Project LAUNCH Expansion Grant
Final Evaluation Report
Texas

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I. EXECUTIVE SUMMARY

Goals and Objectives of Texas LAUNCH

The Texas LAUNCH initiative aimed to improve the developmental and social and emotional outcomes of children age 0 to 8 in three selected expansion communities by implementing best practices within an array of systems supporting young children. Each strategy built upon the others by increasing the early identification of developmental concerns and support for families to access early childhood interventions, strengthening family capacities for promoting children's development and wellness, and enhancing child care and educational programs to support child success. Workforce development efforts supported 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 providers' job stress and burnout.

The community-directed expansion of Texas LAUNCH aimed 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. Community providers within Bexar County, Tarrant County, and Ysleta del Sur Pueblo strived to adapt and replicate these strategies within their communities. Taking a public health approach, activities were directed to all children age 0 to 8 within the identified regions and their caregivers. Texas supported this expansion through an inter-agency collaborative committee and partnerships with other early childhood agencies and organizations.

Texas LAUNCH had four core 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 (all 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.

Purpose of the Evaluation

The purpose of the evaluation was to document the progress toward project goals, identify barriers and effective strategies for overcoming them, and document the impact and outcomes of project activities. The evaluation focused on the following core approaches:

- Collaboration and Leadership;
- Workforce Development;
- Developmental Screening;
- Family Strengthening, and
- Mental Health Consultation.

Each core approach to expansion was associated with evaluation questions and an approach for measuring both process and outcomes associated with the strategy. Within each area, the evaluation aimed to understand how well the strategy was implemented, how many people were involved in the strategy, and what impact the strategy has had on child-serving systems, child caregivers and providers, and children and families. The evaluation was intended to provide regular data to community and state leaders to support adjustments to implementation approaches and regular quality improvement cycles.

Evaluation Questions

The purpose of the Collaboration and Leadership component of the evaluation was 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 addressed 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?
- 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?

The evaluation of workforce development efforts included documenting early childhood training activities, capturing the perceptions of training participants, and examining the broader state impact on workforce capacity. The evaluation addressed 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?

The focus of the developmental screening component of the evaluation was to measure the impact of efforts to increase developmental and social-emotional screenings for young children in the three expansion communities. The following questions were 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 demographics?
- 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?

The primary evaluation aim of the family strengthening strategy was to evaluate the quality and impact of the implementation of Incredible Years (IY) and Parent Cafés. The following questions were answered in the evaluation:

- How many parents/caregivers are participating in parenting groups
- 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?
- How many parents or caregivers are attending Parent Café events?
- 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?

The primary evaluation aim of the mental health consultation strategy was to measure the number of children impacted and the outcomes associated with these activities. The following questions were answered in the evaluation:

- How does the racial and ethnic distribution of children served compare to the community?
- What percentage of parents or other primary caregivers report reduced stress?
- What percentage of providers report decreased stress levels?

Evaluation Approach and Methods

The evaluation approach included documentation of process information through sign-in sheets, meeting minutes, quarterly reports, and surveys of key stakeholders on progress and achievements. Specific approaches to evaluation are defined for each core strategy, including workforce development, developmental screening, family strengthening, and mental health consultation. Evaluation of workforce development activities focused primarily on surveys of training participants following training activities. Evaluation of screening activities included documentation of the number and nature of screening activities and referrals resulting from the screening. Evaluation of family strengthening activities included pre- and post-test measures of child and family functioning, with analyses focusing on change over time. Evaluation of Mental Health Consultation (MHC) began in the third year and included pre- and post-test measures of child functioning for those involved in more than five MHC contacts and a qualitative analysis of MHC foci and activities.

Key Findings

The following key results are documented in the evaluation report:

- The evaluation demonstrated that the state wellness council maintained a robust membership, although there was significant member turn-over during the grant. There were challenges with maintaining parent participation in meetings, although parents have continued to be engaged in phone calls and workgroups. Members reported increased strength of the collaborative effort over the course of the grant, with no sigificant weaknesses at the end of the period. Council members felt that the group created an

avenue for communication and networking, between state agencies and between communities and state agencies.

- Community stakeholders largely feel satisfied with the training and technical assistance they have received, although they report some confusion in the early phases of the grant. They feel that they have had many successes in implementing the strategies, with challenges including the evaluation and the buy-in of community members.

- Overall, the evaluation of the workforce development strategies shows significant impact in each community. The primary trainings offered by the state team enhanced the sustainability of LAUNCH practices through the training of in-state trainers in Mental Health Consultation, Pyramid Model, ASQ tools, and Parent Cafes. Participants generally reported a perceived increase in mastery as a result of trainings and expressed a high likelihood of making changes at work.

- The LAUNCH initiative conducted a large number of developmental and social emotional screenings, with the preponderance occurring in Tarrant County. Tarrant County was able to increase their capacity through the implementation of a web-based platform to access tools. Referrals were made to a variety of supports, with school systems and counseling services most common. There was limited feedback of screening results to pediatricians.

- LAUNCH communities greatly expanded their family strengthening services over the course of the grant. The reach of Incredible Years remained modest, but Tarrant County had significant reach with the Parent Café model. Parents expressed resounding satisfaction with their participation in Parent Cafes and almost unanimously indicated a plan to make changes as a result of their participation. Families in the more intensive Incredible Years program reported significant reductions in their use of harsh and inconsistent discipline strategies; however, there was no noticeable increase in positive parenting practices. The evaluation of Incredible Years was hampered by modest rates of data collection at the completion of classes.

- Most mental health consultation focused on an individual child included participation of the parent. The primary reasons for referral included aggression with peers or teachers, hyperactivity and inattention, and tantrums and crying. The experience of a recent traumatic event was commonly noted. The consultation was generally brief (mode of one interaction) and consisted of psychoeducation, skills development, and referrals to external resources. Each community had a different approach to mental health consultation, and the roles of providers varied significantly.

Recommendations

The following recommendations are included in the evaluation report:

<u>Workforce Development</u>

1. Childcare professionals are interested in receiving information on social, emotional, and behavioral health. Topics of special interest for workforce development included addressing challenging behaviors, the impact of trauma on children, and self-care for

teachers. Future workforce development should include providing resources that aid in the use of the new skills (e.g., screening kits, manuals, flashdrives, children's books) and role playing challenging skills.

2. Developing local trainers in practices allowed for greater reach and sustainability. Practices that did not allow for local or regional training (e.g., Incredible Years) were more challenging to disseminate and sustain. The capacity for regional/local trainers should be considered as a factor when selecting evidence-based practices.

3. Training to support implementation of new practices should plan for booster sessions or coaching to ensure that individuals are comfortable implementing the practice to fidelity. For example, some child care organizations failed to implement the ASQ screening tools without further support. Communities can strengthen the implementation of practices by developing community champions who maintain contact with trainees, problem solve barriers to implementation, and provide booster trainings or coaching to move to mastery of the skills.

4. Providers attending one of the two workshops on Georgetown University's Mental Health Consultation framework were positive, but frequently expressed the desire for more in-depth skill building training targeting consultants. The Tarrant County workshop on mental health consultation was rated highly by participants and provided more concrete tools. The state should continue to examine opportunities to strengthen the available workforce training for this relatively new provider role.

Developmental Screenings

5. Tarrant County has been successful in expanding the community's capacity for developmental and social-emotional screening through an online platform. Project leaders have supported its use through memoranda of understanding with community agencies, regular staff training in the use of the system, and staffing to engage families interested in additional community resources. Tarrant County is exploring a more robust reporting system, that allows the community to track referrals and the resulting services. The state should use these "lessons learned" in the development of a state web-based platform for early childhood screening, ensuring it supports a universal approach to screening and access to referral resources.

6. Communities should monitor potential disparities in referral rates by racial and ethnic subpopulations. While differences in the identification of risk was not evident in the evaluation, White, non-Hispanic children were more likely to be referred for further services than youth of color.

Family Strengthening

7. The outcome evaluation of the Incredible Years program is limited by the small sample sizes, but initial results are positive and suggest decreases in harsh parenting practices and potential reductions in child behavior problems. However, there was an overall small reach for this intervention. Given the level of intensity required by this parenting program, communities may benefit from having it available for families at risk for poor parenting or experiencing child behavior problems. Rather than implementing as a universal program, within childcare or schools, Incredible Years may better serve as a targeted intervention with families at risk of child welfare

involvement or young children identified with disruptive behaviors.

8. The Parent Café intervention was well-liked by families and participants reported changes to their parenting practices. The intervention provides an opportunity for engaging families in community and discussing parenting practices in a non-judgmental manner. The evaluation did not allow for an assessment of the impact on family or child outcomes and further research is needed. However, the high acceptability of the model is promising for a universal approach that descreases stigma related to parenting programs. Texas should consider conduting a pilot study of Parent Cafes in one or more communities.

Mental Health Consultation

9. There was no universal agreement on the definition of mental health consultation in Texas, and this was evident in the different approaches taken by each community. Texas should continue to work to develop a greater consensus on the role of mental health consultants within different systems and raise awareness of this role within early childhood systems.

10. Additional research and evaluation is needed in Texas to document the impact of mental health consultation on teacher retention and stress, classroom climate, family stress, and child social, emotional, and behavioral health. Texas could continue to advance the model through a well-designed, cross-site pilot study inclusive of rural, urban, and suburban communities.

II. TABLE OF CONTENTS PAGE 8

III. LOGIC MODEL

The Texas LAUNCH initiative aimed to improve the developmental and social and emotional outcomes of children age 0 to 8 in three selected expansion communities by implementing best practices within an array of systems supporting young children. Each strategy built 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 supported 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 provider's job stress and burnout. A graphic representation of the Texas LAUNCH logic model is provided in Figure 1.

Texas Landscape (Inputs). Of the nearly 7.5 million Texans 17 years and younger, 50.6% are 8 years old and younger. Many young children, especially those whose families struggle with poverty and lack of access to health care, show poorer outcomes in health, social, and emotional well-being. Texas built upon the strengths of the Project LAUNCH initiative located in El Paso to expand the implementation of effective strategies to promote the mental health and wellness of young children in Texas. Texas supported this expansion through an inter-agency collaborative committee and partnerships with early childhood agencies and organizations.

Texas LAUNCH Strategies. The community-directed expansion of Texas LAUNCH aimed to build on successful elements initially implemented in the El Paso Project Launch pilot program, focusing on promotion of mental health wellness, strengthening 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 were directed to all children age 0 to 8 within the identified regions and their caregivers. Young child caregivers included biological, adopted, and foster parents, as well as teachers and health care providers.

Texas LAUNCH had four core goals, each having associated objectives and activities:

5) *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;
6) *Enhanced Parenting Skills (all communities)*– Increase effective parenting practices through the implementation of Parent Cafés and Incredible Years parenting classes;
7) *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
8) *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.

Outputs. The following expected outputs were planned for each strategy:

Early Childhood Screening: The goal for this strategy was to train and support 20 child providers in the use of developmental and social and emotional screening tools, screen at least 1,700 children across the three communities, and provide referrals to at least 390 parents of the children screened. Outcomes were 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: Texas LAUNCH aimed to increase parenting skills through implementation of the Incredible Years parenting program. Outcomes were assessed using parent self-report questionnaires prior to and after participation in the program. Communities could also enhance the family strengthening strategy by implementing Parent Cafés. The goal for this strategy was to train fourteen providers in the Incredible Years or Parent Café curriculum and to provide family strengthening programs to 322 parents.

Mental Health Consultation: The goal for this strategy was to engage teachers in mental health consultation and for at least 110 children to receive child- or family-focused mental health consultation. Outcomes were assessed from parent and teacher-completed measures of child and family functioning.

Building Competency in the Early Childhood Workforce: The goal for this strategy was 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. Outcomes were assessed through post-training surveys.

Outcomes. Specifically, through implementation of the four core strategies of Texas LAUNCH, several individual level, community level, and state level outcomes were expected. Child and family outcomes included:

- decreased problematic child behaviors,
- decreased parental stress,
- increased positive parenting practices, and
- decreased negative parenting practices.

