Texas LAUNCH Expansion Grantee

Evaluation Plan

Part 1. Introduction

Texas LAUNCH, an expansion of the Project LAUNCH initiative initially implemented in El Paso, Texas, seeks to improve the developmental, social, and emotional health of young children within our 3 expansion communities, San Antonio, Fort Worth, and Ysleta del Sur Pueblo. Through incorporating strategies such as improving access to quality screening procedures, strengthening families through targeted intervention and mental health consultation, and creating a sustainable early childhood workforce at both the local and state level, we aim to increase the resources available to families and young children in the State of Texas. For additional information about our implementation strategies and methods, please refer to our Expansion Plan.

The strategies to be implemented through Texas LAUNCH are empirically supported practices within the research literature. With respect to developmental and social/emotional screening in young children, early identification of children at risk of behavioral and emotional difficulties has been associated with earlier service utilization and improved behavioral and emotional outcomes (Essex, M. J., et al., 2009). Additionally, the ASQ-3 and ASQ-SE (our selected measures) have been shown to successfully identify children who may be at risk of behavioral or emotional difficulties in diverse samples of children, such as those who were born prematurely (e.g., Schonhaut, Armijo, Schonstedt, Alvarez, & Cordero, 2013) and those with chronic health conditions such as epilepsy and cancer (e.g., Eorn, Dezort, Fisher, Zelko, & Berg, 2015; Quigg, Mahajerin, Sullivan, Pradhan, & Bauer, 2013). Additionally, this tool has been utilized in a number of administration settings, such as child daycare settings (e.g., Filgueiras, Pires, Maissonette, & Landeira-Fernandez, 2013) and community healthcare settings (e.g., Armijo, Schonhaut, & Cordero, 2015). Family strengthening and parent training, specifically the Incredible Years curriculum, has been shown to reduce behavioral difficulties in children diagnosed with Oppositional Defiant Disorder (e.g., Hobbel & Drugli, 2013), have positive impacts on parenting behavior in parents with a history of child maltreatment (e.g., Hurlburt, Nguyen, Reid, Webster-Stratton, & Zhang, 2013), and been shown to be a cost-effective way to reduce behavioral difficulties and health inequalities in children (e.g., O'Neill, McGilloway, Donnelly, Bywater, & Kelly, 2013).

Mental health consultation, defined as "a problem-solving and capacity building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals with other areas of expertise," (Cohen & Kaufmann, 2005, p. 4; Perry & Linas, 2012) has shown to improve self-efficacy in early childhood education staff and increase their confidence and capability to address behavioral difficulties of children within their care (Perry & Linas, 2012). Additionally, participating in mental health consultative services has been linked to improvements in educator sensitivity, decreased on-the-job stress levels, reductions in professional turnover, and an improvement in overall quality of care and service provision in early child education settings (Perry & Linas, 2012).

Each of the selected strategies work together to impact the overall system of supports for promoting the developmental success of young children, from parenting and family support, to child care and early education, to health care systems and home visiting. The Texas LAUNCH expansion evaluation is guided by the well-documented strengths of these previous research efforts and is built on the successful evaluation of the initial El Paso Project Launch described below. We aim to utilize similar procedures and measures to those utilized in El Paso Project Launch and/or efficacy trials in an effort to provide results for comparison across the state.

El Paso Project LAUNCH Evaluation

Evaluation of El Paso Project LAUNCH (EPPL) indicated that the core strategies implemented were effective in promoting early childhood mental health within the community. Over the course of the grant, EPPL enrolled 591 families for services and programs and trained 638 providers, including 85 primary care providers, to administer various screening instruments. In total, 606 children and 59 adults were screened. Survey results indicated that this strategy increased providers' knowledge of developmental screenings and that administration of the ASQ-3 and ASQ-SE increased parent knowledge of child development.

In addition to implementing early childhood screening practices, EPPL also brought mental health consultations to children and families in the service area. Mental health consultants provided presentations and trainings to 2717 individuals, and EPPL staff made over 300 referrals to mental health or related services. For families receiving referrals, follow-up rates increased from 37% in Year 2 to 97% in Year 5, and receipt of services increased from 29% to 72% respectively. Results of a follow-up survey indicated that, following the consultation period, teachers and parents receiving mental health consultation saw decreases in the frequency and intensity of problem behaviors in their children.

Implementation of the family strengthening and parent training strategy resulted in 443 parents enrolled and divided into 18 cohorts of Incredible Years. Pre- and post-group survey results indicated that parents who completed the program showed increases in

family protective factors, decreases in parental stress, and increases in time spent reading to their children at home. Finally, EPPL implemented a pilot home visitation program, *Healthy Babies… Healthy Families*. Overall, the program enrolled 23 families, and included at least one home visit as well as developmental screening for all children 0-8 years old. Family members were screened for postnatal depression and/or alcohol/substance abuse when warranted. Results of the program demonstrated that families who completed the program showed increases in family protective factors and decreases in stress levels.

Texas LAUNCH

Texas Launch, the targeted expansion of Project Launch within the State of Texas, will implement three of the successful core strategies implemented by EPPL (developmental and social emotional screening, family strengthening program, and early childhood mental health consultation), as well as a fourth Project LAUNCH core strategy (workforce development). Each identified community will implement developmental and emotional screenings, the Incredible Years parenting program for family strengthening, and workforce development efforts. Communities will be able to choose whether or not to implement Parent Cafés for family strengthening as well as mental health consultation. Evaluation of this expansion effort will utilize a number of standardized tools to assess the efficacy and fidelity of the strategies being implemented. Additionally, the evaluation with gather data from a variety of sources, including self-reports completed by parents and caregivers, measures completed by educators and staff working directly with children, and administrative data provided by community and state stakeholders.

Part 2. Logic Model Narrative

The Texas LAUNCH initiative aims to improve the developmental and social and emotional outcomes of children age 0 to 8 in three selected communities by implementing best practices within an array of systems supporting young children. Each strategy builds upon the others by increasing the early identification of developmental concerns and support for families to access early childhood interventions, strengthening family capacities for the promoting children's development and wellness, and enhancing child care and educational programs to support child success. Workforce development efforts support each of these strategies, as well as the overall knowledge, skills, and abilities of the early childhood workforce in areas such a child development, impact of childhood trauma, and reducing job stress and burnout. A graphic representation of the Texas LAUNCH logic model is provided in Figure 1.

Inputs:

Of the nearly 7.5 million Texans 17 years and younger, 50.6% are 8 years old and younger. To date, Texas has been largely unsuccessful in meeting the needs of this population, ranking 43rd in the country on measures of economic well-being, health, education, family and community. However, Texas is well-poised to implement the strategies identified in Texas LAUNCH, and there are several notable strengths that will support the implementation. First, Project LAUNCH was successfully implemented in El Paso, and members of the original El Paso Project LAUNCH will also be supporting Texas LAUNCH. Second, Texas has a pre-existing state council infrastructure in which the Expansion Oversight Committee will be embedded. Third, state agencies have committed to improving early child serving systems. Finally, First3Years will provide regular consultation and collaboration throughout the project's duration. Texas will conduct initial expansion in three communities, representing two large urban area, one predominantly Hispanic/Latino, and one small tribal community. The diversity of these initial expansion communities will inform further state expansion.

Strategies:

The community-directed expansion of Texas LAUNCH aims to build on successful elements initially implemented in the El Paso Project Launch pilot program, focusing on promotion of mental health wellness, strengthening of family systems, and building the capacity of providers of early childhood services to support the social and emotional health of young children. Taking a public health approach, activities will be directed to all children age 0 to 8 within the identified regions and their caregivers. Young child caregivers will include biological, adopted, and foster parents, as well as teachers and health care providers.

Texas LAUNCH has four major goals, each having associated objectives and activities:

1) *Early Childhood Screening (all communities)*– Increase the number of children who receive developmental and social-emotional screenings to identify potential delays and refer families to appropriate community providers;
2) *Enhanced Parenting Skills (all communities)*– Increase effective parenting practices through the implementation of Parent Cafés and Incredible Years parenting classes;
3) *Mental Health Consultation (select communities)*- Increase the number of early child care and education providers and home visitation providers able to support children's social and emotional development and address challenging behaviors within care settings; and
4) *Building Early Childhood Competency in the Workforce (state infrastructure)*- Strengthen the infrastructure supporting the development of the early childhood workforce, including the infrastructure supporting training in infant and young child mental health, trauma-informed practices, and the dissemination of evidence-based and promising practices targeting young children.

Strategy 1: Early Childhood Screening (all communities).

