to increase their understanding and awareness of the importance of child and family mental health.

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## 10. Workforce Development

Workforce development within Project LAUNCH includes training for service providers to use and deliver specific evidence-based or promising practices, as well as training for professionals across service delivery systems who come into contact with young children and families every day. Pediatricians, child care providers, teachers, nurses, home visitors, and others may need additional specialized training to be best equipped to promote healthy development, including social and emotional development; to support parents in raising their children; and to identify potential developmental problems and make appropriate referrals. All Cohort 3 grantees used workforce development strategies to accomplish the five core strands or strategies of LAUNCH work, and many examples are included throughout other sections of this publication in addition to those below.

Project LAUNCH workforce development is intended to create a shared understanding of how best to support the well-being of young children and families through promotion and prevention efforts, and to build system capacity within and beyond the grant period. Every Cohort 3 grantee provided various professional development opportunities. Workforce development efforts focused on building capacity within the existing early childhood workforce, expanding the use of evidence-based practices, improving quality of services, building cross-sector partnerships, and creating new certification programs such as early childhood mental health endorsement.

### Grantee Spotlights

- Multnomah Project LAUNCH hosted a Young Child Wellness summit during the first year of the grant to provide cross-sector workforce development and build community connections. The one-day summit drew 218 participants from a variety of sectors. The agenda featured a keynote address, *A Public Health Approach to Children's Mental Health*, and the opportunity to hear from a new state representative who had been a longtime early childhood advocate. The workshops were all tied to LAUNCH strategies and community priorities. This summit laid the groundwork for workforce development during the rest of the grant.
- Multnomah Project LAUNCH also started three “communities of practice” to support professional development and alignment in home visiting, early childhood mental health, and early childhood positive behavior interventions and supports. These communities of practice contribute to cross-sector partnership and improved services.
- In the summer of 2013, El Paso Project LAUNCH held its first Growing Great Kids conference. The event focused on promoting child and provider resiliency and self-care. More than 100 providers participated in the three-day event from a diverse audience of

professionals in the fields of social work, health and human services, nursing and primary care, child care, education, and mental health.

- The Project LAUNCH—Weld Systems Navigation Project trained 94 participants on evidence-based practices, including Child Parent Psychotherapy, [Incredible Years® Children’s Small Group Therapy Program](#), Parent Child Interaction Therapy, Positive Solution Groups, and Trauma-Focused Cognitive Behavioral Therapy. They replicated the Denver day-long summit, *Toxic Stress in the First Three Years: Understanding and Mitigating the Lifelong Impact*, in 2014 for 174 people representing 57 agencies from 10 Colorado counties. The summit included a keynote address on childhood toxic stress research, a panel with perspectives from the field, and individual/collective commitments to “immunize” children against toxic stress. Subsequently, LAUNCH supported a session on toxic stress for judicial staff in December 2014, held numerous local trainings for child-serving organizations, and partnered with the state’s Early Childhood Comprehensive Systems project to implement staff trainings to raise awareness of toxic stress and its effect on young children.
- New York City Project LAUNCH provided Incredible Years® Teacher Training to 80 teachers and teaching assistants from 33 classrooms in 10 early care and education sites, and trained more than 100 parent educators in the Circle of Security Parenting (COS-P) program. Throughout the five years, two teams of Nurse Family Partnership (NFP) home visiting nurses received ongoing mental health-informed reflective supervision and three NFP social workers and nurse supervisors were trained to be reflective practice facilitators and provide reflective supervision to NFP teams. Approximately 70 parents and community members received training in the Community Café approach. Additional trainings were provided to 395 people, including pediatric staff at a municipal hospital and a federally qualified health center, on topics including early childhood mental health, social-emotional and developmental screening, referrals, and early intervention. Citywide trainings were also provided to Administration for Children’s Services-funded Early Learn (Head Start and child care) providers on trauma, developmental screening, and the power of play.
- Boone County Project LAUNCH provided training, coaching, and referral support to more than 4,300 physicians, nurses, psychologists, and child care providers. Providers were trained on developmental and behavioral screening using the Ages & Stages Questionnaires® (ASQ-3™ and ASQ:SE-2™).
- Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH increased awareness and utilization of evidenced-based programs for young children by supporting training to a broad range of service providers. During the five years of funding, trainings were provided to a total of 456 providers, including family service workers, early care and education programs, child welfare staff, and primary care providers. Training was provided on a variety of programs including Child First, COS-P, Healthy Alternatives for Little Ones, Child Parent