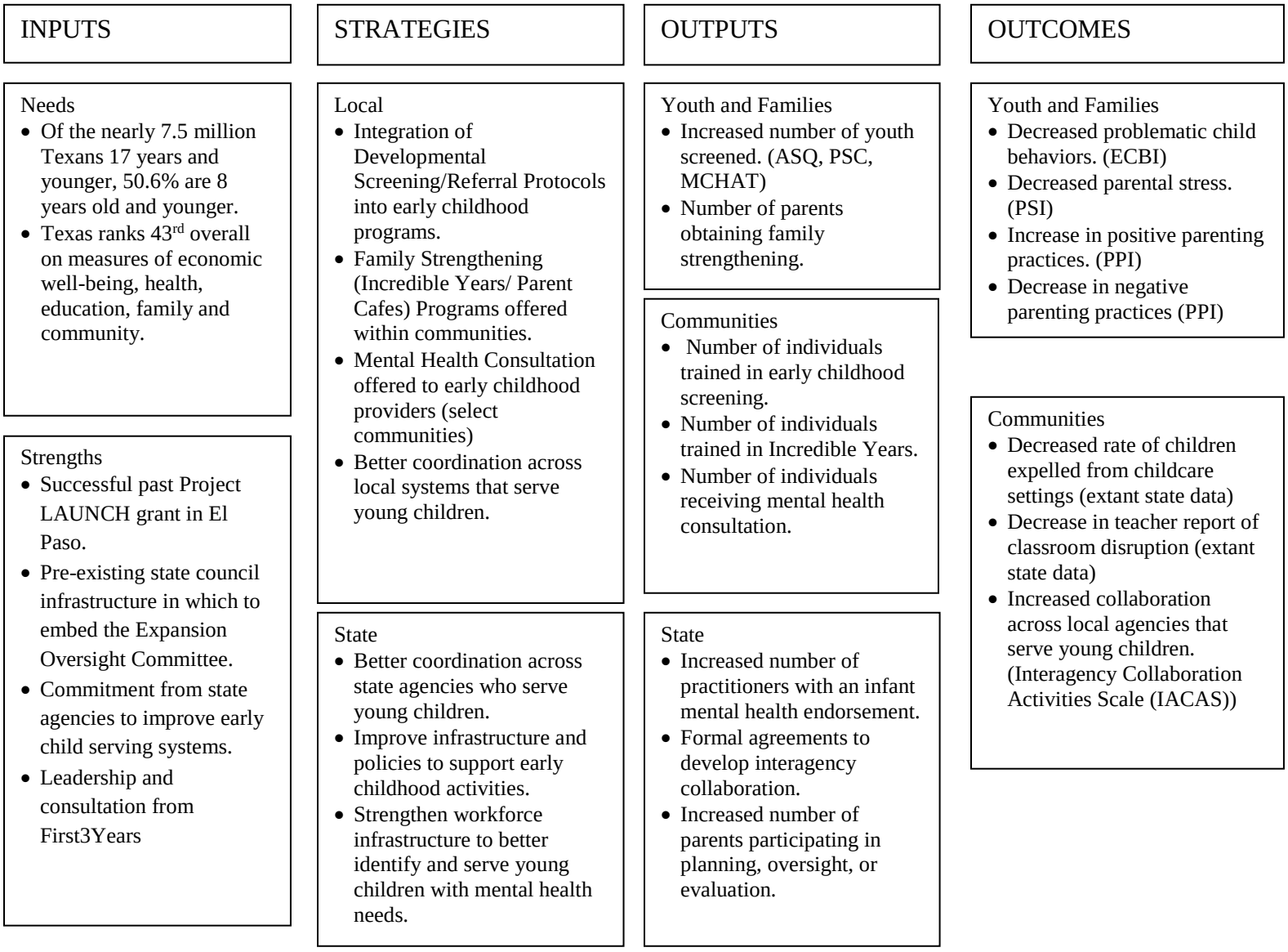
Community level outcomes included:

- decreased rate of children expelled from childcare settings,
- decreased classroom disruption, and
- increased collaboration across local agencies that serve young children.

Finally, state level outcomes included:

- increased collaboration across child-serving state agencies and
- increased number of early childhood staff who have competence or mastery in skills related to early childhood development.

Figure 1. *Texas LAUNCH Logic Model*



IV. Evaluation Design And Findings

Strategy 1: Organizational Collaboration/Coordination

The evaluation of the Organizational Collaboration and Coordination activities focused on 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 was 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.

A. Evaluation Questions

Evaluation questions for this component of the Texas LAUNCH activities are summarized in Table 1. This aspect of the evaluation addressed to what extent the grant was successful in achieving the overall goal of establishing a supportive state and local context to expand early childhood wellness strategies through agency collaboration, policies, and financing.

Table 1. *Summary of Evaluation Questions for Strategy 1 – Organizational Collaboration*

Evaluation Question	Data Collection Method	Source of Data	Measures
1. Are key stakeholders collaborating on system changes to to enhance support for early childhood mental health promotion?	Self-report	Survey	Interagency Collaboration Activities Scale (IACAS); Wilder Collaboration Factors Inventory
2. What are the key accomplishments of the collaborative councils?	Self-report	Survey	Survey of Accomplishments and Barriers
3. What facilitators have advanced the community's efforts? What barriers have the councils encountered and how have they strived to overcome them?	Self-report	Survey	Survey of Accomplishments and Barriers
4. What is the reach of communication and social marketing activities in building awareness and engagement in early childhood activities?	Communication tracking	Distribution of communication tools; website or social media analytics	Reach; pageviews; shares
5. Are policies and procedures present to support and engage Project LAUNCH activities?	Collected from partner agencies	Written policy documents	% with written policies on early childhood workforce and reducing disparities
6. Has the community enhanced partnerships with child-serving organizations to improve care coordination, referrals, and community infrastructure?	Self-report at two time points	Survey	Interagency Collaboration Activities Scale (IACAS); Wilder Collaboration Factors Inventory

B. Approach & Methods

The evaluation design for the Organizational Collaboration component of Texas LAUNCH included a qualitative analysis of existing data and prospectively collected surveys about interagency collaboration. The design also included a time series analysis of variables capturing collaborative activities and strength of the collaborative workgroups. These time series analyses allowed 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.

Measures

Wilder Collaboration Factors Inventory. The Wilder Collaboration Factors Inventory (Mattessich, Murray-Close, & Monsey, 2004) 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 variable/factors, with three showing lower reliability and three 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. Items are scored on a 5-point Likert scale, from strongly disagree (1), somewhat disagree (2), neutral or no opinion (3), somewhat agree (4), or strongly agree (5). The collaboration factors are represented by averages of respective items, with scores of 4.0 or higher representing strengths, scores between 3.0 and 3.9 borderline, and scores of 2.9 or lower indicating concerns that should be addressed.

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

Procedures. The number of organizations collaborating on the council and the number of members who are family members was gathered from Council sign-in sheets, meeting minutes, and community contract reports. Council members' perceptions of collaborative activities were assessed through the Wilder Collaboration Factors Inventory, which was conducted in October 2018 and August 2019. The perceptions of community leaders was gathered through key informant interviews. The Local Lead sent an email invitation to community participants and requested their participation. One community was represented by one informant, and the other two communities were represented by three leaders. Semi-structured phone interviews of seven individuals were completed. Interviews focused on the experience of communities with training and technical assistance through the state LAUNCH team and perceptions of accomplishments and barriers within their LAUNCH activities.

C. Data Analysis

Information on Council members and participation is descriptive and summarized. Responses to the Wilder Collaborative survey with the Texas LAUNCH Early Childhood Committee (TLECC) is summarized. Community key informant interviews are summarized through an informal qualitative analysis to examine trends in the experiences of community leaders. There was an inadequate sample to conduct a formal qualitative analysis.

D. Findings/Interpretations

Texas LAUNCH Early Childhood Committee Membership. The state early child wellness committee membership ranged from 38 to 54 members over the course of the grant. The committee includes representatives from state agencies, expansion communities, parent representatives, and LAUNCH staff. The committee included representation from the following organizations or roles:

- Maternal and Child Health,Department of State Health Services
- Office of Mental Health Coordination, Health and Human Services Commission
- Texas System of Care, Health and Human Services Commission
- Medicaid Policy Development, Health and Human Services Commission
- Medicaid Screening and Case Management, Health and Human Services Commission
- Statewide Behavioral Health Workforce Coordinator, Health and Human Services Commission
- Children's Mental Health Services, Health and Human Services Commission
- Women's Substance Use Disorder Specialist, Health and Human Services Commission
- Office of Disability Prevention for Children, Health and Human Services Commission
- Prevention and Early Intervention, Department of Family and Protective Services
- Texans Care for Children, Advocacy
- Act Early Texas, University fo Texas Health Science Center – Houston
- Texas Pediatric Society
- Texas Children's Hospital, Houston
- Texas Workforce Commission
- Texas Head Start State Collaboration
- Preschool Developmental Grant Director of Early Childhood (cross-agency)
- Early Childhood Edcuation, Texas Education Agency
- LAUNCH State Staff
- LAUNCH Community Representatives
- Parent Representatives

Attendance at quarterly meetings varied over the course of the grant, ranging from a low of 37.9% to 87.2%. While this did reflect some fluctuation in attendance, it also reflected a growth in committee membership. At the initial council meeting, 22 members were included in the invitation or roster. At the end of the grant, there were 58 individual members, representing a growth of 163%. While some of these members could not attend every meeting, they were important contributors to the grant initiative, and received all the materials from the meetings. Over the four year period, there was a significant number of representatives who retired or changed positions, leading to new representatives joining the committee. The state team created a variety of materials to orient new committee members to the work and provided in person or phone orientation sessions prior to their first meeting.

Perceived Collaboration. The TLECC members were asked to complete the Wilder Collaboration Factors Inventory at two time points in the grant, at the end of Year 2 and the end of Year 4. As noted above, the Wilder Collaboration Factors Inventory is intended to assess the capacity and strength of coalitions. The full instrument is available in Appendix 2. Eighteen members responded to the web-based survey at Time 1 and 10 responded at Time 2, representing 46.1% and 58.8% of the attendees respectively. Table 2 represents respondents' average ratings across each collaborative factor. Descriptors are provided to aid interpretation.

Results at the end of the second year suggested most collaboration factors were within the borderline range, indicating neither a strength nor weakness. Three clear strengths were identified by respondents; members indicated that their agency/organization benefited from participating in the group, that the individuals in leadership roles with the committee had good skills for working with other people and organizations, and that members of the collaborative group were flexible in decision-making and open to different approaches to doing the work. Respondents identified one clear weakness on the survey, indicating lower scores for the collaborative group having adequate funding and "people power" to accomplish what it wants to accomplish. One additional borderline item was lower than others; respondents were less likely to agree that agencies in the state have a history of working together and solving problems through collaboration.

At the end of the grant, members rated 16 of the scales (out of 20) as a strength. The highest ratings were for items indicating a favorable political and social climate for the work; mutual respect, understanding, and trust within the membership; and members see collaboration as mutually beneficial to them. No scales fell within the weakness range at Time 2, but adequate funding and staff resources remained the lowest rated scale. All subscales showed some increase from Time 1 to 2. To minimize the risk of inflation of Type II error, change in the collaborative strength of the workgroup was examined based on a total mean score across all items. The total score on the Wilder Collaboration Factors Inventory increased over time, going from a mean of 3.80 (*SD*=0.95) to 4.16 (*SD*=0.70), although this was not statistically significant (t=1.05, df=26, p=0.30). Members perceived the TLECC as a strong early childhood body by the end of the grant, with many different factors suggesting a well-functioning collaboration.