The three communities will receive training and technical assistance from the El Paso Project LAUNCH team in the use of the tools and strategies to engage community staff across multiple settings in the use of the selected screening tools. Project staff in each community will become skilled at training others to effectively use the tools and provide technical assistance to implement screening programs. Each community will receive an Ages and Stages Toolkit for use in their region. Additional materials will be created to communicate the importance of screening to families, medical providers, and other child-serving settings, such as brochures, presentations, or videos. Each community will identify or develop tools to support appropriate referrals following positive screens. Focus for implementation will primarily be upon child care providers, Head Start staff, primary care, and Home visiting staff. This will allow for the ability to reach a wide range of young children and therefore have the broadest impact. By specifically targeting children and families in communities with behavioral health disparities and limited options to access quality care, we expect early childhood screenings conducted through Texas LAUNCH will assist in identifying any potential developmental concerns earlier than might happen otherwise. Children who receive positive screens will then be referred to appropriate services, which will also increase receipt of early intervention.

Enhanced Parenting Skills (all communities). A two-tiered approach will be implemented to enhance parenting skills. First, following the example of El Paso, The Incredible Years Parenting Program will be implemented in all three communities. Incredible Years is based on the principles of video modeling, observational and experiential learning, rehearsal and practice, individual goal setting, self-management, self-reflection and cognitive self-control.

Incredible Years (IY) aims to improve parenting skills in an effort to increase positive outcomes for children with social, emotional, and behavioral issues (Webster-Stratton, C., & Taylor, T., 2001). Research has shown that positive parenting techniques (e.g., praise) serve as protective factors for a variety of social-emotional delays (Tremblay et al., 2004). Parents and caregivers who receive IY demonstrate improved parenting skills, including decreased use of critical statements, increased use of praise, and increased use of appropriate discipline (Webster-Stratton, 1998). Furthermore, children whose parents or caregivers participated in IY also demonstrated positive intervention effects (Posthumus, J. A., Raaijmakers, M. A. J., Maassen, G. H., van Engeland, H., & Matthys, W., 2011). It is expected that, when implemented with fidelity to the model, parents and caregivers who participate in IY groups under Texas LAUNCH will experience similar improvements in parenting skills, and that their children will experience similar increases in positive outcomes related to social, emotional, and behavioral health. Since Incredible Years is considered an early intervention program and may not be appropriate for all families, Texas will also encourage the use of the Parent Café model to engage and

increase the number of parents who are exposed to enhanced parenting skills. Evaluation of the Parent Café model has demonstrated that 99% of participating parents feel it was helpful, 97% intend to attend additional Cafés, and 85% report increased knowledge of protective factors (Be Strong Families, n.d.).

Mental Health Consultation (select communities). Early childhood mental health consultation (ECMHC) has been identified as a best practice for addressing challenging behaviors and supporting social and emotional wellness within early childhood settings. Indeed, evaluations of the effects of ECMHC have found that children who received mental health consultation had significantly lower ratings of a variety of behavioral and social-emotional challenges, including hyperactivity, restlessness, externalizing behaviors, and problem behaviors than they did prior to receiving ECMHC (Gilliam, W. S., Maupin, A. N., & Reyes, C. R., 2016; and Conners-Burrow, N. A., Whiteside-Mansell, L., McKelvey, L., Virmani, E. A., & Sockwell, L., 2012). Additionally, research indicates that teachers engaged in mental health consultation demonstrate higher levels of sensitivity in interactions with children in their classrooms, higher quality teacher-child interactions, lower levels of punitiveness and detatchment, and higher use of positive classroom-management strategies than do teachers not engaged with ECMHC (Conners-Burrow, N. A., Whiteside-Mansell, L., McKelvey, L., Virmani, E. A., et al., 2012; Virmani, E. A., Masyn, K. E., Thompson, R. A., Conners-Burrow, N. A., & Mansell, L. W., 2013; and Conners-Burrow, N., McKelvey, L., Sockwell, L., Ehrentraut, J. H., Adams, S., & Whiteside-Mansell, L., 2013). Given the documented positive outcomes of ECMHC in other states, it is anticipated that similar results will be achieved on the following key constructs: classroom climate and social, emotional, and behavioral challenges. Suspension and expulsion rates will also be collected to determine if there is a correlation between these rates and children receiving ECMHC.

Building Early Childhood Competency in the Workforce (infrastructure).
The Texas LAUNCH expansion project will work to expand the competency of the workforce serving infants, toddlers and young children. The workforce will be defined broadly to include health care providers, child care providers, early childhood educators, and mental health providers. The initiative will work to advance the promotion and prevention strategies through training on a) mental health promotion and child development; b) trauma-informed care; c) developmental and social-emotional screenings; d) the Incredible Years parent training program; and e) mental health consultation. Training will focus on the three expansion communities, with the aim of reaching additional members of the workforce as the project matures.

Outputs:

Early Childhood Screening: The goal for this strategy is to train and support 20 child providers across the three participating communities in the use of developmental and social and emotional screening tools, screen at least 600 children across the three

communities, and provide appropriate referrals to parents of 90% of the children identified through screenings. Outputs will be measured through surveys of providers participating in training and support, as well as completion of a screening and referral tool, documenting the number of children screened, the outcomes of the screening, subsequent referrals, and any waitlist period of greater than one month before accessing services.

Enhanced Parenting Skills: The goal for this strategy is to train six providers across the three participating communities in at least two IY curricula and to provide the IY parenting program to 300 parents. These numbers will be tracked using sign-in sheets.

Mental Health Consultation: The goal for this strategy is to engage 23 teachers in mental health consultation and for 110 children to receive mental health consultation, across the three participating communities.

Building Early Childhood Competency in the Workforce: The goal for this strategy is to train 640 early childhood professionals in the areas of infant and young child mental health, trauma-informed practices, and/or evidence-based and promising practices for mental health promotion in young children. These numbers will be tracked using sign-in sheets.

Outcomes:

Given the established research support and documented outcomes of these strategies, we anticipate, with sustained effort to adhere closely to proven models, that our implementation will be able to achieve similar outcomes for the children and families of Texas. Specifically, through implementation of the four core strategies of Texas LAUNCH, several individual level, community level, and state level outcomes are expected. On the individual level, expected outcomes include decreased problematic child behaviors, decreased parental stress, increase in positive parenting practices, and decrease in negative parenting practices. These will be achieved through implementation of early childhood screening, enhanced parenting skills, and mental health consultation. On the community level, expected outcomes include decreased rate of children expelled from childcare settings, decrease in teacher report of classroom disruption, and increased collaboration across local agencies that serve young children. Mental health consultation and early childhood workforce development will support these outcomes. Finally, on the state level, expected outcomes include increased collaboration across state agencies that serve young children and increased number of early childhood staff who have competence or mastery in skills related to early childhood development.

Impact of Strategies on Behavioral Health Disparities

Hispanic families, who experience mental health disparities, will be targeted in Texas LAUNCH through several strategies. To ensure that children and families of Hispanic origin are being served by Texas LAUNCH, demographic information, including ethnicity, will be collected for children who are screened, parents/caregivers who participate in family strengthening groups (i.e., Incredible Years and Parent Cafes), and children/families who receive mental health consultation services. All activities will be available in Spanish to families preferring this. Screenings will be conducted in Spanish and Incredible Years groups will be developed that specifically target Spanish speaking parents. Parent Cafés will also be adapted to engage Hispanic families, based on input from the community, using such strategies as hosting groups in churches, Hispanic community groups, etc. In addition, the expansion plan will utilize the extensive community health worker (promotoro/a) system in Texas to provide outreach to the Hispanic community. Promotoros will receive training and referral materials to support outreach for child screening and parent enhancement programs. The evaluation of impact will examine data on access, use, and outcomes by ethnicity. Further research questions and data analysis plans are described under each strategy.

The *Tigua tribe*, based in the Ysleta del Sur Pueblo, has developed a health and human services clinic that incorporates culturally sensitive whole health approaches to wellness. Rather than bringing external services to Ysleta del Sur, Texas LAUNCH will provide technical assistance to providers in the clinic to adapt the core strategies in a way that is culturally appropriate for the tribal community. Texas LAUNCH will seek guidance from previous Project LAUNCH grantees that have used the Incredible Years program within tribal communities, such as the Muscogee (Creek) Nation or the Kumeyaay Nation.

Each selected community provider will be required by contract to adhere to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards. The evaluation plan includes an assessment of compliance with this requirement in Year 2 and technical assistance for quality improvement will be available from regional staff within the Center for the Elimination of Disproportionality and Disparities, an office within Texas HHSC.

Texas LAUNCH Expansion Evaluation Plan

Expansion to Ysleta del Sur Pueblo, Fort Worth, and San Antonio

INPUTS

Needs

- Of the nearly 7.5 million Texans 17 years and younger, 50.6% are 8 years old and younger.
- Texas ranks 43rd overall on measures of economic well-being, health, education, family and community.