Psychotherapy, sensory processing in early childhood and strategies for effective interventions, Ages & Stages Questionnaires<sup>®</sup> or ASQ-3<sup>™</sup> and ASQ:SE-2<sup>™</sup>, and the Devereux Early Childhood Initiative's Feelings-Limits-Inquiries-Prompts model to reduce children's behavioral health challenges.

## Lessons Learned, Opportunities, and Conclusions

Grantees identified a significant need across systems for workforce development and support around social and emotional development, trauma, developmental screening, referrals, infant mental health, and reflective practice. Grantees described the work as complex and multifaceted and identified the use of evidence-based practices to address existing needs as critical to ensure provider participation and facilitate program success. Grantees utilized workforce development as a sustainability strategy to expand the capacity of the workforce in various systems (e.g. health care, social services, early education, behavioral health) for supporting prevention and early intervention activities for young children and their families beyond Project LAUNCH. In other words, it was important for Project LAUNCH grantees to develop the local workforce for future sustainability so that the reach of the project would extend beyond just providing direct services to young children and their families.



## 11. Summary, Conclusions, and Recommendations

Children are our future. Promotion of children’s and families’ social and emotional health can improve their well-being and support achievement of a bright future for their communities and the nation. A 19-year retrospective study funded by the Robert Wood Johnson Foundation indicated that kindergarten children who displayed social competencies (e.g., sharing, cooperating, or helping other children) were, by age 25, more likely to graduate from high school on time, complete a college degree, and obtain stable and full-time employment than children without these skills (Jones, Greenberg, & Crowley, 2015). Through high school, they were also less likely to be involved with the criminal justice system, less likely to binge drink or use marijuana, and less likely to be on medication for emotional or behavioral issues (Jones et al., 2015).

Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health), initiated by the United States Department of Health and Human Services (HHS) Substance Abuse Mental Health Services Administration’s (SAMHSA) Center for Mental Health Services in 2008, promotes the health and well-being of children from birth to age 8. The goal of Project LAUNCH is to achieve school readiness and life success for all children by improving coordination across child-serving systems, building infrastructure, and increasing access to evidence-based prevention and wellness promotion services for young children, their parents or caregivers, and their families (U.S. Department of Health and Human Services, 2010). Project LAUNCH utilizes a public health approach to promote individual, family, and system-level outcomes.

Although state or tribal entities have been the primary recipients of Project LAUNCH funding, Cohort 3 included six grantees that were specifically funded for five years, beginning in 2010, at the local level. The local grantees included Boone County Project LAUNCH (Boone County, Missouri); El Paso Project LAUNCH (El Paso, Texas); NYC Project LAUNCH (New York, New York); Multnomah Project LAUNCH (Multnomah County, Oregon); Project LAUNCH—Weld Systems Navigation Project (Weld County, Colorado); and Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH (New Britain, Connecticut). Each local grantee implemented five core prevention and promotion strategies (Exhibit 11-1), including (1) [screening and assessment](#) in child-serving and community settings, (2) [integration of behavioral health into primary care settings](#), (3) [enhanced home visiting through increased focus on social and emotional well-being](#), (4) [mental health consultation in early care and education](#) programs, and (5) [family strengthening and parent skills training](#); Cohort 3 local grantees also implemented (6) workforce development strategies and (7) promotion and public awareness strategies. This summary report highlights how several grantees



implemented each strategy. To learn about each grantee’s comprehensive approach, please refer to the grantee profiles.