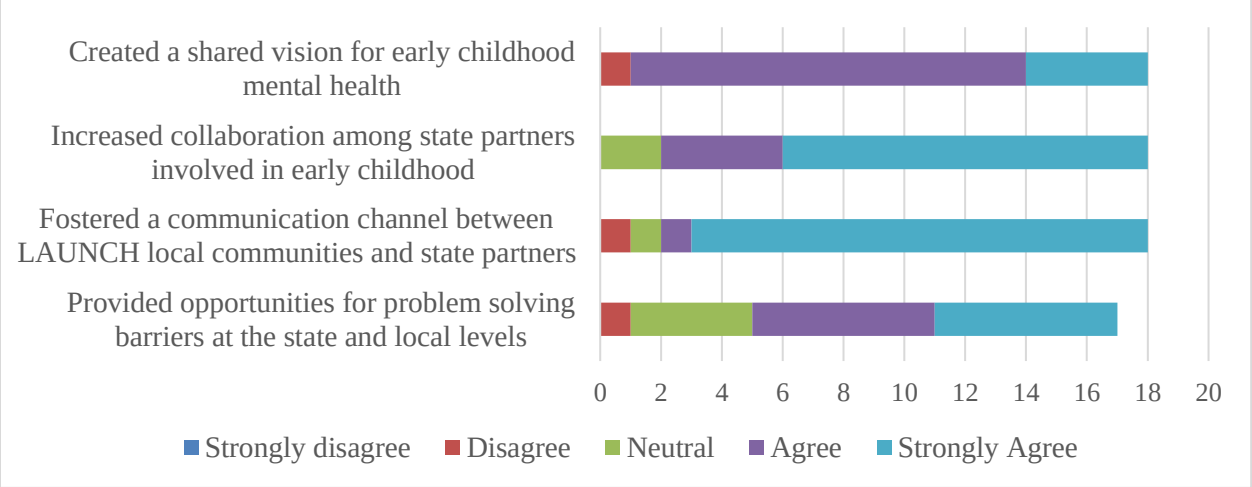
Table 2. *Scores on the Wilder Collaboration Factors Inventory*

Factor Group	Factor (number of items)	Year 2 Mean (SD)	Year 4 Mean (SD)	Descriptor Change over Time
Environment	History of collaboration or cooperation in the community/state (2)	3.17 (0.94)	3.85 (0.75)	Borderline → Borderline
	Collaborative group seen as a legitimate leader in the community (2)	3.67 (0.68)	4.00 (0.56)	Borderline → Strength
	Favorable political and social climate (2)	3.97 (0.84)	4.50 (0.51)	Borderline → Strength
Membership Characteristics	Mutual respect, understanding, and trust (2)	3.94 (0.83)	4.45 (0.69)	Borderline → Strength
	Appropriate cross-section of members (2)	3.75 (1.08)	4.30 (0.57)	Borderline → Strength
	Members see collaboration as being in their self-interest (1)	4.17 (0.71)	4.50 (0.53)	Strength → Strength
	Ability to compromise (1)	3.61 (0.78)	4.22 (0.44)	Borderline → Strength
Process and Structure	Members share a stake in both process and outcome (3)	3.94 (0.90)	4.30 (0.47)	Borderline → Strength
	Multiple layers of participation (2)	3.55 (0.91)	3.90 (0.85)	Borderline → Borderline

	Flexibility (2)	4.03 (0.74)	4.10 (0.64)	Strength → Strength
	Development of clear roles and policy guidelines (2)	3.58 (0.97)	3.85 (0.75)	Borderline → Borderline
	Adaptability (2)	3.69 (0.82)	4.10 (0.55)	Borderline → Strength
	Appropriate pace of development (2)	3.86 (0.76)	4.00 (0.65)	Borderline → Strength
Communication	Open and frequent communication (3)	3.87 (0.87)	4.33 (0.61)	Borderline → Strength
	Established informal relationships and communication links (2)	3.86 (0.87)	4.05 (0.60)	Borderline → Strength
Purpose	Concrete, attainable objectives (3)	3.69 (1.13)	4.20 (0.48)	Borderline → Strength
	Shared vision (2)	3.83 (0.88)	4.45 (0.51)	Borderline → Strength
	Unique purpose (2)	3.94 (1.06)	4.45 (0.69)	Borderline → Strength
Resources	Sufficient funds, staff, materials, and time (2)	2.94 (1.09)	3.25 (1.21)	Weakness → Borderline
	Skilled leadership (1)	4.06 (0.94)	4.50 (0.53)	Strength → Strength

Perceptions of Accomplishments. Additional items were added to the web-based survey to gather committee members' perceptions about the extent to which certain goals had been accomplished by the state committee and its workgroups. Results are shared in Figure 2. Participants strongly agreed that the committee created a communication channel for state and local early childhood partners, as well as increased the collaboration among state partners. Almost all participants felt that the committee had created a shared vision for early childhood mental health, although there were fewer strong agreements. Results were positive, but less so, for the extent to which the committee provided opportunities for problem solving barriers at the state and local levels.

Figure 2. *Accomplishment of State Committee Goals*



Perceptions of Technical Assistance and Support. The Texas LAUNCH structure had a state team responsible for providing training, technical assistance, and organizational support for the three expansion communities. Technical assistance included monthly phone calls with each community, in person site visits to the communities, and regular communication. The state team also attempted to meet the identified needs of the community through training opportunities, a community of learning, community gatherings, and support for meetings with relevant state agency partners (e.g., Medicaid). A key informant interview by an evaluator who had not been involved in these strategies was conducted at the end of the third year with community leaders (see methodology). The following themes were identified from the interviews:

Theme 1: Communities felt a collaborative partnership was formed between the state team and community team. Community leaders indicated overall satisfaction with the support and technical assistance provided by the state team. They indicated that the team provided the right amount of regular communication, and that they felt informed and up-to-date. The community stakeholders highlighted that technical assistance was provided with a sense of mutuality and a willingness to meet the community where they are. Community members indicated an appreciation that the state team was willing to travel to their location to provide needed trainings and attend council meetings. For example, one participant mentioned how the technical assistance meetings were inclusive and that their voice was heard; it felt more like a team environment as opposed to an authoritarian approach, a sense of "we're going to do this together". Another example provided of the collaborative approach to problem solving was the willingness to host a call with the Incredible Years purveyor to negotiate the use of time out approaches along side other strategies used in a trauma framework and achieve terminology that was acceptable to all parties. Two of the three communities indicated that the technical assistance and support that they received was an important factor in their growth and development.

Theme 2: Community stakeholders had a mixed perception on the role of technical assistance in sustaining LAUNCH strategies. When asked about sustainability, two of the three communities talked about how they felt they've received the necessary training and guidance to keep implementing their LAUNCH strategies after the grant. They felt well-situated to continue their efforts. The other community, while expressing positive experiences with technical assistance, indicated that it may not have been necessary for their sustainability. This community indicated that they choose grants that overlap with their goals, and can draw upon their prior knowledge for sustainability. Another member of the same community did express the desire to have more assistance with how to sustain their work after the final year.

Theme 3: Community members felt confused about their roles and responsibilities during the initial roll-out of the grant. The transition period that took place at the beginning of the granting period was a challenge for community providers and they reported frustration because roles and responsibilities were not fully established. The addition of new strategies over the early grant years led to some confusion as staff had to take on additional responsibilities. Similarly, the evaluation protocol was not fully established at the beginning of the grant, and providers reported confusion as new requirements were added and responsibilities adjusted. There was a general feeling that having the various roles and protocols fully developed at the beginning of the grant would have enhanced the speed of implementation.

Theme 4: Stakeholders felt that some of the evaluation tasks were burdensome in addition to their existing workload. Providers did not expect to be responsible for data entry activities, and felt frustrated to have to learn the data systems. Providers shared that they had difficulty taking on these responsibilities in addition their service roles. *Note*: The evaluation team took on the responsibility for data entry early in Year 2.

Accomplishments by Community: Each community was asked to share accomplishments within their community, as well as facilitators of their progress.

- **Bexar County:** Informants from Bexar County considered workforce development to have been a success. They highlighted the growth of attendance from initial trainings and the impact that the trainings have had on their community. Additionally, there is a feeling of satisfaction knowing that they are able to provide support within schools and to teachers as evidenced by growing requests for training and presentations. One provider considered the growing success of parent education classes (infant and pre-school) as an accomplishment, since she noted that they are difficult to build, but their participation is something to be happy about. Lastly, although they have not been able to impact the number of children they would like, one provider considered the Early Childhood Mental Consultation as being successful because of the great quality of care provided.

- **Ysleta del Sur Pueblo:** This community considered the parental involvement in their work to be successful. They also indicated that the workforce development and child screenings have been significant accomplishments.

- **Tarrant County:** The community reported that raising awareness in the community has started important conversations, and as a result would be considered a success. Additionally, the development of an early childhood system is considered an accomplishment, stating "LAUNCH gave us the ability to bring together in our community an Early Childhood System". They described exceeding all of their original targets, increasing the capacity of trainers, the and the success of the ASQ Enterprise System. They also reported fine tuning their skills in mental health consultation through evidence-based practices such as the Georgetown and Pyramid models. Overall, they were proud to be able to be increase the resources for families within their communities.

Barriers faced by community: Key informants were also asked to reflect upon the barriers that they faced during implementation of the LAUNCH strategies and how they were overcome, when applicable.

- **San Antonio:** The beginning of the grant period created a barrier for their success as a result of staffing issues, undefined roles and responsibilities, and struggles with communication between stakeholders (see themes 3 & 4). They also indicated that recruitment and marketing of their activities in the community was challenging. They also reported some struggles with buy-in from schools, with staff not acting upon plans or recommendations (MHC).

- **Ysleta del Sur Pueblo:** Likewise, this community struggled in the beginning to understand all of the grant expectations. More specifically, communication problems created confusion because there were differences of opinion with regards to what Mental Health Consultation is and how to carry it out in their community. They attributed this problem to the Georgetown Model and the considered the possibility that it may not be appropriate for their population.

- **Fort Worth:** This community reported some difficulties understanding the complexities and logistics for the the different systems and protocols in place for evaluation. They also reported that it was challenging to delay training in Mental Health Consultation, and that they wanted additional training in the Georgetown Model. They indicated that there was some difficulty getting community buy-in for all practices, such as IY or MHC, and some challenges due to subcontracting.

Communication Strategies. The communication strategies were varied but had modest reach. Texas LAUNCH continued to host a webpage, and moved to providing materials from the oversight council meeting electronically. Over the year, the Texas LAUNCH Facebook page hosted 81 messages, with a reach of 4,056 people. The page has 39 followers. The LAUNCH team also developed a monthly/quarterly newsletter in the reporting period that is shared with expansion community and state partners and available on the website. and provides timely notice of new resources and community accomplishments. Eighteen newsletter editions were distributed over the grant period. Lastly, the Project Director coordinated an outreach campaign to advertise the newly revised developmental screening course available through Texas Health Steps at conference and through a mailing to all Medicaid providers. This effort led to a 66% increase in usage of the training. These communication strategies showed some success, although reach was modest.

Summary of Collaboration / Partnerships. The evaluation demonstrated that the state wellness council maintained a robust membership, although it showed significant turn-over during the grant. There were challenges with maintaining parent participation in meetings, although parents continued to be engaged in phone callse and workgroups. Members reported that participating in the council wass beneficial to them and that the political or social environment was strong for the work. The overall collaboration grew over the course of the grant period, with no clear areas of weakness by the end of the grant. Council members felt that the group created an avenue for communication and networking, between state agencies and between communities and state agencies. Community stakeholders largely felt satisfied with the training and technical assistance they have received, although they report some confusion in the early phases of the grant. They felt that they have had many successes in implementing the strategies, with challenges including the evaluation and the buy-in of community members.

Strategy 2: Workforce Development

Through the Workforce Development strategy, Texas LAUNCH aimed to build early childhood competency within the workforce and strengthen the supportive infrastructure for early childhood care within the state. Workforce development efforts included 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 focus of this evaluation was to measure the impact of training efforts to increase the early childhood mental health workforce both at the state and expansion community levels. The evaluation was intended to document the number and type of trainings occurring in each community and around the state, some characteristics of the early childhood professionals trained, data around knowledge gained and individual satisfaction associated with these trainings, and estimates of the number of children and families who may be served by these professionals following these trainings.