Strengths

- Successful past Project LAUNCH grant in El Paso.
- Pre-existing state council infrastructure in which to embed the Expansion Oversight Committee.
- Commitment from state agencies to improve early child serving systems.
- Leadership and consultation from First3Years

STRATEGIES

Local

- Integration of Developmental Screening/Referral Protocols into early childhood programs.
- Family Strengthening (Incredible Years/ Parent Cafes) Programs offered within communities.
- Mental Health Consultation offered to early childhood providers (select communities)
- Better coordination across local systems that serve young children through the Early Childhood Wellness Councils.

State

- Better coordination across state agencies who serve young children.
- Improve infrastructure and policies to support early childhood activities.
- Strengthen workforce infrastructure to better identify and serve young children with mental health needs.

OUTPUTS

Youth and Families

- Increased number of youth screened. (ASQ, PSC, MCHAT)
- Number of parents obtaining family strengthening.

Communities

- Number of individuals trained in early childhood screening.
- Number of individuals trained in Incredible Years.
- Number of individuals receiving mental health consultation.

State

- Increased number of practitioners with an infant mental health endorsement.
- Formal agreements to develop interagency collaboration.
- Increased number of parents participating in planning, oversight, or evaluation.

OUTCOMES

Youth and Families

- Decreased problematic child behaviors. (ECBI)
- Decreased parental stress. (PSI)
- Increase in positive parenting practices. (PPI)
- Decrease in negative parenting practices (PPI)

Communities

- Decreased rate of children expelled from childcare settings (extant state data)
- Decrease in teacher report of classroom disruption (extant state data)
- Increased collaboration across local agencies that serve young children. (Interagency Collaboration Activities Scale (IACAS))

State

- Increased collaboration across state agencies that serve young children. (Interagency Collaboration Activities Scale (IACAS))
- Increased number of early childhood staff who have competence or mastery in skills related to early childhood development.

Part 3. Evaluation Design - Table and Narrative

Texas will collect data for the required SAMHSA infrastructure indicators and performance measures, including:

- Number of people in the mental health and related workforce trained in specific mental health-related practices/activities specified within the grant (Infrastructure indicator W2);
- Number of organizations collaborating/coordinating/sharing resources with other targeted organizations (Infrastructure indicator PC2);
- Number and percentage of work group/advisory group/council members who are consumers/family members (Infrastructure indicator A4);
- Number of people receiving evidence-based mental health-related services as a result of the grant (Infrastructure indicator T3);
- Number of individuals screened for mental health, co-occurring mental health and substance abuse or related intervention (Infrastructure indicator S1);
- Number of individuals referred to mental health, co-occurring mental health and substance abuse or related services (Infrastructure indicator R1);
- Percentage of children demonstrating improved social-emotional skills/functioning (Common indicator 1);
- Percentage of children suspended/expelled from programs serving children birth to age eight (Common indicator 1);
- Percentage of parents or other primary caregivers demonstrating or reporting improvements in parenting (e.g., responsiveness, nurturing, and positive discipline; Common indicator 3);
- Percentage of parents or other primary caregivers reporting reduced stress (Common indicator 4);
- Percentage of providers reporting decreased stress levels (Common indicator 5);
- Percentage of programs with written policies to support early childhood workforce development related to social and emotional development and well-being (Common indicator 6);
- Percentage of programs with written policies to improve access for underserved racial and ethnic populations to services that promote social and emotional well-being for children and their families (Common indicator 7);
- Percentage of parents or other primary caregivers who screen positive for parental depression (Common indicator 8); and
- Percentage of parents or other primary caregivers reporting improved social support (Common indicator 9).

Workforce development: Through Workforce Competency component of Project LAUNCH, partners aim to build early childhood competency within the workforce in order to strengthen the supportive infrastructure for early childhood care within the state. Workforce development efforts will include training in infant and young child mental health, trauma-informed practices, as well as the

dissemination of evidence-based and promising practices to promote mental wellness. The early childhood workforce includes day care and early childcare providers, teachers, health care providers, early interventionists, and behavioral health providers.

The evaluation will address the following questions:

- Is the early childhood workforce better prepared to promote social and emotional development?
- How many individuals are trained in best practice early childhood practices?
- What is the increase in the workforce certified in early childhood mental health?
- What is the perceived impact of each training opportunity on the work of the participants?
- What percentage of providers report decreased stress levels following training?
- What barriers and/or facilitators did communities experience in the workforce development efforts?

Design: The evaluation design for the workforce development strategy is a process-oriented tracking of the number and type of participants impacted by the training activities, as well as a pre-test, post-test design to measure the impact of training activities on the participants. The tracking of training types and participants, as well as descriptive feedback from participant surveys, will allow project staff to identify gaps in training, issues of training quality, and geographical impact. The pre-test/post-test design allows for measuring change in key outcomes (e.g., perceived competence, compassion fatigue) over time, without the resources that would be required by an experimental design.

Measures:

The Professional Quality of Life Scale (ProQoL;Stamm, 2010): The Professional Quality of Life Scale (ProQol) is a 30-item, self-report measure of the positive and negative effects of working with people who have experienced extremely stressful events. It contains two scales: compassion satisfaction (i.e., the pleasure one derives from being able to do their work well) and compassion fatigue (i.e., emotions related to burnout and secondary traumatic stress). Studies have demonstrated good construct validity of the ProQol, as well as reliability for both the compassion satisfaction (Cronbach's alpha = .88) and compassion fatigue scales (for the burnout scale, Cronbach's alpha = .75 and for the secondary traumatic stress scale, Cronbach's alpha = .81) (Stamm, 2010).

Training Summary Sheet (TSS): The primary measure for this evaluation was developed to track important information about the trainings received as a result of Texas LAUNCH activities. This form collects information about the goal of the training, setting, number and type of participants, and role of LAUNCH in the workforce development activity.

Inventory of Training and Technical Assistance, Walker & Bruns, 2010 (IOTTA) : The Inventory of Training and Technical Assistance asks participants about their satisfaction regarding different aspects of the training they received as well as how important and impactful they perceive the training to be. Additionally, the measure assesses the participant's perceived prior mastery of the domain of skills before their training attendance as well as their anticipated mastery of the domain of skills following the training and into the future. This tool has been used frequently in effective implementation and intervention practice change research conducted by the National Wraparound Initiative (NWI) through the Substance Abuse and Mental Health Systems Administration (SAMHSA).

Early Childhood Mental Health Endorsements: The number of providers seeking and achieving early childhood credentials through First3Years will be collected quarterly from an existing registry held by First3Years.

Procedures:
At each training event conducted by Texas LAUNCH or partner agencies, the number of professionals trained will be documented from participant sign-in sheets. Partners will provide a brief description of the training event, using the Training Summary Sheet, submitted with copies of the sign-in sheets. This will allow the evaluators to identify the target audience of the training, the training topic, and key information about the length of the training and qualifications of the trainers. At the end of each training, participants will complete the IOTTA, documenting the perceived impact of the training and their competency or mastery of the skills. This measure will be paper-and-pencil for workshop participants and through a web-based survey for those participating in online training events. Qualitative information collected on the IOTTA will be summarized following each training, and will be aggregated across training events to allow for the identification of themes annually. For a subset of workforce trainings focused on reducing compassion fatigue or burnout in the workforce, participants will also receive the ProQol, a self-report measure on provider stress. These participants will be contacted by email three months following the training to respond to the questions on provider stress (ProQol) and determine any changes over the 3-month period.

Additionally, changes in the rate of providers seeking early childhood credentials through First3Years endorsement process will be tracked quarterly to identify any potential increases over time in partnership with the organization. No identified information on individuals seeking endorsement will be gathered, merely the number seeking endorsement by category and the number successfully achieving endorsement by category.

Analysis Plan: The primary evaluation questions will be addressed through descriptive statistics, summarizing the type and number of trainings conducted. Descriptive statistics (e.g., means, standard deviations, frequencies) will be used to summarize participant feedback after training events. The IOTTA includes a pre-training measure of perceived competency and a post-training item, which

will be analyzed with dependent t-tests. For some training events, surveys will be collected at three months post-event, and analyzed with dependent t-tests. If interventions are undertaken to improve the quality of trainings, the evaluation may also utilize independent t-tests to assess changes in survey responses across training cohorts. Differences in satisfaction and perceived competence will be explored across participant race/ethnicity groups using ANOVAs. Lastly, increases in individuals receiving early childhood credentials will be analyzed with descriptive statistics, showing trends by quarter over the course of the project. If the data warrants an examination of a change in the slope of the data, based on an intervention, this will be examined with an interrupted time series segmented regression analyses. The temporal proximity of the measurement of impactto the training event strengthens the internal validity of the evaluation; however, validity may be weakened to the extent the survey results in biased reports of competency due to self-report and expectancy biases.