**Exhibit 11-1: Overview of Project LAUNCH Strategies**



Source: [Project LAUNCH](#)

**Screening and Assessment**

**Overview.** All LAUNCH Cohort 3 local grantees promoted the use of comprehensive screening in a wide range of settings, including child care, primary care, early childhood education, and mental health and substance abuse treatment programs serving families of young children. Grantees increased the use of validated screening instruments, with a particular emphasis on social and emotional functioning. Among the projects described, more than 20,000 children were screened and almost 1,300 documented referrals were reported for follow-up services as a result of the screening.

**Approaches.** LAUNCH Cohort 3 local grantees used a variety of approaches to promote screening in their respective communities. Projects promoted the integration of universal screening with available early-childhood mental health consultations in primary/pediatric care settings, child care settings, and in the community. Community settings included Women, Infants, and Children (WIC) offices; public libraries; parent support group meetings; Home Instruction for Parents of Preschool Youngsters (HIPPI) events; and community festivals.

**Results.** Screenings resulted in increased referrals, and were well received by parents as indicated by parent satisfaction surveys. Other results included increases in provider knowledge of children’s socioemotional and behavioral health and development, knowledge of the available options for follow-up services for children with developmental challenges, use of screening and/or assessment of children, and use of mental health consultation for children with mental or behavioral health issues.

**Challenges and Opportunities.** Projects identified limits of Medicaid reimbursement for early childhood screenings by private providers as the primary barrier to screening activities. States and federal jurisdictions are encouraged to seek creative ways to fund evidence-based child developmental and social-emotional screenings for school readiness and to enhance children’s social competencies. To avoid screening duplication, parents and caregivers need access to screening results such as Health Insurance Portability and Accountability Act (HIPPA)-compliant parent portals or other mechanisms so they can share results with appropriate providers or organizations serving children. In addition, enhanced communication and coordination across providers is necessary for child and family access to appropriate services and supports based on screening and referral information.

**Recommendations.** A variety of recommendations related to screening and assessment emerged from Cohort 3 grantees, as follows:

- 1) Support pediatricians in following the American Academy Periodicity Guidelines (American Academy of Pediatrics, 2014) for early childhood screens.
- 2) Train providers serving young children and their parents on evidence-based screening tools.
- 3) Conduct early childhood developmental and social-emotional screenings at every pediatric well child checkup.
- 4) Seek state and federal funding mechanisms to reimburse early childhood developmental and social-emotional screenings.
- 5) Develop local resources that will meet the needs of young children and their parents referred to treatment or services as a result of screenings and assessments.

## Integration of Behavioral Health Into Primary Care

**Overview.** The Health Resources Services Administration Center for Integrated Solutions, which is part of HHS and SAMHSA, promotes the development of integrated primary and behavioral health services to meet the needs of individuals with mental health and substance use conditions (Heath, Wise Romero, & Reynolds, 2013). A pediatric primary care setting is an appropriate place to assess child and family behavioral health concerns with mental health clinicians and other specialty

consultants. Two grantees, NYC Project LAUNCH and Project LAUNCH–Weld Systems Navigation Project, integrated screening, mental health consultation, referrals, and workforce training into primary care settings, including a private pediatric clinic, a municipal hospital pediatric clinic, and federally qualified health clinics.

**Results.** Both grantees were able to integrate or enhance integration of behavioral health into pediatric settings. Among the children screened in New York City communities, 19–32% had results indicating the need for further assessment or services. For both grantees, pediatric clinic providers reported positive changes in their knowledge about young children’s mental health and available services to address developmental and behavioral problems.

**Challenges and Opportunities.** Grantees reported that successful behavioral health integration requires primary care provider buy-in through awareness, relationship building, and sustainable funding. The integration also requires developing a coordinated and streamlined system for screening and referrals, which may include increased capacity for early childhood mental health treatment in the community. Moreover, providers need a solid understanding of community resources in order to make appropriate referrals and optimize use of developmental and behavioral services. A strong working relationship between integrated mental health staff and other pediatric clinic staff is also important in promoting the structure, logistics, and flow of the integration process. Integrating mental health in primary care is resource intensive in terms of time, staffing, and funding.