A. Evaluation Questions

Evaluation questions for this component of the Texas LAUNCH activities are summarized in Table 3. This aspect of the evaluation addressed to what extent the grant was successful in strengthening the early childhood workforce within the expansion communities and statewide.

Table 3. *Summary of Evaluation Questions for Strategy 2 – Training and Technical Assistance*

Evaluation Question	Data Collection Method	Source of Data	Measures
1. How many individuals are trained in best practice early childhood practices?	Teacher-report	Training Sign-in Sheets	Training Summary Sheet (TSS)
2. What is the increase in the workforce certified in early childhood mental health?	Administrative data maintained by First3Years	First3Years, the Infant Mental Health endorsement organizations	Count of Staff endorsed each quarter
3. What barriers and/or facilitators did communities experience in their workforce development efforts?	Interviews	Expansion community leads; local training partners	Interview Prompts (internally created)
4. What is the perceived impact of training opportunities on the work of participants?	Self-report	Survey	Impact of Training and Technical Assistance (IOTTA)
5. What percentage of providers report decreased stress levels following training?	Self-report	Survey collected at training and 3 months post-training	Professional Quality of Live Scale (ProQoL)

B. Approach and Methods

The evaluation design for the workforce development strategy was 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, allowed project staff to identify gaps in training, issues of training quality, and geographical impact. The pre-test/post-test design allowed 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).

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.

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 were documented from participant sign-in sheets. Partners provided a brief description of the training event, using the Training Summary Sheet, submitted with copies of the sign-in sheets. This allowed 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 completed the IOTTA, documenting the perceived impact of the training and their competency or mastery of the skills. This measure is paper-and-pencil for workshop participants and through a web-based survey for those participating in online training events.

Additionally, we intended to track the changes in the rate of providers seeking early childhood credentials through First3Years endorsement process to identify any potential increases over time. A collaboration with First3Years was intended to be established in Year 1 of the project, but contracting difficulties caused delays. While this component was planned through carry forward funding in Year 3, it was not able to be pursued because of the delay in approval and

contracting for carryforward funds. The project will be unable to evaluate any change in the number of individuals receiving an early childhood endorsement (Question 2). Evaluators also had challenges assessing the impact of trainings on provider self-care using the ProQOL. While several trainings on this topic did occur, they were generally conducted by partner organizations, which made it more challenging to ensure that the training hosts followed this unique procedure for workshops related to self-care.

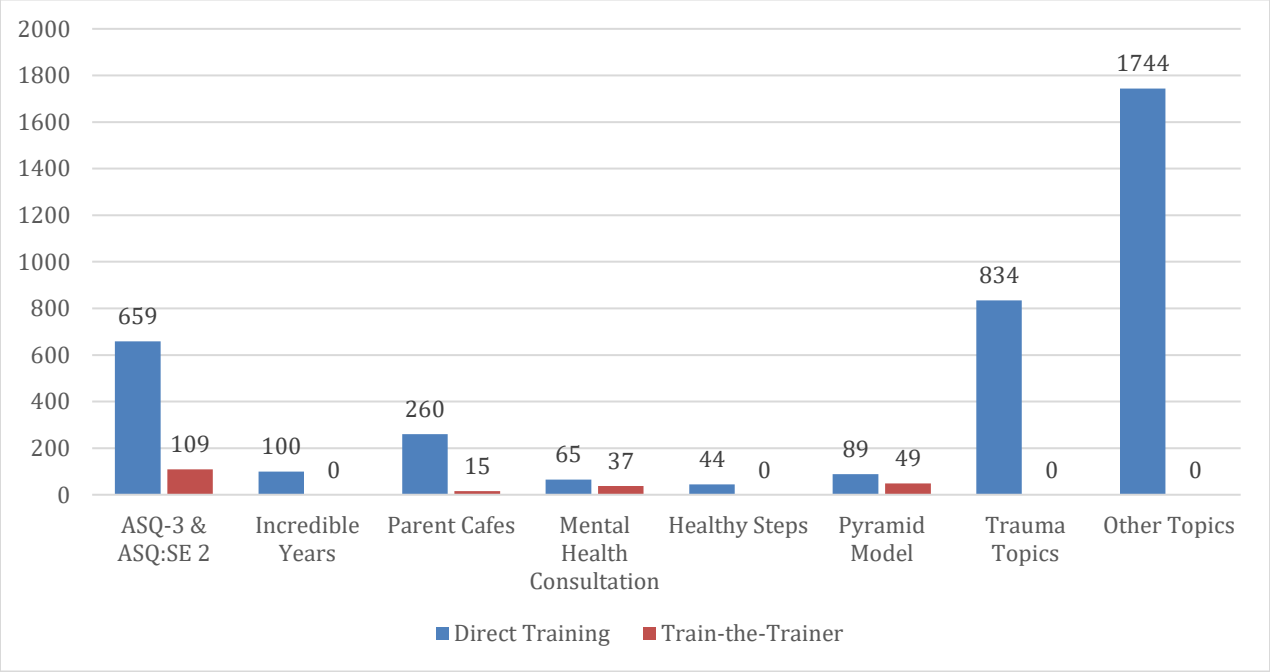
C. Data Analysis

Descriptive analyses have been conducted to summarize the number of individuals trained. Quantitative and qualitative information collected on the IOTTA are summarized for different training types. Qualitative information is aggregated across participants to allow for the identification of common responses.

D. Findings/Interpretation:

Overall Workforce Development. Texas LAUNCH trained over 4,000 individuals in a variety of early childhood practices. Figure 3 illustrates the number of people trained in key content areas. Texas strived to create sustainable practices by also building trainers in many of these practices, including developmental screening, Parent Cafes, and mental health consultation.

Figure 3. *Individuals Trained in the LAUNCH Initiative*



Community Workforce Development. Tarrant County, Bexar County, and Ysleta del Sur Pueblo communities conducted formal trainings to build, enhance, and sustain the early childhood mental health workforce within their respective communities. Each community took an individualized approach to providing trainings that were tailored to community-specific needs and interests. In addition, the state team provided and hosted trainings to support the expansion of LAUNCH strategies across the state. As can be seen in Table 4, each community promoted the training of professionals conducting development and social-emotional screenings. Tarrant County also focused on trainings to support the expansion of Parent Cafes, as well as specialized

trainings like Healthy Steps. The state team provided training on screening, Incredible Years, Mental Health Consultation, and other relevant topics. Highlights of workforce development accomplishments in each community are summarized in the following sections.

Table 4. *Texas LAUNCH Trainings Broken Down By Community*

Training	Tarrant County	Bexar County	Ysleta del Sur Pueblo / El Paso	Other Texas Communities	Total
ASQ3 & ASQ:SE2	490	32	38	99	659
Incredible Years	34	4	2	60	100
Parent Café	260	2	1	0	260
Mental Health Consultation	26	5	3	31	65
ASQ TOT	22	4	0	83	109
Parent Café TOT	15	0	0	0	15
Mental Health Consultation TOT	3	2	2	30	37
Other Training Topics	822	1,182	161	595	2,760
All Trainings	1,672	1,229	206	898	4,005

Tarrant County Key Trainings. The Tarrant County community strived to build sustainability for the widespread use of Parent Cafes to build family protective factors and reduce the risk of adverse childhood experiences. LAUNCH leaders worked with Be Strong Families, the developer for Parent Cafes, to structure a train-the-trainer protocol for the community. Be Strong Families provided web-based training to prepare the trainers for an on-site visit. During the on-site visit, the 15 trainers conducted Parent Café trainings, receiving real time coaching, as well as post-event debriefing. As a part of the training certification, the 15 Parent Café trainers trained an additional 107 Parent Café facilitators.

Table 5 illustrates the perceptions of the Parent Café train-the-trainer workshop participants. Participants reported experiencing some increase in competence as a result of the training, with strong levels of competence at the completion of the training. The training had moderate ratings of training organization, but other indicators were high. All but one participant indicated that they were “very likely” to share the information with colleagues and make changes within their work setting as a result of the training. Participants indicated that understanding how to describe the protective factors was very helpful, as well as the opportunity to practice the training and receive real-time coaching. Several participants indicated that they would have liked a better understanding of the agenda and the expectations of them prior to the training, as well as indicating they would like more preparation prior to having to train others.

Table 5: *Evaluation of Parent Café Train-the-Trainer*

Item	Average (n=14)	Standard Deviation
Note: Items range from 0 to 10, with 10 representing highest/greatest level of the criteria.		
Existing mastery/competence	6.07	2.23
Post-training mastery/competence	8.21	0.89
Importance of training goals	8.00	2.80
Trainer credibility	9.50	0.85
Training organization	7.36	1.78
Training interest	8.79	1.48
Overall impact on work	8.57	2.31
Impact on assessment & service planning	8.86	0.53
Note: Items range from 1 to 4, with 1=”not at all” and 4=”very likely”		
Likelihood of sharing with colleagues	3.86	0.53
Likelihood of making changes at work	3.86	0.53

Table 6 examines the experiences of participants being trained in Parent Café facilitation by the novice trainers. To provide a benchmark, ratings are compared to the ratings that were received in two previous Parent Café trainings conducted by Be Strong Families in the Tarrant County community. Differences in mean ratings on each item were compared through an independent t-test, with a $p<.01$ utilized as the cut-off for significance. A more conservative p value was selected to guard against Type II error, as multiple comparisons were made.

Participants in the Parent Café trainings reported modest competence prior to training, with a significant increase in mastery following training (t=-9.08, df=58, $p<.001$). Generally, participant ratings for the novice trainers were not significantly different than the ratings for the Be Strong Families trainers; however, participants did rate the trainings conducted as a part of certification to be less organized than the Be Strong Families training events.

Table 6: *Evaluation of Parent Café Trainings Conducted by Local Trainers versus National Trainers*

Item	Local Trainers Average (SD) n=59	Be Strong Families Average (SD) n=48	Significant Difference
Note: Items range from 0 to 10, with 10 representing highest/greatest level of the criteria.			
Existing mastery/competence	5.10 (2.68)	6.06 (2.40)	n.s.
Post-training mastery/competence	7.93 (1.07)	7.79 (1.56)	n.s.

Importance of training goals	8.88 (1.78)	8.68 (1.45)	n.s.
Trainer credibility	9.19 (1.12)	9.13 (1.20)	n.s.
Training organization	8.38 (1.70)	9.28 (0.99)	t=3.25; p=.0016
Training interest	8.71 (1.54)	9.23 (1.04)	n.s.
Overall impact on work	8.69 (1.56)	8.58 (1.20)	n.s.
Impact on assessment & service planning	8.84 (1.34)	8.63 (1.28)	n.s.
Note: Items range from 1 to 4, with 1=”not at all” and 4=”very likely”			
Likelihood of sharing with colleagues	3.84 (0.41)	3.74 (0.57)	n.s.
Likelihood of making changes at work	3.79 (0.49)	3.68 (0.59)	n.s.

In the final year of the grant, Tarrant County hosted a training in mental health consultation to strengthen that strategy. The training was provided by experienced providers from Illinois and intended to focus on concrete skills development. Overall ratings of the training were very high, with small standard deviations indicating that these high ratings were consistent across the respondents (see Table 7). Respondents indicated that they were very likely to share the information that they learned with colleagues (M=3.96 on 4.0 scale) and very likely to make changes in their practice (M=3.96 on 4.0 scale). Participants rated their competence in mental health consultation as fairly low prior to the training (M=3.79 on 10.0 scale), but increasing to a moderate to moderately high range following training (M=6.33 on 10.0 scale). This represented a significant change in partcipant mastery (t=10.5, df=32, p<.0001), based on participant self-report.