Agency or Organizational Collaboration/Coordination/Resource Sharing: The focus of this evaluation component is examining the nature and impact of efforts to enhance collaboration and support early childhood efforts within the three communities and the state. The purpose of the evaluation is to document accomplishments and challenges in the project, identify successful strategies that can be replicated, and provide continuous quality improvement information to state and local oversight teams.

This evaluation will address the following questions:

- Are key stakeholders collaborating on system changes to enhance support for early childhood mental health promotion?
- What are the key accomplishments of the collaborative councils?
- What facilitators have advanced the community's efforts? What barriers have the councils encountered and how have they strived to overcome them?
- What is the reach of communication and social marketing activities in building awareness and engagement in early childhood activities?
- Are policies and procedures present to support and engage Project LAUNCH activities?
- Has the community enhanced partnerships with child-serving organizations to improve care coordination, referrals, and community infrastructure?

Design: The evaluation design for the Organizational Collaboration component of Texas LAUNCH includes a qualitative analysis of existing data and prospectively collected surveys about key accomplishments and barriers. The design also includes a time series analysis of variables capturing social marketing and communication reach, parent or caregiver participation, collaborative activities, and strength of the collaborative workgroups. These time series analyses will allow for changes in these variables over the course of the project to be documented and tracked, in relation to strategies undertaken to strengthen collaboration and family voice. This design

will also allow for a correlational analysis of collaborative strength and community accomplishments, allowing the evaluators to identify key indicators of collaborative strength and their impact on key measures of expansion success.

Measures:
Interagency Collaboration Activities Scale (IACAS) (Greenbaum & Dedrick, 2000): The Interagency Collaboration Activities Scale (IACAS) is a 12-item, self-report questionnaire measuring specific organizational collaborative practices and activities in three domains (financial and physical resources, program development and evaluation, and collaborative policies) in organizations focused on delivering services to children with mental health challenges. (Dedrick & Greenbaum, 2011). The IACAS has acceptable documented reliability. For the three aforementioned domains, Cronbach's alpha was .84, .83, and .86 for financial and physical resources, program development and evaluation, collaborative policies, respectively (Dedrick & Greenbaum, 2011).

Wilder Collaboration Factors Inventory (Mattessich, Murray-Close, & Monsey, 2004): The Wilder Collaboration Factor Inventory is a 40-item instrument which measures 20 collaboration factors (variables). These 20 Wilder factors are grouped into the six categories: environment, membership, process and structure, communication, purpose, and resources. While the instrument is theoretically derived, some evidence of adequate reliability has been found for 14 of the 20 items, with three showing lower reliability and three items existing in single-item factors, so reliability could not be assessed (Townsend & Shelley, 2008). Even though the psychometrics of the instrument are not well known, it has been widely used as a tool to support the development of collaborative groups.

Surveys of Accomplishments and Barriers: Council members will complete a survey identifying the accomplishments from the previous year and barriers to achievement of council goals. Additional information on accomplishments and barriers will be gathered from council meeting minutes.

Communication and Social Marketing Reach: Distribution of communication tools and website or social media analytics will be used to measure the reach and impact of communication activities. Data will be collected quarterly.

Procedures:
The number of organizations collaborating and sharing resources with other targeted organizations will be gathered quarterly from Council sign-in sheets, meeting minutes, and community contract reports. This will include information on the number of members who are consumers or family members. Council member's perceptions of collaborative activities will be assessed at the end of Year 1 and Year 3 through the IACAS. Perceptions of the strength of the Council will be assessed at the end of Year 2 and 4 through a survey of members using the Wilder Collaboration Factors Inventory. Along with these measures, council members will report on accomplishments completed by the Council and barriers to goals.

Analysis Plan: Council accomplishments at the state and local levels will be qualitative and analyzed through descriptive analyses, such as the number of new members, number of systems involved, or number of policies changed. Similarly, strength of collaborative activities and the collaborative group will be primarily descriptive, presented through means, standard deviations, and frequencies. Dependent t-tests will be used to examine changes in measures across the two time points, for each of the measures of collaboration. If possible, the evaluators will explore opportunities to examine the strength of the relationship between collaborative strength and community accomplishments, such as the number of workforce trained or children screened. Communications and social marketing reach will be measured through descriptive time series graphs, with the aim of demonstrating increasing reach over time, through a positive slope.

Family Strengthening:

Incredible Years

The primary evaluation aim of this strategy is to evaluate the quality and impact of the implementation of Incredible Years (IY) into three communities in Texas. The following questions will be answered in the evaluation:

- How many parents/caregivers are participating in parenting groups
- What percentage of parents/caregivers is attending at least three quarters of the sessions within a group series?
- Are there any differences in service usage patterns based on age, sex, or race/ethnicity? How does the racial and ethnic distribution of children served compare to the community?
- Is there intervention integrity and fidelity to the IY model?
- Are the IY parent groups associated with significant changes in levels of positive parenting behaviors?
- Are the IY parent groups associated with reductions in problematic child behavior?
- Are the IY parent groups associated with changes in levels of parental stress?
- Are the IY parent groups associated with changes in perceived social support?
- Are lower levels of intervention integrity associated with attenuated outcomes?
- Are there any differences in outcomes based on age, sex, or race/ethnicity?

Design:

The IY evaluation will be conducted using a pre-test and post-test design. The impact of the intervention will be examined by measuring key variables prior to the intervention and at the end of participation in the group. The extent to which treatment integrity, including dosage and adherence to the model, will be examined as a potential mediator of the effect.

Measures:

Collaborative Process Checklist: The Collaborative Process Checklist is a 56 question, self-report checklist designed to be completed by a supervisor following a session by group leaders, or to be completed by a group leader for him/herself as a method of standardized feedback on implementation fidelity. This measure has demonstrated adequate inter-rater reliability and discriminant validity (Webster-Stratton, Reid, & Marsenich, 2014).

Parent Practices Interview (LIFT; Webster-Stratton, Reid, & Hammond, 2008): The Parent Practices Interview is a 72-item questionnaire that was adapted from the Oregon Social Learning Center's (OSLC) discipline questionnaire and revised for young children. The LIFT can be administered as an interview or used as a self-report questionnaire completed by the child's primary caregiver. It is composed of seven subscales—Harsh Discipline (14 items), Harsh for Age (9 items), Inconsistent Discipline (6 items), Appropriate Discipline (16 items), Positive Parenting (15 items), Clear Expectations (3 items), and Monitoring (9 items)—rated on a 7-point scale ranging from 1 (never) to 7 (always). It should be noted that although the PPI subscales were revised in 2006 to six subscales. It takes approximately 15 minutes to complete.

Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999): The Eyberg Child Behavior Inventory (ECBI) is a parent-report measure used to assess both the frequency of child disruptive behaviors and the extent to which the parent finds the child's behaviors troublesome. It is a 36-item questionnaire of child externalizing behavior problems, consisting of common, maladaptive behaviors. The ECBI yields two scores: the intensity score, which is the frequency with which the child engages in each of the 36 behaviors and the total problem score, which is the number of behaviors reported as problematic. (Gross et al., 2007; & Weis, Lovejoy, & Lundahl, 2005). The ECBI possesses adequate test-retest reliability (Cronbach's alpha = .75), and excellent (Cronbach's alpha = .94) (National Child Traumatic Stress Network, 2012). The ECBI has also demonstrated good convergent and discriminant validity in diverse samples within the literature (National Child Traumatic Stress Network, 2012).

Parenting Stress Index (PSI-SF; Abidin, 1990): The Parenting Stress Index (PSI) is a 36-item, self-report measure of parenting stress, which assesses three areas of stress in the parent-child relationship: child characteristics, parent characteristics, and stress stemming from characteristics within the parent-child relationship. (National Child Traumatic Stress Network, 2012). The PSI has well-documented test-retest reliability and internal consistency (Cronbach's alpha = .83 and .81, respectively) (National Child Traumatic Stress Network, 2012). The PSI also possesses good convergent and discriminant validity among diverse samples (National Child Traumatic Stress Network, 2012).

National Outcomes Measures Survey (NOMS): The National Outcomes Measures Survey (NOMS) is a measure used by the Substance Abuse and Mental Health Services Administration (SAMHSA) for cross-site evaluation of a variety of mental health initiatives. The tool is used to gather information around demographics, housing stability, education, employment, and criminal justice involvement. Additionally, it assesses current functioning (including daily functioning, mental health, and substance use), exposure to violence and trauma, and social connectedness. Finally, collected only at follow up, are questions related to perception of care, services received, and discharge status. In this initiative, one or more parents or caregivers will complete the NOMS interview.