**Recommendations.** The following actions will enhance and sustain behavioral health integration within pediatric primary care:

- 1) Develop funding, infrastructure, workforce development, and data systems to support integrated services.
- 2) Develop training initiatives to expand the workforce of community-based child mental health clinicians trained in evidence-based models, including parent-child treatment, so that children and families can be successfully referred out for treatment when needed.
- 3) Develop an information system to streamline screening and community referrals and improve data collection and quality improvement.

Federal and state health care reform initiatives present a unique opportunity to promote and monitor the integration of behavioral health into primary care, which is especially important for the prevention of long-term adverse impacts of childhood mental health conditions. Pediatric primary care providers have an essential role in identifying these conditions, intervening early, and improving the health, mental health, and developmental outcomes of children.

## Enhanced Home Visiting

**Overview.** As a Project LAUNCH strategy, enhanced home visiting includes evidence-based home visiting programs *plus* early childhood or mental health consultation for mothers and families. This model, which includes training, reflective supervision, and consultation to home visitors (individually or in groups), can enhance the capacity of home visitors to identify and address the unmet mental health needs of children, parents, and their families. The National Conference of State Legislatures encourages states to establish and fund effective and research-based home visiting policies (National Conference of State Legislatures, 2015). In Cohort 3, evidence-based and promising practice home visiting programs that were enhanced with mental health consultation included Child First, Healthy Families America, Healthy Babies-Healthy Families, Nurse Family Partnership, Parents as Teachers, and Promoting Maternal Mental Health During Pregnancy.

**Results.** Grantees reported program, provider, and family successes. These included positive changes in home visitor knowledge and practice; increases in child and family referrals; strong model fidelity; and high parent satisfaction. Specifically, grantees found significant improvements in mothers with depression who met with maternal mental health consultants (Weld County); home visitor increases in self-reported knowledge about children’s and adults’ mental health, and the ability to involve parents as partners (Multnomah County); and significant increases in family protective factors and enrollment in school, GED, and/or vocational training (El Paso).

**Challenges and Opportunities.** Grantees learned that enhanced home visiting requires significant time to build relationships among mental health consultants, home visitors, and families in order to clarify roles and establish trust for working together. There is also a need to clearly identify the added value that mental health consultation can bring to established home visiting services. In addition, implementing responsive home visiting programs requires that communities identify specific cultural and linguistic needs of all families.

**Recommendations.** Cohort 3 grantees suggested the following, which will enhance home visiting services:

- 1) Promote legislation to fund EC mental health consultation as an enhancement to home visiting programs.
- 2) Provide routine evidence-based depression screens (e.g., Edinburgh Postnatal Depression Screen) for new mothers.
- 3) Include mental health consultation for home visitors or providers and participants in home visiting programs.
- 4) Increase access to culturally responsive home visiting programs.

## Mental Health Consultation

**Overview.** Early childhood mental health consultation (ECMHC) services are individualized according to the needs of programs, children, and families. In the Cohort 3 grantee experience, ECMHC was provided to child care and home-based providers, Head Start staff, other young child-serving organizations, and families.

**Results.** Among rural child care and home-based providers, provider knowledge and competence increased, provider stress decreased, and there is preliminary evidence that child social-emotional health increased (Boone County). Teacher knowledge and use of effective practices for promoting social-emotional growth and child social-emotional competencies increased and child problem behaviors decreased (NYC).

**Challenges and Opportunities.** As long-term investments, ECMHC programs must be implemented with a high degree of fidelity. Consequently, they are resource intensive, requiring both a pool of well-trained early childhood mental health professionals to serve as consultants and accompany the home visitor on home visits if requested, and adequate funding to sustain services over time. In light of promising evidence that ECMHC promotes social-emotional wellness in young children, it is critically important that legislators support public funding structures for expanding and strengthening early childhood consultation services in all communities.