Table 7: *Evaluation of Mental Health Consultation Training in Tarrant County*

Item	Average (n=33)	Standard Deviation
Note: Items range from 0 to 10, with 10 representing highest/greatest level of the criteria.		
Existing mastery/competence	3.79	2.36
Post-training mastery/competence	6.33	1.95
Importance of training goals	9.03	1.13
Trainer credibility	9.76	0.44
Training organization	9.64	0.55
Training interest	9.28	0.85
Overall impact on work	9.32	0.79
Impact on services	9.45	0.89
Note: Items range from 1 to 4, with 1=”not at all” and 4=”very likely”		
Likelihood of sharing with colleagues	3.97	0.17
Likelihood of making changes at work	3.97	0.17

Ysleta del Sur Pueblo Community Trainings. Texas LAUNCH team members within the tribal community of Ysleta del Sur Pueblo targeted workforce development activities to the Tuy Pathu Early Learning Center, located within the Tribal Empowerment Department, and a community childcare center, Bright Stars. Many of the trainings provided were small and informal. Texas LAUNCH staff provided two larger trainings on Continuity of Caregivers and Infant Mental Health to 13 and 15 early childhood educators respectively. Table 8 summarizes participant perceptions from these two training events. Participants indicated an increase in competency in the topics and felt that the overall impact on their work would be high. One respondent summarized the message of the training as "Every child needs somebody who is crazy about them."

Table 8: *Evaluation of Select Trainings Conducted by Ysleta del Sur Pueblo*

Item	Continuity of Care *n*=13		Infant Mental Health *n*=15	
	Mean	SD	Mean	SD
	Note: Items range from 0 to 10, with 10 representing highest/greatest level of the criteria.			
Existing mastery/competence	5.92	1.75	6.67	1.54
Post-training mastery/competence	7.54	1.27	8.20	0.77
Importance of training goals	8.85	1.21	9.33	0.82
Trainer credibility	8.77	1.42	8.93	0.88
Training organization	8.92	1.08	8.73	0.96
Training interest	9.25	0.87	9.07	0.96
Overall impact on work	9.25	0.75	9.13	0.74
Impact on assessment & service planning	8.58	1.00	9.20	0.94
	Note: Items range from 1 to 4, with 1="not at all" and 4="very likely"			
Likelihood of sharing with colleagues	4.00	0	3.87	0.35
Likelihood of making changes at work	4.00	0	3.87	0.35

Bexar County Community Trainings. Family Services Association and its partner, Voices for Children, offered a range of trainings to early childcare providers. Training topics included self-esteem, effective communication strategies, biting and toileting, social and emotional learning, trauma informed care, and self care for teachers. Participant perceptions of two example trainings are presented in Table 9. One focused on strategies for providing positive guidance to young children and the second focused on the use of children's books to teach social and emotional skills.

Participant ratings on the Guidance and Discipline training, held at The Neighborhood Place Childcare Center, were moderate, indicating some potential concerns with the training organization and degree to which it kept participants' interest. Qualitative responses suggested

that participants wanted more expamples of behaviors, more scenarios or video examples, more practical tips, and time for discussion. Ratings on the second training were very high across all domains, suggesting that participants found it highly engaging and impactful. Participants in the training on the use of children's books indicated that they learned how to engage children by acting out the emotion in books. A number of participants also discussed learning how to help relate the stories to things that may happen in a child's life to create "teachable moments." Many participants commented that they would have loved to receive a book they could use in their classroom.

Table 9: *Evaluation of Select Early Childhood Trainings in Bexar County*

Item	Guidance & Discipline *n*=35		Children's Books *n*=61	
	Mean	SD	Mean	SD
	Note: Items range from 0 to 10, with 10 representing highest/greatest level of the criteria.			
Existing mastery/competence	6.29	1.64	7.31	2.27
Post-training mastery/competence	6.74	1.63	8.52	1.49
Importance of training goals	7.57	1.88	9.21	1.24
Trainer credibility	7.00	1.91	9.39	0.90
Training organization	6.41	1.71	9.24	1.19
Training interest	6.12	1.87	9.25	1.25
Overall impact on work	6.88	1.89	9.15	1.30
Impact on assessment & service planning	6.97	1.84	9.07	1.47
	Note: Items range from 1 to 4, with 1="not at all" and 4="very likely"			
Likelihood of sharing with colleagues	3.31	0.69	3.88	0.33
Likelihood of making changes at work	3.32	0.70	3.91	0.28

State Training Opportunities. State LAUNCH staff focused most of their training efforts on expanding the training to additonal regions in the state and creating trainers of select models. The state team hosted trainings in Incredible Years, Mental Health Consultation and the ASQ-3 and ASQ:SE-2. Train-the-trainer workshops were also held for the ASQ tools and Mental Health Consultation. The team also provided trainings in childhood trauma, social emotional learning, behavioral health screening, and the eDECA assessment tool.

Across the grant period, the state offered four trainings in the Incredible Years programs, inviting expansion community providers and others in the state. Responses of participants are presented in Table 10. Participants reported moderate levels of competency prior to the training and moderately high ratings at the end of the workshop. Ratings of the trainer credibility, training organization, training impact were all high. To support sustainability of the significant investment in developmental screenings, the state offered four trainer workshops for the ASQ-3 and ASQ:SE-2. Participants reported moderate to moderately low mastery prior to the event, suggesting many participants had little to no exposure to the ASQ tools. They reported

moderately high ratings of mastery at the end of the training. Participants reported some difficulty with "skipping around," but generally reported only positive feedback. Participants enjoyed practicing scoring the tools, role playing a parent-teacher conference, and the screening kit and trainer resources that were provided to all participants.

Table 10: *Evaluation of Select Early Childhood Trainings in Bexar County*

Item	Incredible Years Basics and Babies *n*=89		ASQ Trainer Workshops *n*=82	
	Mean	SD	Mean	SD
	Note: Items range from 0 to 10, with 10 representing highest/greatest level of the criteria.			
Existing mastery/competence	5.58	2.38	4.40	2.96
Post-training mastery/competence	7.93	1.51	7.95	1.39
Importance of training goals	8.91	1.44	8.89	1.37
Trainer credibility	9.55	0.85	9.41	1.18
Training organization	9.44	1.10	9.19	0.95
Training interest	9.19	1.32	9.11	0.86
Overall impact on work	9.01	1.27	8.87	1.17
Impact on assessment & service planning	8.91	1.31	8.92	1.30
	Note: Items range from 1 to 4, with 1="not at all" and 4="very likely"			
Likelihood of sharing with colleagues	3.91	0.29	3.95	0.22
Likelihood of making changes at work	3.80	0.43	3.77	0.55

In the third year of the grant, the state team hosted a series of trainings on the Pyramid Model, a framework for supporting social and emotional competency in early childhood programs. One training track was held to support the development of early childhood staff, including child care providers, home visitors, and child care health consultants. Forty-six individuals were trained in this track. A second track was offered for early childhood mental health clinicians, including 43 participants. The two tracks were aligned with Level 2 and Level 3 of the Infant Mental Health Endorsement system. Table 11 presents responses from participants in both Pyramid Model trainings. Overall, participants reported moderate to high satisfaction with the Track 1 training and high satisfaction with the Track 2 training. Participant comments from Track 1 suggest that home visitors may have had more difficulty identifying the relevance to their position, with many identifying a desire for more information on use in home visits and for information on infants and toddlers. Participants in Track 2 identified appreciation for the practical tools and strategies provided, with the most frequently identified takeaway being the "5 Big Bang" strategies for the classroom.

Table 11: *Evaluation of Pyramid Model Training*

Item	Track 1 Non-mental Health Average (SD)	Track 2 Mental Health Average (SD)
Note: Items range from 0 to 10, with 10 representing highest/greatest level of the criteria.		
Existing mastery/competence	6.48 (1.75)	5.60 (2.02)
Post-training mastery/competence	8.10 (1.53)	8.00 (1.01)
Importance of training goals	8.85 (1.35)	9.00 (1.04)
Trainer credibility	9.07 (1.23)	9.83 (0.45)
Training organization	8.78 (1.24)	9.40 (0.78)
Training interest	7.68 (1.81)	9.15 (1.64)
Overall impact on work	8.22 (1.60)	8.95 (1.81)
Impact on assessment & service planning	8.37 (1.51)	8.68 (1.97)
Note: Items range from 1 to 4, with 1=”not at all” and 4=”very likely”		
Likelihood of sharing with colleagues	3.78 (0.48)	3.89 (0.39)
Likelihood of making changes at work	3.75 (0.63)	3.87 (0.41)

A subsequent training was held with 49 participants to develop state trainers in the Pyramid Model. Participant responses are shown in Table 12. Overall, the training was very well-received. Participants had very high ratings of the trainer credibility, training organization, and training interest, with minimal variability (suggesting a consensus of participants). Participants reported that the training binder would be very helpful, and they appreciated the practical tools and resources. Participants noted that they looked forward to using the training with teachers. Most participants indicated that they received all that they needed, with several suggesting that they could have benefited from an additional training day.

Table 12: *Evaluation of Pyramid Model Train-the-Trainer*

Item	Average	Standard Deviation
Note: Items range from 0 to 10, with 10 representing highest/greatest level of the criteria.		
Existing mastery/competence	5.59	1.89
Post-training mastery/competence	8.06	1.13
Importance of training goals	8.88	1.51
Trainer credibility	9.73	0.64
Training organization	9.48	0.85
Training interest	9.46	0.77
Overall impact on work	9.29	0.92
Impact on assessment & service planning	9.20	0.94

Note: Items range from 1 to 4, with 1=”not at all” and 4=”very likely”		
Likelihood of sharing with colleagues	3.94	0.25
Likelihood of making changes at work	3.91	0.28

Summary of Results in Workforce Development. Overall, the evaluation of the workforce development strategies shows significant impact in each community. While many trainings focused on the skills to implement the core strategies, these trainings went well beyond LAUNCH staff to train a significant number of professionals in the expansion communities and beyond. Communities were also able to offer trainings that met specific needs of each community. This was important for building community support across a variety of settings. For example, the Local Lead in Ysleta del Sur Pueblo was able to bring trainings that the community identified, such as Positive Indian Parenting and Trust-based Relational Intervention, which strengthened rapport with the tribal community. The primary trainings offered by the state team enhanced the sustainability of LAUNCH practices through the training of in-state trainers in Mental Health Consultation, Pyramid Model, and ASQ tools. Participants generally reported a perceived increase in mastery as a result of the trainings and expressed a high likelihood of making changes at work.

Strategy 3: Early Childhood Screening

The focus of this component of the evaluation was to measure the impact of efforts to increase developmental and social-emotional screenings for young children in the three expansion communities. The evaluation was 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 received further services after a positive screen.

A. Evaluation Questions

Evaluation questions for this component of the Texas LAUNCH activities are summarized in Table 13. This evaluation addressed to what extent the grant was successful in increasing capacity of communities to screen for developmental and social and emotional delays and refer for appropriate assessment or early interventions.

Table 13. *Summary of Evaluation Questions for Strategy 3 – Developmental Screening*

Evaluation Questions	Data Collection Method	Source of Data	Measures
1. How many young children are communities screening?	Screening Provider Report	Screening Provider Report	Screening and Referral Form
2. What are the characteristics of children screened in the project?	Screening Provider Report	Screening Provider Report	Screening and Referral Form
3. How does the racial and ethnic distribution of children served compare to the community?	Screening Provider Report	Screening Provider and Census Data	Screening and Referral Form
4. What percentage of children screened are identified as at risk for developmental or social-emotional concerns?	Screening Provider Report	Screening Provider and Scoring of Screener Instrument(s)	Screening and Referral Form
5. What percentage of children identified as at risk and referred for further services receive subsequent interventions?	Screening Provider Follow-up	Caregiver Report	Screening and Referral Form
6. Are there any differences in the receipt of subsequent interventions by age, sex, or race/ethnicity?	Screening Provider Follow-up	Analysis of Caregiver Report	Screening and Referral Form

B. Approach and Methods

Texas LAUNCH staff within each of the expansion communities provided early childhood screenings, as well as supported the training of community partners to conduct early childhood and parental screenings. Texas LAUNCH focused on screenings using the Ages and Stages Developmental and Social and Emotional scales (ASQ-3 and ASQ:SE-2), although information was collected on all screenings conducted through Texas LAUNCH. Screening providers reported on screening information by completing the Screening and Referral Form immediately following a screening event. This form collected information on the screening location, the child

screened, the results of the screening, and any referrals provided to the family. In the intial evaluation plan, the screening provider was asked to contact the family to inquire about the results of the referral, including whether further services were accessed, barriers to access (if any), and satisfaction with the service received. The information collected through the Screening and Referral Form allows for measuring racial and ethnic sub-populations, geographic regions targeted by communities for reducing behavioral health disparities, and difference in access to and satisfaction with care by sub-populations.