Procedures: IY group facilitators will meet with each parent or caregiver referred to the program prior to the first group session. During this meeting, facilitators will gather information about the family, learn about the program, complete consent forms, and complete baseline instruments. The NOMS form will be conducted by interview, with other measures (i.e., LIFT, PSI-SF, ECBI) completed as self-report, unless there are literacy issues. Follow-up measures will be collected at the final meeting of the group, or within one month of completion (i.e., NOMS, LIFT, PSI-SF, ECBI). IY group facilitators will complete the Collaborative Process Checklist at the end of each group session. In addition, each facilitator will submit one audiotaped group session in each year of the project for external review by IY Trainers or evaluation staff.

Analysis Plan: Implementation fidelity will be analyzed through descriptive statistics, benchmarking against existing standards of fidelity. The primary analyses measuring the impact of IY will be independent t-tests, comparing summary measures of parenting behaviors (LIFT Positive Index, Negative Index), parenting stress, and child behavior problems (ECBI total). Results will be benchmarked against effect sizes found in research trials of IY. Exploratory analyses will examine differences in outcomes by racial/ethnic groups, dosage (number of groups attended), and level of fidelity (high vs. low). Depending on the qualities of the data (e.g., equivalence at baseline), the analysis may use ANOVAs or analysis of covariance. Missing data on individual scales will be imputed, based on the standardized rules for each instrument about allowable missing data. Children or families with missing baseline or follow-up measures will be excluded from the analyses, given the limited number of assessment points. Potential threats to internal validity include possible regression to the mean or Hawthorne effects. External validity is strengthened by the use of existing community providers and referred families, but may be threatened if only "easily engaged" families are recruited.

Parent Cafés

Parent Cafés provide a safe and nourishing environment for parents to have candid, authentic conversations about their families and discuss ways in which to strengthen their families and communities. Parents and families draw on their established strengths, aided by skilled group leaders focused on familial protective factors, and ultimately, gain awareness and confidence in their role and responsibility in shaping healthy, strong families and communities. Additionally, participation in Parent Cafés assist parents with

enhancing their social and emotional skills (Parent Café Training Institute Participant Manual, pg. 7; URL: www.bestrongfamilies.net).

The primary evaluation aim of this strategy is to evaluate the quality and impact of the implementation of Parent Cafés into three communities in Texas. The following questions will be answered in the evaluation:

- How many parents or caregivers are attending Parent Café events?
- How does the racial and ethnic distribution of familiies served compare to the community?
- How many parents or caregivers are returning for more than one event?
- How many parents or caregivers are reporting a perceived change in knowledge and confidence following attendance at a Parent Café event?

Design: The evaluation design for the Parent Café strategy is a process-oriented tracking of the number of participants impacted by the Parent Cafés, as well as a post-test design to measure participants' preception of change on knowledge and parenting confidence, as well as satisfaction after attendance at Parent Café activities. The tracking of participants, as well as descriptive feedback from participant surveys, will allow project staff to identify gaps in training, issues of training quality, and geographical impact. The post-test design allows for measuring perceived change in key outcomes (e.g., perceived competence, knowledge, and service satisfaction) over time, without the resources that would be required by an experimental design. Given the relatively brief interaction in this intervention, a pre-test was not feasible.

Measures:
Parent Café Evaluation Measure: The Parent Café Evaluation is a measure used by the developer of the Parent Café model (Be Strong Families) to gather information about participants' perceptions regarding their experience during a Parent Café. The tool assesses participants' learning about protective factors or strategies to strengthen their families, impact on the participants' social network through participation in the Parent Café, and intentions to change/alter their parenting practices as a result of Parent Café participation.

Procedures: Parent Café group facilitators will recruit families who receive services from a community service provider or within the expansion community and have a child aged 0-8. Prior to the beginning of the Parent Café, facilitators will gather administrative data (e.g., sign in sheets) from the participants, explain the nature of the Café as well as their participation in the project to improve service provision for their family and families similar to theirs. Satisfaction measures will be collected at the conclusion of the Café.

Analysis Plan: Analysis of evaluation data from Parent Cafés will be primarily descriptive in nature, using means, standard deviations, and frequencies. Results will be benchmarked against the results demonstrated in initial evaluation studies by BeStrong Families. Locations of Parent Cafés will be mapped using ArcGIS to demonstrate geographical impact over time.

Mental Health Consultation. Early childhood mental health consultation involves collaboration between a professional consultant with mental health expertise working with early care and education staff, programs, and families to improve their ability to prevent, identify, and respond to mental health issues in their care. Early childhood mental health consultation differs from traditional therapeutic services in that it is an indirect approach to reducing problem behaviors in young children as well as promoting positive social and emotional development (Georgetown University Center for Child and Human Development, http://gucchd.georgetown.edu/67637.html). Mental health consultation can focus at a classroom level, promoting the social and emotional wellness of all students, or at an individual child and family level, supporting interventions at school and home to address behavioral or emotional difficulties and intervene early with possible mental health challenges. In Texas LAUNCH, mental health consultation is an optional strategy for communities with implementation planned for later grant years.

The following questions will be addressed in this evaluation:

- How does the racial and ethnic distribution of children served compare to the community?
- What percentage of children whose teacher or parent participates in mental health consultation demonstrate improved social-emotional skills/functioning?
- What percentage of children are suspended/expelled from programs serving children birth to age eight prior to and after mental health consultation?
- What percentage of parents or other primary caregivers report reduced stress?
- Are there any differences in outcomes based on age, sex, or race/ethnicity?
- Do teachers and child care providers participating in mental health consultation change the classroom climate following the intervention?
- What percentage of providers report decreased stress levels following mental health consultation?

Design: The mental health consultation evaluation will be conducted using a single group, pre-test and post-test design. For child-focused consultation, pre-test and post-test measures will examine change in the child's social and emotional functioning and reductions in parenting stress. For classroom-based consultation, pre-test and post-test measures will focus on changes in teacher job stress and changes to the mental health climate in the classroom. Changes in the number of children suspended or expelled from childcare or early childcare settings will be assessed for both child-focused and classroom-focused interventions.

Measures:

Devereaux Early Childhood Assessment Clinical Form (DECA-C; LeBuffe & Naglieri, 2003): The Devereaux Early Childhood Assessment Clinical Form (DECA-C) is a 62-item form that can be completed by parents or teachers. It assesses children two through five years old for behavioral and social-emotional concerns, including aggression, attention problems, emotional control problems, and withdrawal/depression. In addition, it contains resilience and strength-based items, including attachment, initiative, and self-control. Studies indicate that the DECA-C demonstrates internal reliability for both parent and teacher reporters (Cronbach's alpha = .76 and .88 respectively). Furthermore, the criterion validity of the DECA-C has been well established, and discriminant analysis using the Total Behavioral Concerns Scale resulted in 74% classification accuracy (LeBuffe & Naglieri, 2003).

Parenting Stress Index (PSI-SF; Abidin, 1990): The Parenting Stress Index-Short Form (PSI-SF) is a 36-item, self-report measure of parenting stress, which assesses three areas of stress in the parent-child relationship: child characteristics, parent characteristics, and stress stemming from characteristics within the parent-child relationship. (National Child Traumatic Stress Network, 2012). The PSI-SF has well-documented test-retest reliability and internal consistency (Cronbach's alpha = .83 and .81, respectively) (National Child Traumatic Stress Network, 2012). The PSI-SF also possesses good convergent and discriminant validity among diverse samples (National Child Traumatic Stress Network, 2012).

National Outcomes Measures Survey (NOMS): The National Outcomes Measures Survey (NOMS) is a measure used by the Substance Abuse and Mental Health Services Administration (SAMHSA) for cross-site evaluation of a variety of mental health initiatives. The tool is used to gather information around demographics, housing stability, education, employment, and criminal justice involvement. Additionally, it assesses current functioning (including daily functioning, mental health, and substance use), exposure to violence and trauma, and social connectedness. Finally, collected only at follow up, are questions related to perception of care, services received, and discharge status. In this initiative, one or more parents or caregivers will complete the NOMS interview.

The Professional Quality of Life Scale (ProQoL;Stamm, 2010): The Professional Quality of Life Scale (ProQol) is a 30-item, self-report measure of the positive and negative effects of working with people who have experienced extremely stressful events. It contains two scales: compassion satisfaction (i.e., the pleasure one derives from being able to do their work well) and compassion fatigue (i.e., emotions related to burnout and secondary traumatic stress). Studies have demonstrated good construct validity of the ProQol, as well as reliability for both the compassion satisfaction (Cronbach's alpha = .88) and compassion fatigue scales (for the burnout scale, Cronbach's alpha = .75 and for the secondary traumatic stress scale, Cronbach's alpha = .81) (Stamm, 2010).