**Recommendations.** To promote ECMHC services that can benefit providers and the families they serve, communities and states should consider the following:

- 1) Document early childhood mental health consultation models utilized and provider and child/family outcomes.
- 2) Fund early childhood mental health consultation in a variety of settings to increase the early childhood knowledge and skills of providers and to promote social-emotional health in young children.
- 3) Build positive relationships with school systems to promote coordination, teamwork, and commitment needed to integrate early childhood mental health consultation.

## Family Strengthening and Parent Skills Training

**Overview.** Cohort 3 grantees implemented a range of evidence-based and promising family strengthening and parent skills training programs. These include: 211info Family, Child-Parent Psychotherapy, Circle of Security Parenting (COS-P) program, Incredible Years® series and Children’s Small Group Therapy program, parent-child interaction therapy, Positive Solutions Groups, system navigation services, and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).



**Results.** Every Cohort 3 grantee experienced high success in terms of provider gains in knowledge and practice, and child/family outcomes, such as increased parenting and/or child development knowledge, parenting skills, and reduced parental stress. Trained facilitators who implemented COS-P with Spanish-speaking families reported high program fidelity (New Britain, CT) and participants in COS-P classes experienced reductions in depressive symptoms and improvement in parent-child relationship quality (NYC). Workforce development with certified trainers and local supervision contributed to high program fidelity and high program participation (Multnomah County and Weld County). System navigation services implemented for families with multiple needs demonstrated increased family empowerment, referrals to community resources, and 100% parental satisfaction (Weld County). Two grantees (Multnomah County and Weld County) reported improved provider knowledge and practice related to early childhood competencies and increased knowledge or skills for parents. One grantee (Multnomah County) demonstrated that enhanced 211info Family can serve families on a broad continuum of need.

**Challenges and Opportunities.** Relationship-based prevention models and approaches can be very successful with appropriate outreach and promotion to targeted populations. Challenges experienced by grantees included a need to build trust among service providers and families. Successful projects met the needs of parents and providers, communicated a consistent message to stakeholders, and resolved issues in an ongoing and effective manner.

**Recommendations.** For effective family strengthening and parent skills training, this strategy must:

- 1) Include workforce development implemented by certified trainers.
- 2) Provide ongoing support of trained participants by certified trainers and local supervisors trained in evidence-based and promising programs.

## Systems Development

All Project LAUNCH grantees developed infrastructure through the formation of community-wide wellness councils with child-serving organizations and family consumers. These councils promoted program leadership and capacity, coordinated partnerships, and facilitated LAUNCH activities to support young children’s health. This collaborative effort also enhanced evaluation capacity to meet the unique local needs of young children and families. All Cohort 3 grantees conducted a needs assessment with an environmental scan, developed a strategic plan, and created an evaluation plan specific to their project goals, objectives, and activities. El Paso Project LAUNCH engaged key child-serving partners to fund home visiting, develop a community of practice for early childhood education providers, and create a wellness directory on a free downloadable mobile application. The Weld Systems Navigation Project developed a *Blue Print* planning model for local partners engaged in workforce development and LAUNCH-supported activities. Colorado’s endorsement of

Culturally Sensitive Relationship-Focused Practice Promoting Infant Mental Health<sup>®</sup> was created with LAUNCH funding, and plans for full replication of the project in other Colorado communities by private funders is underway. Staffing for Envision (Early Intervention Part C) increased in Weld County, partly due to higher service requests and referrals. Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH’s results of the Levels of Collaboration survey indicated interagency coordinated efforts.

**Challenges and Opportunities.** System development activities can be very successful in increasing program capacity and integration of services when driven by appropriate collaboration, communication, participation, planning and assessment. Challenges experienced by grantees included turnover among council members, rapid growth in participation and subsequent changes in networking and collaborative structures, and limited parent participation in some projects.

**Recommendations.** For effective systems development, this strategy must:

- 1) Utilize a collaborative needs assessment and strategic planning process to guide efforts.
- 2) Include ongoing communication and collaboration between partners in a consistent fashion.
- 3) Incorporate assessment of collaboration activities into ongoing implementation efforts to ensure understanding of progress made, detect challenges as they arise, and provide a target for which partners can strive.