Barriers or Limitations. During the course of the year, Tarrant County implemented a web-based tool for conducting developmental and social and emotional screenings. This increased the community's capacity to conduct screening, but led to unexpected challenges for the evaluation. The evaluation team worked closely with Tarrant County to identify ways to download and transfer data in a manner that was consistent with the evaluation to date. This resulted in monthly data transfers that had to be manually entered by evaluation staff. There was also some recognition of inaccurate data previously reported for screening referrals and follow-up, as referral information was not reported through the web-based tool. Tarrant County staff were able to revise the referral data for the final six quarters of the grant by querying screening staff and examining program records. Lastly, there were some data inaccuracies reflected in the system during the transition to the web-based platform. Staff continued to enter some screening into the evaluation system, but this data was duplicated in the data transfers. This duplication was not recognized initially because different identification numbers were used in the two systems and minor differences were present in the record (one month age difference). These duplicated records have been removed for the current analysis. As a result of these challenges, the decision was made to focus on reliable referral data and to stop attempting to collect data on the receipt of services following referral. The community was encouraged to build these data elements into the data platform to allow for efficient collection in the future. They are in the process of purchasing a data system that allows for tracking of referrals and linkages to electronic healt records.

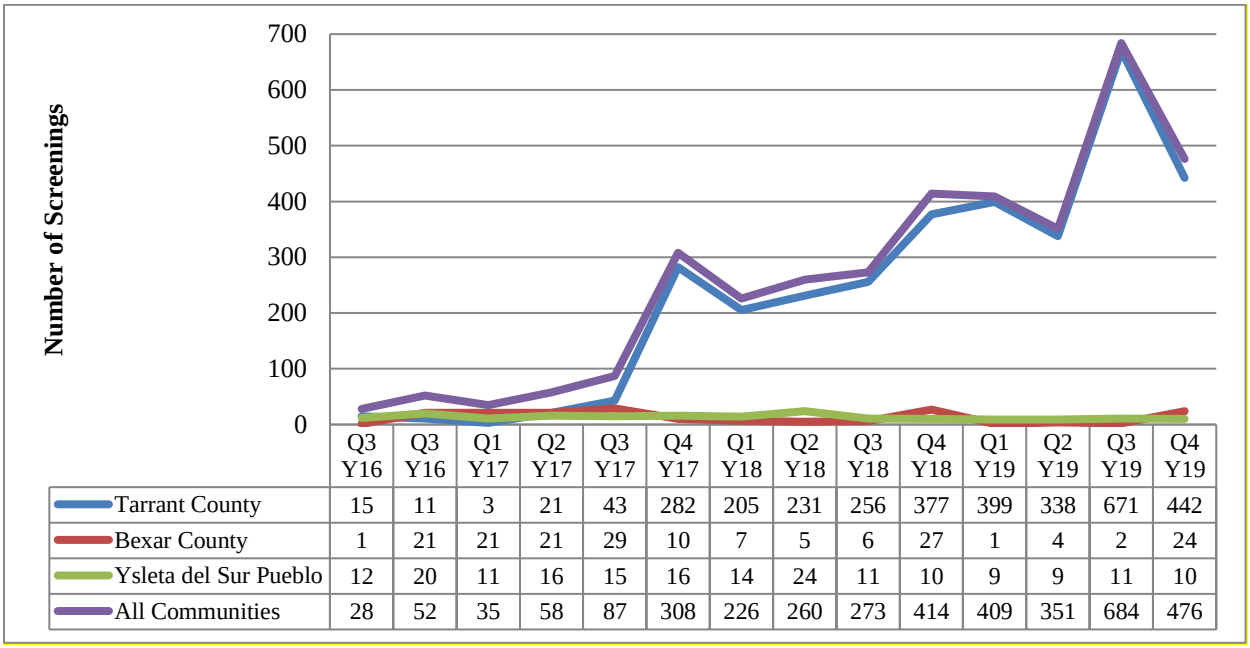
C. Data Analysis

Descriptive data analyses are reported, summarizing relevant aspects of the screening process. It should be noted that state aggregated data over-represents the Tarrant County community.

D. Findings/Interpretation:

Number of Children Screened. Texas LAUNCH had a goal of screening 1,705 children during the grant period. This goal was exceeded, with a total of 3,661 children and families screened. Figure 4 illustrates the number of children screened in each community by quarter over the grant period. The majority of young children screened were from the Tarrant County region.

Figure 4. *Developmental Screenings by Quarter*

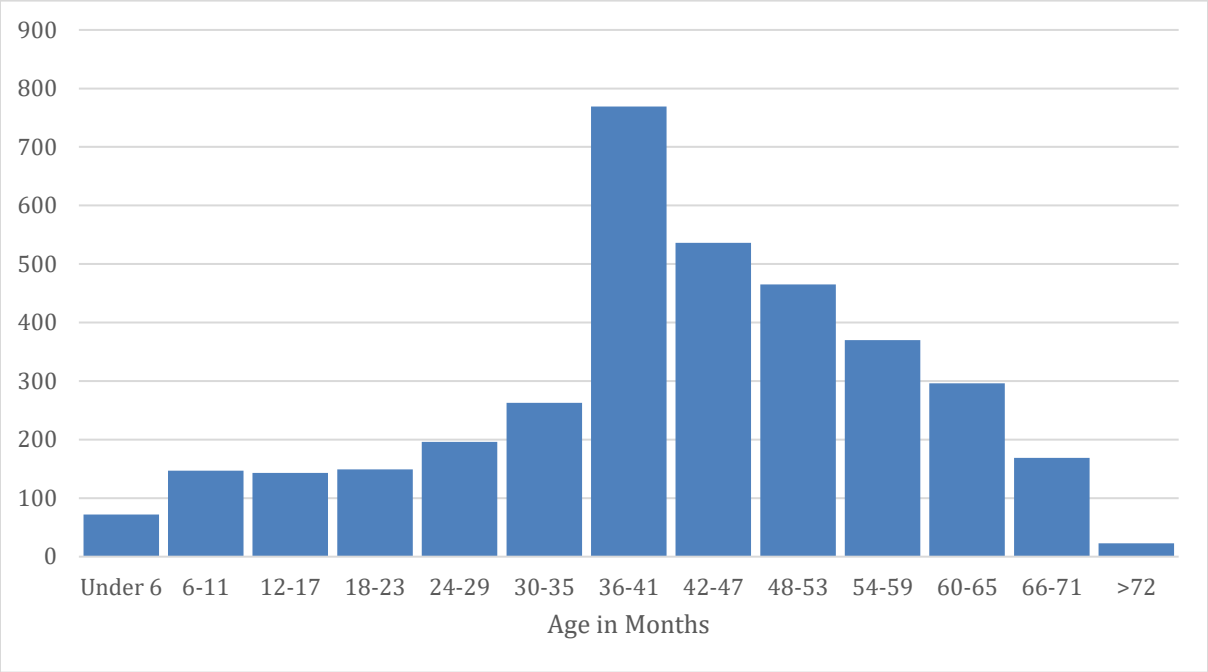


	Q3 Y16	Q3 Y16	Q1 Y17	Q2 Y17	Q3 Y17	Q4 Y17	Q1 Y18	Q2 Y18	Q3 Y18	Q4 Y18	Q1 Y19	Q2 Y19	Q3 Y19	Q4 Y19
Tarrant County	15	11	3	21	43	282	205	231	256	377	399	338	671	442
Bexar County	1	21	21	21	29	10	7	5	6	27	1	4	2	24
Ysleta del Sur Pueblo	12	20	11	16	15	16	14	24	11	10	9	9	11	10
All Communities	28	52	35	58	87	308	226	260	273	414	409	351	684	476

Ysleta del Sur Pueblo screened a total of 188 children or families over the course of the grant, reflecting a fairly steady rate of children served within the early childhood education programs. In Year 3, Ysleta del Sur also began screening for postpartum depression in partnership with the tribal health department, and six maternal screenings with the Edinburgh Postnatal Depression Scale were conducted. Bexar County screened 179 children during the grant. The screenings were conducted within early learning programs. There were slightly higher rates of screening in the first two grant years; the decline was due to a disruption in the relationship with one early learning program after a change in leadership. Family Services Association created new partnerships in the subsequent grant years. Tarrant County screened a total of 3,294 children during the grant period. During the first two years, the community's rate of screening was similar to Bexar County and Ysleta del Sur Pueblo. However, in the third and fourth year Tarrant County had implemented the ASQ Enterprise system and their rates of screening steadily increased as new partner agencies were trained in using the system. With the addition of this electronic platform, coordinated community training, and staff support, Tarrant County was able to screen in multiple settings, including the early childhood hotline, an early childhood website, child care and early learning centers, a home visiting program, and primary care. The ASQ Enterprise system allowed providers to directly access the screening tools and receive immediate feedback on any elevations. Families were able to access the ASQ screenings directly from the community's early childhood website, with a staff member tasked with contacting families for further discussion and referrals, when indicated.

Characteristics of Children Screened. The children screened across the three expansion communities had a mean age of 41.5 months (*SD* = 16.0 months). Age data was either missing or not provided for 73 children. The number of children screened by age is depicted in Figure 5. Three years was the most frequent age at which children were screened. The mean age for Ysleta del Sur Pueblo (*M*=25.8, *SD*=25.8) and Bexar County (*M*=33.4, *SD*=15.2) were both younger than Tarrant County (*M*=42.7, *SD*=15.5). Sixty-one percent of children screened were male, 38.4 percent were female, and 0.03 percent reflected other (8 were missing).

Figure 5. *Number of Children Screened by Age*



Racial and Ethnic Characteristics. The communities aimed to address behavioral health disparities by screening a greater proportion of child of color than represented in their communities. The proportion of children screened by race/ethnicity are illustrated in Figure 5. Children with unknown race/ethnicity were removed from the analysis (*n*=242). There were mixed results for this goal. The LAUNCH initiative did outreach to a greater proportion of Native American children (5.6%), compared to the less than 0.5% of the state child population. Black or African American children made up 27.7% of the sample, which is higher than the 11.6% reflected in the Texas child population. However, the LAUNCH initiative failed to screen a higher propoortion of Hispanic or Latino children. Only 23.0% of the children screened were identified as White, Hispanic, while White, Hispanic children represent 49.7% of the state's population under nine. Moreover, White, non-Hispanic children were slightly over-represented within the screening sample. Thirty-four percent of the population screened were identified as White, non-Hispanic, with this category making up 30.9% of the state population.

The under-representation of Hispanic children may be due to the limited screening that occurred in Bexar County, which is a predominantly Hispanic community. Bexar County also failed to identify the child's race and ethnicity for the majority of screenings. It may also be due to community outreach methods. Since each community conducted screenings in child care or early learning centers, Hispanic families may be under-represented in these settings, preferring to use family or home-based child care options. This hypothesis has some support within the data. Although only a small number of children had been screened while at their pediatrician's office (*n*=31) at the end of the grant, the proportion of children identified as Hispanic were more similar to the state's population (48.4%). This suggests the importance of screening in a setting in which almost all children can be accessed, such as at well child visits.