Preschool Mental Health Climate Scale (PMHCS; Gillian, 2008). The PMHCS is a measure to gauge the success of the ECMHC program, addressing the full range of classroom characteristics associated with mentally healthy environments for young children. The measure has 50 items that are scored on a 5-point Likert scale with "1" indicating never or not true, "3" indicating moderately frequent or moderately true and "5" indicating consistently or completely true. Items are grouped into nine domains: Transitions, Directions and Rules, Staff Awareness, Staff Affect, Staff Cooperation, Teaching Feelings and Problem-Solving, Individualized and Developmentally Appropriate Pedagogy, Staff-Child Interactions and Child Interactions. Estimates of inter-rater reliability were acceptable (Gilliam, 2008) and internal consistency ranged from .98 for Total Positive Indicators and .75 for Total Negative Indicators.

Procedures: Following child referrals to the mental health consultant (MHC), the parent will meet with the MHC to hear about potential services, complete consent forms, and complete baseline assessment forms, including the Devereaux Early Childhood Assessment Clinical Form (DECA-C), the Parenting Stress Index Short Form (PSI-SF), and the National Outcomes Measures Survey (NOMS). The MHC will conduct the NOMS using an interview format, with additional measures completed by the parent or other caregiver, unless literacy issues suggest an interview for all scales. Follow-up assessments will be completed at the end of the intervention by the parent or other caregiver, with the interview led by the MHC. Follow-up assessments will only be conducted if the family has participated in at least five meetings with the MHC. If the family leaves the setting prior to the end of the intervention, staff will attempt to contact the parent to complete discharge assessments. For agency and classroom interventions, the MHC will meet with administrators interested in being involved in the service. Administrators will work with staff to document the number of children who had been suspended or expelled from the program in the previous twelve months. After initiating the agreement for collaboration, the administrator will support the completion of the job stress survey with all early childhood teachers in the facility. Agencies may decide to have the instrument collected on paper-and-pencil or online. The survey will be completed again after one year of collaboration. When the MHC is asked to provide support to one or more classrooms, he or she will conduct the PMHCS through an observation of the class. The instrument will be repeated after 6 months.

Analysis Plan: Child or family-level outcomes will be analyzed through dependent t-tests, including reductions in parenting stress (PSI-SF) and increases in social and emotional functioning (DECA). If sample size allows, additional analyses will examine differences in outcomes by racial/ethnic groups using ANOVAs or analysis of covariance. Classroom level outcomes will be measured will be analyzed through a descriptive measure of change in the percentage of children suspended and expelled in the year prior to and after intervention. If enough agencies are included in the analyses, dependent t-tests will be used to measure the statistical significance of the change over time. Changes in teacher job-related stress will be analyzed with a dependent t-test. Missing data on individual scales will be imputed, based on the standardized rules for each instrument about allowable missing data. Children or families with

missing baseline or follow-up measures will be excluded from the analyses, given the limited number of assessment points.

Developmental and Social Emotional Screening and Referral: The focus of this component of the evaluation is to measure the impact of efforts to increase developmental and social-emotional screenings for young children in the three expansion communities. The evaluation is intended to document the number and type of screenings occurring in each community, the characteristics of the children screened, the results of these screenings, and the number and percentage of children who receive further services after a positive screen.

The following question will be addressed in this evaluation:

- How many young children are communities screening?
- What are the characteristics of children screened in the project? How does the racial and ethnic distribution of children served compare to the community?
- What percentage of children screened are identified as at risk for developmental or social-emotional concerns?
- What percentage of children identified as at risk and referred for further services receive subsequent interventions?
- What barriers do parents report to accessing services following a referral?
- Are there any differences in the receipt of subsequent interventions by age, sex, or race/ethnicity?

Design:
This component of the evaluation will be a non-experimental process design. The design will focus on the number of screenings conducted, the number of children identified by screening with a developmental or social/emotional concern, and the number/percent of children or parents who access services as a result of the screening. There is no current plan to measure developmental or behavioral health outcomes of children or parents as a result of the screening activities.

Measures:
Texas LAUNCH Screening and Referral Form: The primary measure for this evaluation was developed to track the necessary information on child and/or parent screenings. This form collects de-identified information about the child's age, gender, ethnicity, the zip code of the screening services, the screening tools used, the results of the screening, and types of referrals provided. Additional information on services received and barriers to accessing services is provided for select families.

In addition to the Screening and Referral Form (SRF), a number of screening tools can be selected by providers, based on the needs of the setting and the age of the child. The SRF will collect summary scores from any tools used in the screening and assessment. The following primary tools may be used:

Ages and Stages Questionnaire, Third Edition (ASQ-3; Squires, Twombly, Bricker, & Potter, 2009): The Ages and Stages Questionnaire tracks developmental progress in children between the ages of one month to 5 ½ years. The measure is designed for use by early childhood educators and health care professionals and is available in a number of languages. The ASQ-3 has strong, documented test-retest reliability with coefficients ranging from .75 to .82 in intraclass comparisons. Additionally, the ASQ-3 demonstrated good internal consistency. Alphas ranged from .6 to .85 when correlations between overall score and developmental area were calculated. At the item level, the ASQ-3 has also demonstrated reasonably good internal consistency. Item level alphas ranged from .51 to .87 in these analyses.

Ages and Stages Questionnaire, Social Emotional (ASQ-SE; Squires, Bricker, & Twombly, 2002): The Ages and Stages Questionnaire, Social Emotional Second Edition is modeled after the ASQ-3; however, it is tailored to identify and screen for concerning social and emotional behaviors in young children. This parent-completed measure is rated on a 3-point Likert Scale (Rarely or Never, Sometimes, and Often or Always) and includes items such as, "Does your child laugh or smile when you play with him/her?, Does your child greet or say hello to familiar adults?, and When you leave, does your child stay upset and cry for more than an hour?"). The ASQ-SE has well-documented and acceptable indicators of internal consistency, with coefficients ranging from .67 to .91, with an overall alpha of .82. In addition, the *Technical Report on ASQ:SE* details considerable research findings on the validity of this measure.

Pediatric Symptom Checklist (PSC, Jellinek & Murphy, 1988): The Pediatric Symptom Checklist is a brief, developmental screening questionnaire designed for use by pediatric health care providers. The questionnaire contains 35 items that are completed by the child's caregiver in an effort to improve the identification and treatment of psychosocial problems in children. Each item is rated on a three-point scale (e.g, Never, Sometimes, Often) and includes items such as, "complains of aches or pains, acts as if driven by a motor, and is feels sad or unhappy." Positive screens are those with scores above 27 for ages 6-18 and scores of 24 and higher for children ages 4 and 5. It is available in a number of languages. The PSC has well-documented validity and reliability data and it is listed as a recommended, evidence-based developmental screening measure (for further reliability/validity information: Bernal et al., 2000; Kelleher et al.,1998).

Modified Checklist for Autism in Toddlers (M-CHAT-R; Robins, Fein, & Barton, 2009): The Modified Checklist for Autism in Toddlers (M-CHAT-R) is an autism screening tool designed to identify children 16 to 30 months of age who should receive a more thorough assessment for possible early signs of autism spectrum disorders (ASDs) or developmental delay. Additionally, the M-

CHAT is recommended by the American Academy of Pediatrics as an evidence-based developmental measure with suggested administrations at 18 and 24 months of age. Research has documented acceptable internal consistency with coefficients ranging from .63 to .79 (Robins, Casagrande, Barton, Chen, Dumont-Mathieu, & Fein, 2013).

Patient Health Questionnaire (PHQ; Spitzer, Williams, & Kroenke, 1995): The Patient Health Questionnaire is a diagnostic tool for mental health disorders used by health care professionals. The self-report measure assesses the frequency and severity of a number of physical, emotional, and behavioral symptoms. Parents or other primary caregivers may complete this measure in conjunction with one or more of the developmental measures described above. The PHQ has well-researched and well-documented reliability and validity in a number of different studies (e.g., Spitzer, Williams, Kroenke, et al., 2000; Kroenke, Strine, Spitzer, Williams, Berry, & Mokdad, 2009).