## Workforce Development

All Cohort 3 grantees provided training for service providers to deliver specific evidence-based screening tools and practices, which was essential for the success of the project. Every Cohort 3 grantee developed and implemented various professional development opportunities. For example, Boone County Project LAUNCH provided training on [Ages & Stages Questionnaires<sup>®</sup> \(ASQ-3<sup>TM</sup> and ASQ:SE-2<sup>TM</sup>\)](#) to physicians, nurses, psychologists, and child care providers with training, coaching, and referral support. El Paso Project LAUNCH held its first Growing Great Kids conference on promoting child and provider resiliency and self-care. Multnomah Project LAUNCH hosted a Young Child Wellness summit during the first year of the grant with a keynote presentation, *A Public Health Approach to Children’s Mental Health*. Promising Starts—Wheeler Clinic’s New Britain Project LAUNCH trained providers to implement evidenced-based programs for young children including Child First, Healthy Alternatives for Little Ones, and the Devereux Early Childhood Initiative’s FLIP IT model to reduce children’s behavioral health challenges. Similarly, NYC Project LAUNCH delivered [Incredible Years<sup>®</sup> teacher training](#) to early care and education sites and trained parent educators in the COS-P program across the city. The Weld Systems Navigation

Project sponsored a session on toxic stress and young children for judicial staff at one of their judicial trainings.

## Promotion and Public Awareness

Promotion and public awareness of early childhood mental health and the prevention of toxic stress and adverse childhood experiences are important to Project LAUNCH. NYC Project LAUNCH produced numerous child development, mental health, and screening health education materials for parents and providers covering a range of ages and languages with almost one million copies in circulation through the NYC 311 telephone system as well as on the New York City Health Department website. Additionally, NYC Project LAUNCH developed a health department bulletin with guidance on early childhood developmental screening, maternal depression, and social-emotional development circulated to more than 27,000 health care providers. The Weld Systems Navigation Project conducted an all-day summit, *Toxic Stress in the First Three Years: Understanding and Mitigating the Lifelong Impact* for participants from 10 counties, resulting in individual and collective commitments to help “immunize” children against toxic stress. The Weld Project also featured the *Raising of America* documentary program on young children and their families for local businesses and organizations and promoted May as National Mental Health (Obama, 2014) and SAMHSA’s Children’s Mental Health Awareness Day (U.S. Department of Health and Human Services, SAMHSA, 2014) in local communities. The Weld Project also implemented two-hour workshops on toxic stress for early childhood organizations and providers in Weld County. Multnomah Project LAUNCH utilized publicity and social marketing to promote young child wellness through 211info Family for advice, information, and/or connection to resources. Outreach efforts included Facebook advertisements, ads on buses and light rail, articles in local parenting magazines, and appearances on morning TV shows. Multnomah also presented a short ad before the previews in a few movie theaters—an innovative way to reach families.

## Summary

The Project LAUNCH initiative has successfully transformed child-serving systems to promote the best possible outcomes for young children, their families, and communities by fostering collaboration and integration among caregivers, early childhood educators, and providers of mental health and primary care services. Between 2010 and 2015, Cohort 3 local grantees implemented evidence-based practices, enhanced prevention programs, developed strategies to educate and support providers, and successfully impacted the social and emotional health and wellness of young children and families. Through these efforts, framed in a public health approach, local infrastructures were enhanced and strengthened, innovative solutions were generated and tested, evidence-based and promising practices were expanded, and strengths-based programming was delivered to young children and families. All these efforts were accomplished through collaborative community-based partnerships. As a unique cohort exclusively comprised of local communities, Cohort 3 grantees were able to maximize existing resources at the local level to foster sustainability, and some grantees promoted statewide expansion to realize their goal of helping children, families, and communities. These effective prevention and promotion practices and strategies for overcoming barriers and challenges, employed by Project LAUNCH Cohort 3 serve as examples for other communities and states working to improve systems and policies to ensure the best possible outcomes for our young children.

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