Figure 6. *Proportion of Screenings by Race and Ethnicity Compared to Texas Child Population*

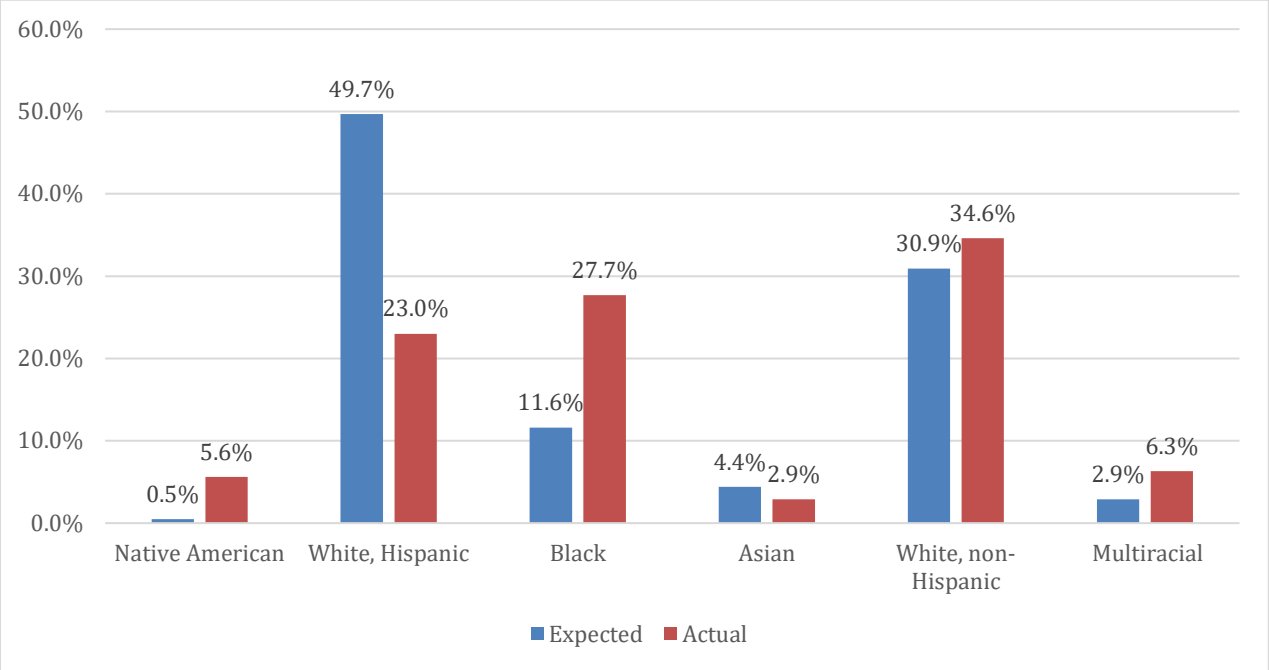


Table 14 illustrates the racial and ethnic breakdown of screening participants for each community, along with the associated expected proportion according to the US census data. As expected, Ysleta del Sur primarily screened children who identified as American Indian and Hispanic. Bexar County served a proportionate number of Hispanic children, and reached a greater number of Black children than would be expected from the population. Tarrant County was successful in serving a higher proportion of Black families, but screened a lower proportion of Hispanic families than would be expected by the population of the county. Tarrant County also engaged almost nine percent of the population in a language other than English. Spanish was the most common language after English, but families also spoke French, Korean, Nepali, Swahili, Tigrinya, and others.

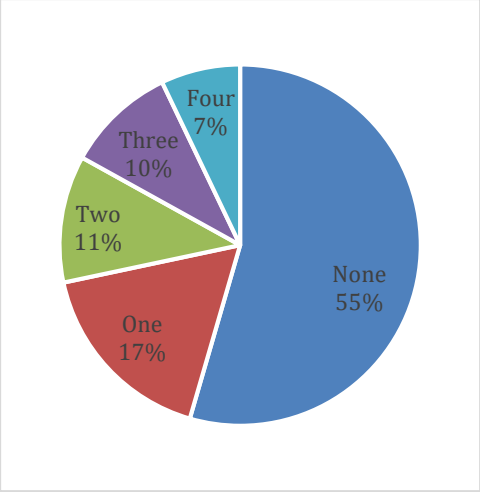
Table 14. *Race and Ethnicity of Screening Participants by Community*

	YDSP Expected	YDSP Actual	Bexar Expected	Bexar Actual	Tarrant Expected	Tarrant Actual
Number to be Screened	-	188	-	179	-	3294
Mean Age in Months	-	25.8 (15.9)		33.3 (15.2)		42.7 (15.5)
By Race/Ethnicity						
African American	0%	1 (0.5%)	8.5%	8 (13.8%)	16.7%	940 (29.6%)
American Indian/Alaskan Native	100%	180 (95.7%)	1.2%	0 (0%)	0.9%	12 (0.4%)
Asian	0%	0 (0%)	3.1%	1 (1.7%)	5.5%	97 (3.1%)
White (non-Hispanic)	0%	1 (0.5%)	28.2%	11 (19.0%)	47.9%	1165 (36.6%)
White (Hispanic or Latino)	0%	7 (3.7%)	59.9%	37 (63.8%)	28.4%	743 (23.4%)
Native Hawaiian/Other Pacific Islander	0%	0 (0%)	0.2%	0 (0%)	0.2%	0 (0%)

Two or more Races	0%	0 (0%)	2.3%	1 (1.7%)	2.4%	214 (6.7%)
Unknown or Refused	N/A	0	N/A	121	N/A	115
By Gender						
Female	UNK	102 (54.3%)	50.7%	70 (39.3%)	51.1%	1232 (37.4%)
Male	UNK	86 (45.7%)	49.3%	108 (60.7%)	48.9%	2061 (62.6%)
Other / Missing		0 (0%)		1 (0%)		1 (0%)
Primary Language						
English	-	184 (97.4%)	-	41 (23.0)	-	2907 (88.2%)
Spanish	-	2 (1.1%)	-	0 (0%)	-	214 (6.5%)
Other	-	0 (0%)	-	0 (0%)	-	71 (2.2%)
Missing/Unknown	-	3 (1.5%)	-	137 (77.0%)	-	104 (3.2%)

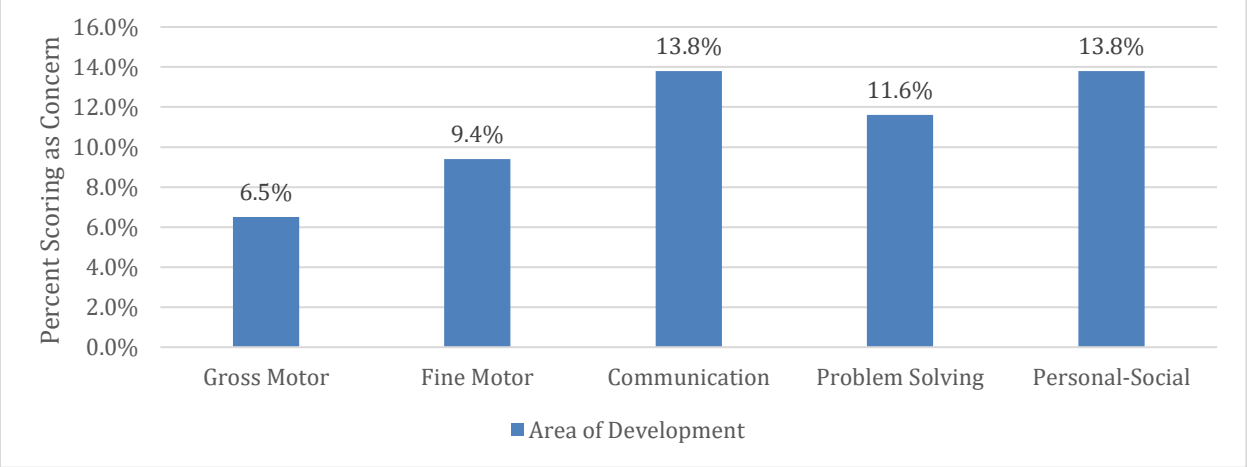
Results of Developmental Screenings. Almost one-half of the children (45.5%) screened in the LAUNCH initiative demonstrated one or more developmental concerns. Figure 7 illustrates the number of developmental concerns identified for children who had a completed ASQ-3. This rate varied by community.

Figure 7. *Number of Developmental Concerns on ASQ-3*



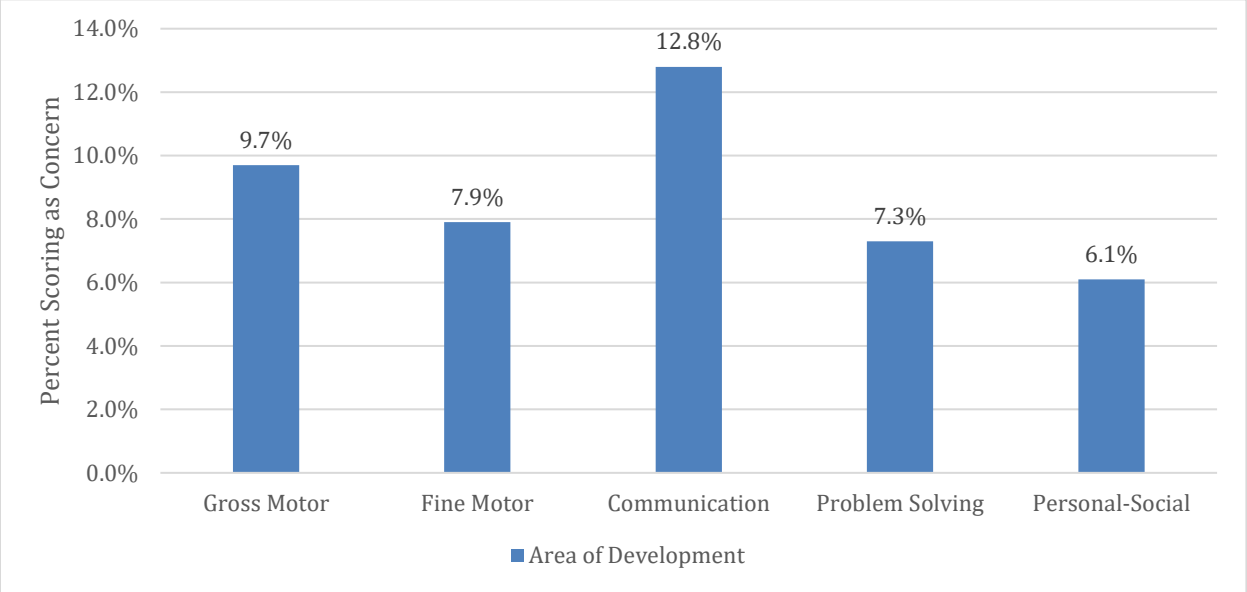
Ysleta del Sur Pueblo**.** Ysleta del Sur Pueblo screened 189 children or families. Only two of the 163 children screened with the ASQ:SE-2 were identified with a social or emotional concern. Of the 138 children screened with the ASQ-3, 34 had areas of concern on the screening tools, representing 24.6 percent of those screened. Figure 8 illustrates the percent of children with elevations on each of the subscales of the ASQ-3. Communication and Personal-Social domains reflected the most common areas of concern.