Procedures:
Data will be collected by the provider of the screening or other staff designated by the agency. Parents or other legal guardians will be asked to participate in the screening intervention and related data collection prior to any service delivery. Screening providers will either send the informed consent to parents through the staff at the screening setting (e.g., child care agency) to be returned or they will conduct an informed consent discussion over the phone or in person. If the caregiver consents, he/she will each be asked to complete screening surveys related to the developmental and behavioral functioning of the child and surveys about their own physical and emotional well-being. The procedures will vary somewhat, depending on the developmental measures being utilized. Based on the scores of those measures, the caregiver may then receive a referral for additional evaluation or further service provision. Following the screening event, the provider will record summary information about the screening event through the Texas LAUNCH Screening and Referral Form. If referrals for additional evaluation or service provision were made, providers will contact the caregiver by phone or text at 3 months following the screening event to inquire whether the family received additional services and any barriers to accessing those services.

Analysis Plan: The analysis for this component will be primarily descriptive, summarizing the characteristics of the children or caregivers screened using frequencies, means, and standard deviations. The geographic location of youth screened will be mapped within each community and associated with identified measures of inequity. Measures of the percentage of children or caregivers receiving subsequent services will be tracked over time and if specific interventions are undertaken to improve service access, an interrupted time series analysis may be conducted. Differences in access to services following referral will be analyzed by racial/ethnic groups (dummy coded) using chi square analyses.

Expansion Evaluation Plan - Table

	Research Questions	Design	Measure	Methods	Schedule
Overall Expansion	**Overall Expansion** Process:	Design:	Measures:	Methods:	Schedule:
	• What strategies do project stakeholders perceive as most impactful in the community?	Descriptive analysis	Survey of Council Accomplishments (internally designed)	Surveys completed by council members distributed and collected at council meetings	Collected at the end of Year 2, 3, and 4
	• Does the strength of the Early Childhood Wellness Council impact the success of the LAUNCH strategies?	Correlations of collaboration factors and ratings of impact	Survey of Council Accomplishments and Wilder Collaboration Factors Inventory (Mattessich, Murray-Close, & Monsey, 2004)	Surveys completed by council members distributed and collected at council meetings	Wilder survey completed at end of Year 2 and 4
	• Are policies and procedures present to support and engage Project LAUNCH activities?	Descriptive; simple description of bi-annual measurement	% of programs with written policies around early childhood workforce % of programs with written policies around reducing disparities	Collection of policies from all documented key collaborators (contractors, core referral site, service site)	Collected in Year 2 and 4
	• What facilitators and barriers have been found for the provision of technical assistance and the support for implementation?	Qualitative analysis identifying key themes	Semi-structured interview of Sate Lead and Local Lead	In-person semi-structured interview, followed by the identification and coding of key themes	Completed at end of Year 4
Training/ Policy/ Partnerships	**Training/Collaboration/Partnership** Process:	Design:	Measures:	Methods:	Schedule:
	• Are key stakeholders collaborating on system changes to enhance support for early childhood mental health promotion?	A pre-post single-group design will be used to measure strength of collaboration among stakeholders.	Interagency Collaboration Activities Scale (Greenbaum & Dedrick, 2000) Wilder Collaboration Factors Inventory (Mattessich, Murray-Close, & Monsey, 2004)	Surveys completed by council members distributed and collected at council meetings	IACAS completed at end of Year 1 and 3 Wilder survey completed at end of Year 2 and 4
	• What facilitators have advanced the community's efforts? What barriers have the councils encountered and how have they strived to overcome them?	Qualitative analysis of survey responses to identify themes across the four councils; may also incorporate themes from council minutes	Survey of Accomplishments and Barriers	Aggregation of responses, followed by identification and coding of thematic areas	Completed at the end of Years 2, 3, and 4
	• What is the reach of communication and social marketing activities in building	Communication and social media reach will be studied in a repeated measure simple time series design.	Analytics on website, social media, distribution of printed materials	Communication reach measured through electronic systems, such as google analytics, tweet deck	Communication reach measured quarterly

	awareness and engagement in early childhood activities?	Qualitative information on changes in communication strategies will be documented to understand changes in reach.			
	• How many individuals are trained in best practice early childhood practices?	Descriptive; number of staff trained in best practices	Training Activity Summary	Training Activity Summary completed by trainer or host at the end of each training event	On-going, following each event; summarized each quarter
	• What is the increase in the workforce certified in early childhood mental health?	A simple time series analysis will be used to measure the impact of workforce efforts on the number of individuals certified in early childhood mental health.	Number of individuals certified in early childhood mental health (by level)	Counts of certified workforce gathered by state certification body, First 3 Years	Certified infant mental health workers measured quarterly through Years 2-4
	• What barriers and/or facilitators did communities experience in the workforce development efforts?	Qualitative analysis identifying themes	Stakeholder interviews with semi-structured format	Interviews conducted by phone; analyzed by two researchers reaching consensus on themes	Interviews in Year 4
	Outcome:				
	• What are the key accomplishments of the collaborative councils?	Evaluation of the accomplishments of the councils will be a descriptive, qualitative design.	Survey of Council Accomplishments (internally designed)	Surveys completed by council members distributed and collected at council meetings	Accomplishments survey completed at end of Years 2, 3, and 4
	• Has the community enhanced partnerships with child-serving organizations to improve care coordination, referrals, and community infrastructure?	A pre-post single-group design will be used to measure strength of collaboration among stakeholders and participant perceptions about the effectiveness of early childhood policies.	Interagency Collaboration Activities Scale (Greenbaum & Dedrick, 2000) Wilder Collaboration Factors Inventory (Mattessich, Murray-Close, & Monsey, 2004)	Surveys completed by council members distributed and collected at council meetings	IACAS completed at end of Year 1 and 3 Wilder survey completed at end of Year 2 and 4
	• What is the perceived impact of each training opportunity on the work of the participants?	Evaluation of participant perceptions of competency and impact of training will in a pre-post design. Group differences across training opportunities will also be examined, when sample sizes allow.	Impact of Training and Technical Assistance (Walker & Bruns, n.d.)	Surveys collected following trainings by project staff, completed by training participants	IOTTA measure at end of trainings; abbreviated measure for trainings lasting less than 4 hours.
	• What percentage of providers report decreased stress levels following training?	Descriptive; pre-post design	Professional Quality of Life Scale (ProQol) (Stamm, 2010)	Surveys collected at trainings intended to impact compassion fatigue either on paper or web-based	Collected at beginning of training and in follow-up at 3 months
State	**Mental Health Consultation:** Process:	Design:	Measures:	Methods:	Schedule:

	• How does the racial and ethnic distribution of children served compare to the community?	Descriptive; chi-square analysis with post-hoc comparisons, as sample size allows	National Outcomes Measures Survey (NOMS)	Administered by MH Consultant through interview of caregiver	Measured at entry into service; analyzed at least annually
	• Do teachers and child care providers participating in mental health consultation change the classroom climate following the intervention?	A pre-post single-group design will be used to measure changes in the classroom environment	Preschool Mental Health Climate Scale (PMHCS; Gillian, 2008)	Completed by the mental health consultant at the beginning of classroom consultation and 6 months later	Measured at the beginning of classroom consultation and 6 months later.
	• What percentage of parents or other primary caregivers report reduced stress?	A pre-post single-group design will be used to measure strength of intervention effect on levels of parental stress	Parenting Stress Index (Abidin, 1990)	PSI completed by parents/caregivers	Administered at beginning of family consultation and at the end of services
	• What percentage of providers report decreased stress levels?	A pre-post single-group design will be used to measure strength of intervention effect on levels of provider stress	Professional Quality of Life Scale (ProQol) (Stamm, 2010)	ProQoL completed by service providers	Measured at the beginning of classroom consultation and 6 months later.
	• Are there any differences in outcomes based on age, sex, or race/ethnicity?	Post-hoc analysis as sample size allows	NOMS for race/ethnicity; DECA-C for outcomes	Post-hoc with existing data	Analyzed in Year 4
	Outcome:				
	• What percentage of children whose teacher or parent participates in mental health consultation demonstrate improved social-emotional skills/functioning?	A pre-post single-group design will be used to measure strength of intervention effect on social-emotional skills/functioning.	Devereaux Early Childhood Assessment Clinical Form (DECA-C) (LaBuffe & Naglieri, 2003)	DECA-C will be completed by service providers regarding child's current clinical presentation	Measures will be collected at the beginning of service provision and again at the conclusion of services for those services conducted with individual children and families
	• What percentage of children are suspended/expelled from programs serving children birth to age eight prior to and after mental health consultation?	A pre-post single-group design will be used to measure changes in the children suspended or expelled	Agency expulsion/suspension rates	The data should be existing; the MH Consultant will ensure the data is received from the program administrator.	The rate for the 12 months prior to agency consultation and the 12 months following consultation will be collected.
	Incredible Years: Process:	Design:	Measures:	Methods:	Schedule:
	• How many parents/caregivers are participating in parenting groups?	Simple descriptive counts	Parent group sign-in sheets, attendance at one or more groups	Gathered from enrollment and sign-in sheets	Sign in sheets will be collected at the beginning of every Incredible Years group; analyzed quarterly
	• What percentage of parents/caregivers is attending at least three quarters of the sessions within a group series?	Simple summary of data; examined across sites	Parent group sign-in sheets, administrative participant retention data	Gathered based on number of parents enrolled in IY	Sign in sheets will be collected at the beginning of every Incredible Years group; analyzed quarterly

	• Are there any differences in service usage patterns based on age, sex, or race/ethnicity? How does the racial and ethnic distribution of children served compare to the community?	Descriptive analysis; t-tests	Demographic information from NOMS	Gathered at enrollment	Analyzed annually
	• Is there intervention integrity/fidelity to the Incredible Years parenting intervention?	Descriptive analysis	Collaborative Process Checklist (Webster-Stratton, Reid, & Marsenich, 2014)	Completed by group facilitators who lead Incredible Years groups.	Measures completed by the group facilitators will be filled out at the conclusion of every Incredible Years group.
	• Are lower levels of intervention integrity associated with attenuated outcomes?	Moderator analysis	Collaborative Process Checklist and Eyberg Child Behavior Inventory and Parent Practices Inventory	Post-hoc analysis	Analyzed annually
	• Are there any differences in outcomes based on age, sex, or race/ethnicity?	Mediator analysis	NOMS and Eyberg Child Behavior Inventory and Parent Practices Inventory	Post-hoc analysis	Analyzed annually
	<u>Outcome:</u>				
	• Are the IY parent groups associated with changes in levels of parental stress?	A pre-post single-group design will be used to measure strength of intervention effect on levels of parental stress.	Parenting Stress Index (Abidin, 1990)	Completed by parents/caregivers participating in Incredible Years parent groups.	Parent/caregiver measures will be collected prior to the beginning of the Incredible Years intervention and again at the conclusion of services (up to 30 days following the last Incredible Years group).
	• Are the IY parent groups associated with changes in levels of parental stress?	A pre-post single-group design will be used to measure strength of intervention effect on levels of social support	National Outcomes Measure (NOMS)	Completed by parents/caregivers participating in Incredible Years parent groups.	Parent/caregiver measures will be collected prior to the beginning of the Incredible Years intervention and again at the conclusion of services (up to 30 days following the last Incredible Years group).
	• Are the IY parent groups associated with significant changes in levels of positive parenting behaviors?	A pre-post single-group design will be used to measure strength of intervention effect on changes in positive and negative parenting behavior frequency.	Parent Practices Interview (LIFT) (Webster-Stratton, Reid, & Hammond, 2008)	Completed by parents/caregivers participating in Incredible Years parent groups.	Parent/caregiver measures will be collected prior to the beginning of the Incredible Years intervention and again at the conclusion of services (up to 30 days following the last Incredible Years group).
	• Are the IY parent groups associated with reductions in problematic child behavior?	A pre-post single-group design will be used to measure strength of intervention effect on	Eyberg Child Behavior Inventory (Eyberg & Pincus, 1999)	Completed by parents/caregivers participating in Incredible Years parent groups.	Parent/caregiver measures will be collected prior to the beginning of the Incredible Years intervention and again at

		frequency of problematic child behavior.			the conclusion of services (up to 30 days following the last Incredible Years group).
	Parent Cafés: Process:	Design:	Measures:	Methods:	Schedule:
	• How many parents or caregivers are attending Parent Café events?	Descriptive counts	Café sign in sheets	Obtained from participants	At beginning of event
	• How many parents or caregivers are returning for more than one event?	Descriptive counts	Café sign in sheets	Obtained from participants	At beginning of event
	• How many parents or caregivers are reporting a perceived change in knowledge and confidence following attendance at a Parent Café event?	Post-test survey of perceived change measured through survey	Parent Café Evaluation Measure	Obtained from participants	At conclusion of event
	Developmental Screening: Process:	Design:	Measures:	Methods:	Schedule:
	• How many young children are communities screening?	Descriptive counts	Texas LAUNCH Screening and Referral Form (internally designed)	Screenings reported by screening providers	Reported after each screening event
	• What are the characteristics of children screened in the project? How does the racial and ethnic distribution of children served compare to the community?	Descriptive counts and percentages	Texas LAUNCH Screening and Referral Form (internally designed)	Screenings reported by screening providers	Reported after each screening event
	• What percentage of children screened are identified as at risk for developmental or social-emotional concerns?	A time series analysis will be used to measure: 1) the impact of efforts to improve training and access to developmental screening on the number of children and families receiving developmental screenings, and 2) the resulting percentages of children screened who identified at-risk for developmental concerns.	Texas LAUNCH Screening and Referral Form (internally designed)	Screenings reported by screening providers	Reported after each screening event

	• What percentage of children identified as at risk and referred for further services receive subsequent interventions?	A time series analysis will be used to measure: 1) the impact of efforts to improve training and access to developmental screening on the number of children and families receiving developmental screenings, and 2) the resulting percentages of children screened who identified at-risk for developmental concerns.	Texas LAUNCH Screening and Referral Form (internally designed)	Follow-up by screening providers by phone or text	Follow-up 3 months following referral
	• What barriers to parents report to accessing services following referral?	Descriptive analysis with qualitative analysis of any uncategorized responses	Texas LAUNCH Screening and Referral Form (internally designed)	Follow-up by screening providers by phone or text	Follow-up 3 months following referral
	• Are there any differences in the receipt of subsequent interventions by age, sex, or race/ethnicity?	Group comparisons as sample size allows	Texas LAUNCH Screening and Referral Form (internally designed)	Follow-up by screening providers by phone or text	Follow-up 3 months following referral

Part 4. Dissemination Strategy

The evaluation team will regularly report findings from the evaluation to the Leadership Team to facilitate continuous quality improvement. The evaluation team will report on a series of benchmarks, spread over the years of the project, which can be used to evaluate ongoing progress in expansion. These benchmarks will be used as status indicators on proposed goals or as triggers to implement changes, as well as time series points for evaluation. The evaluation staff will work closely with project staff and regularly share information during weekly project meetings. Written reports will be shared quarterly and presentations of data will be made at each Council meeting. Evaluation data will also be shared with the public as a component of the communication plan, highlighted on the website or in newsletters. Community-level evaluation data will be shared with local project management and community Young Child Wellness Councils to facilitate improvement in local efforts and to identify effective practices and barriers. This information will be documented to identify effective strategies for similar communities implementing Project LAUNCH strategies in the future.

The Leadership Team will utilize data collected for GPRA reporting, as well as local evaluation data, to track the accomplishment of project goals and objectives. The team will develop benchmarks for progress, in consultation with local leadership, and track achievement over time. The evaluation will assist in the collection of information on local and state barriers, strategies chosen to address barriers, and the success of these strategies. The evaluation team is experienced in utilizing Plan, Do, Study, Act (PDSA)

cycles to guide system transformations and using rapidly available data to determine the effect of rapid changes. As described below, tracking of goals and objectives will include a review of data reflecting any behavioral health disparities.

The evaluation team will also work to empower the local Young Child Wellness Councils and community leadership to use data to guide community efforts. The evaluation team will aim to ensure community stakeholders have input on local evaluations, feel empowered to participate in evaluation activities, receive timely feedback on data, and assist the evaluation staff in interpretation of findings. The community participatory approach will aim to prepare local leadership to continue to track and use data in a sustainable way following the end of the grant. The evaluation team will also assist the communities in identifying existing data held by participating agencies that may be useful in understanding community needs, gaps in services, or behavioral health disparities. The evaluation team will also work to ensure families are active participants in the evaluation activities, including contributing to the planning, data collection, interpretation, and dissemination of evaluation results.

In addition to project reports, the evaluation team will work to develop engaging tools for sharing the results of the evaluation, such as the use of family stories or quotes, brief video segments, or infographics. Finally, data from the evaluation will inform state policy and workforce issues that should be addressed to establish facilitating infrastructure for the core strategies. The data will also impact plans for further expansion of the Project LAUNCH activities to other communities.

Part 5. Appendices

The appendices section should include supplemental information that provides further detail on your grantee-specific evaluation. Please include supporting documentation referenced in the Evaluation Plan or other documentation that is helpful for understanding how the evaluation was conducted and the results obtained. This section could include:

a) sample instruments as appropriate (questionnaires, interview guides, protocols)
b) psychometric characteristic of selected measures
c) the reliability of data collection instruments
d) Plans for submission of proposed evaluation design to IRB(s)
e) Confidentiality procedures

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