Figure 8. *Developmental Screening Results for Children in Ysleta del Sur Pueblo*



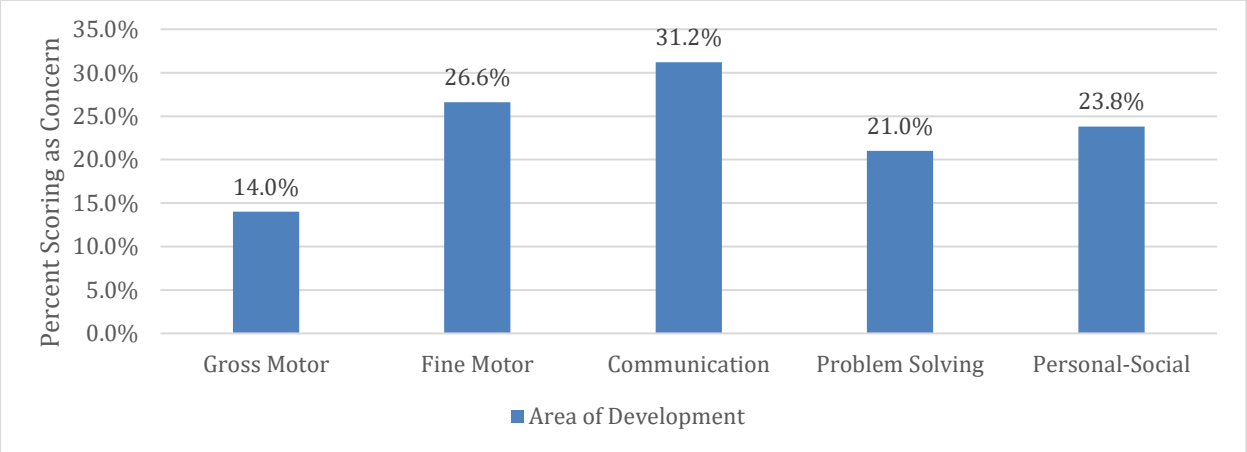
Bexar County. Bexar County screened 179 children during the grant. Of the 165 children screened with the ASQ-3, 35 (21.2%) were identified with one or more developmental concerns. Eighty-six children were screened with the ASQ:SE-2, and three children (3.5%) were identified with an elevation. The areas of developmental concern are illustrated in Figure 9. Gross Motor and Communication subscales were the most commonly identified areas of concern.

Figure 9. *Developmental Screening Results for Children in Bexar County*



Tarrant County. The Tarrant County community screened 3,296 children and families. Of the 3,028 children screened with the ASQ-3, 1,360 (44.9%) were identified with one or more elevations suggesting concern. Fewer concerns were raised on the ASQ:SE-2. For the 2,637 screened with the social and emotional scale, 427 children (16.2%) were identified with a concern. The areas of developmental concern are illustrated in Figure 9. Fine Motor and Communication subscales were the most commonly identified areas of concern, followed by the Personal-Social domain. The results in Tarrant County showed a significantly higher rate of concern than those found in the other expansion communities. This is likely due to the primary use of the tools within a population identified as high risk and engaged in prevention programs.

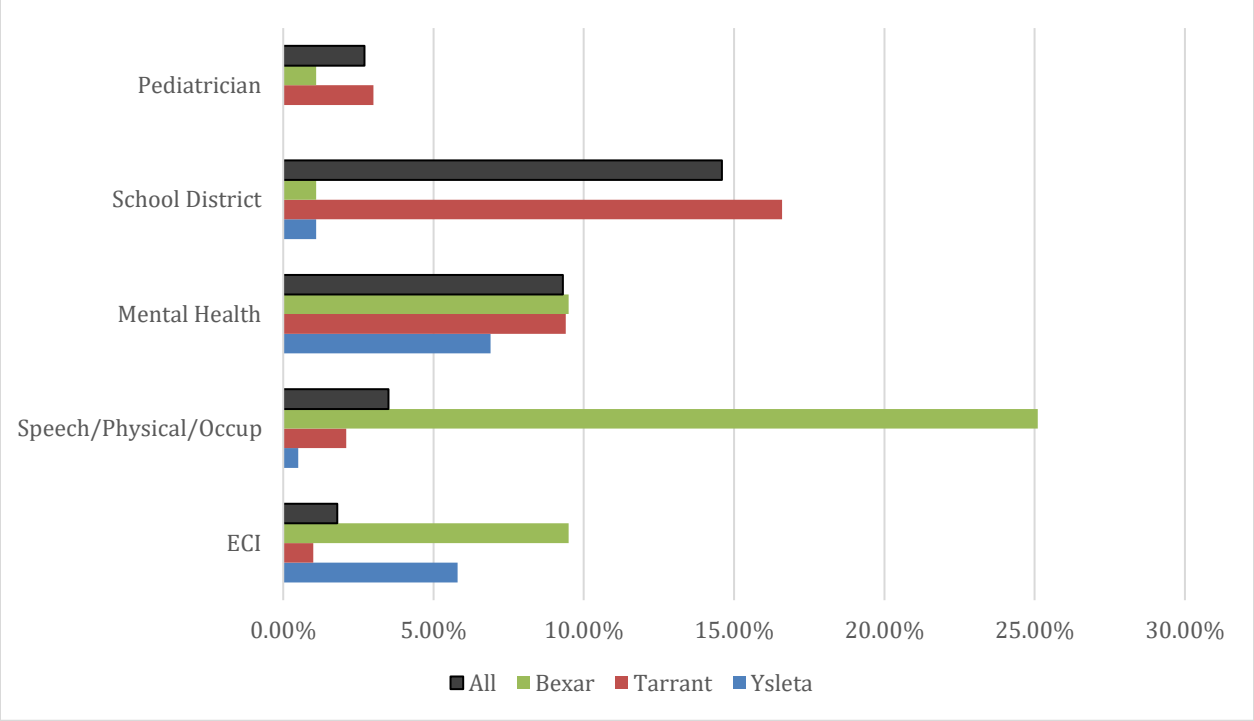
Figure 10. *Developmental Screening Results for Children in Tarrant County*



Referrals Following Screening. Following a completed developmental screening, 27.5% of children screened were referred for additional services. This number is higher than would be expected from screening of the general early childhood population, from which 10 to 20% are expected to have an elevated score. This elevated referral rate is a result of Tarrant County primarily implementing their screening practices with an early childhood prevention program, where some risk for developmental or social and emotional problems has led the family to the program. The referral rates were lowest in health care (13.3%) and educational or child care settings (30.7%) and highest in the prevention program (34.5%) and other settings (41.9%), which primarily reflects caregivers accessing screening through the website.

The types of providers that families were referred to are illustrated in Figure 11. The most common referral was to the local school district (14.6%). The education system provides further assessment for children three and older and may provide developmental services and supports through IDEA. The second most frequent referral was to a mental health or behavioral health agency (9.3%). This included families who were served in the Hopes prevention program in Tarrant County as well as those referred to family counseling, play therapy, or parenting programs. Families were less likely to be referred to a speech, physical, or occupational therapy provider (3.5%), Early Childhood Intervention (ECI, 1.9%), or physician (2.7%).

Figure 11. *Types of Referrals for Children Screened*



In Ysleta del Sur Pueblo, 21 of the 189 children screened (11.1%) were referred to one or more providers. Thirteen families (6.9%) were referred for services at the tribal behavioral health department or other mental health provider. Eleven children (5.8%) were referred to Early Childhood Intervention (ECI). The Local Lead was able to strengthen the referral process to ECI, as the community reported minimal services in the past. Referrals to the educational system (1.1%) and physical, speech, or occupational therapy (0.5%) were less common. No families were referred to a doctor.

In Tarrant County, the sample reviewed was limited to those with accurate referral data (April 2018 – September 2019). Within the period, Tarrant County referred 710 children and families (28.6%) for additional assessment or services. The most common referral was to the local school district for an evaluation (*n*=389; 16.6%), followed by mental health providers (*n*=234; 9.4%). Referrals to physicians (*n*=74; 3.0%), physical, speech, or occupational therapy (*n*=53; 2.1%), and ECI (*n*=25; 1.0%) were less common. Most of the screenings performed in Tarrant County occurred as a component of the initial evaluation for a family prevention program. The children have access to a wide variety of services within this program (e.g., speech therapy); therefore, referrals are primarily for other community supports outside of the participating organizations. Some families accessed the screening through a community website, and a staff member follows up to discuss potential referrals.

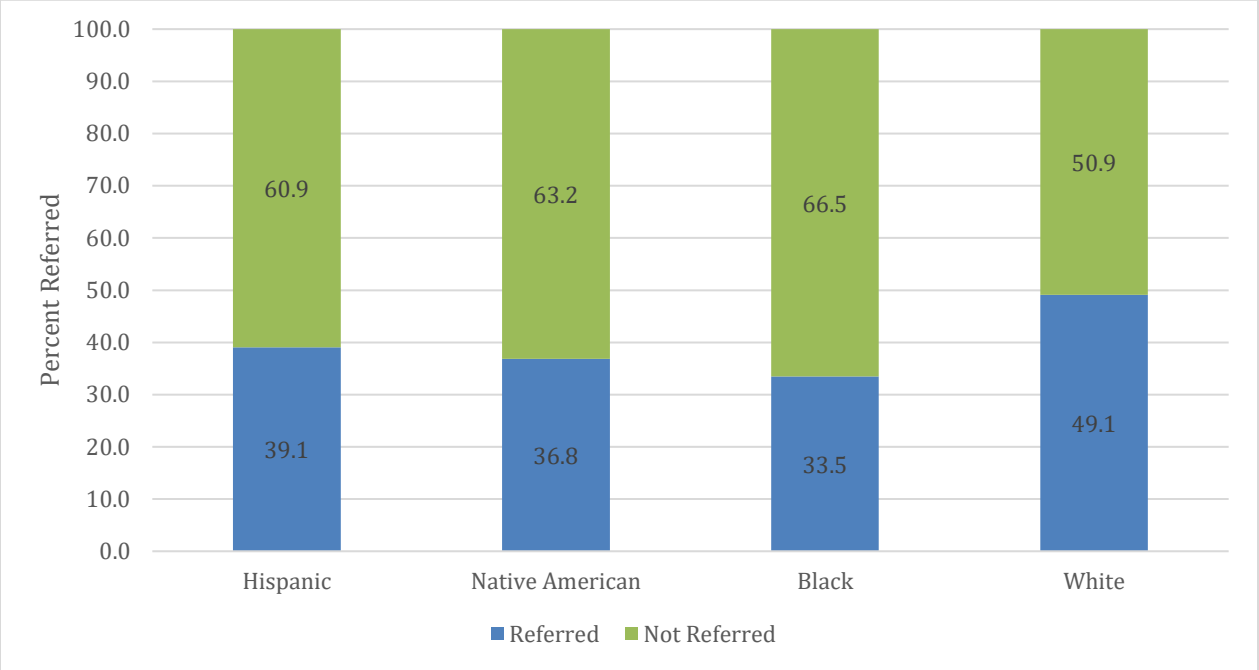
Bexar County referred 53 children and families (29.6%) for additional services or support. Most of these children (*n*=45; 25.1%) were referred for speech, physical, or occupational therapy. Referrals to a mental health provider (*n*=17; 9.5%) and ECI (*n*=17; 9.5%) were also common. Referrals to physicians (*n*=2; 1.1%) and the educational system (*n*=2; 1.1%) were less common.

Differences in Referrals by Child Characteristics. The ASQ-3 data reflected that male children were more likely than females to have one or more elevated subscales (X^2=47.5, df=2, p<.0001). Forty-eight percent of males had an elevated subscale on the ASQ-3, compared to 35.5% of females. An examination of the gender differences on ASQ-3 and ASQ-SE subscales shows differences on Fine Motor, Communication, Problem Solving, and Social Concerns. No differences were found in the proportion of males and females identified with Gross Motor and Social-Emotional Concerns. There was not an identified gender difference for referrals (X^2=2.82, df=2, p=.09). For children identified with an elevation on the ASQ-3, a similar proportion of males (43.5%) and females (37.9%) were referred for further assessment or services.

An examination of the proportion of children identified with a developmental concern by race and ethnicity indicated some difference from what would be expected by chance (X^2=30.3, df=3, p<.0001). An examination of the data suggests that Native American children were less likely to be identified with a concern (26.6%), compared to children identified as Hispanic (49.9%), Black or African American (41.7%), and White, non-Hispanic (42.2%). While this may suggest a disparate outcome or inadquacy of the the assessment, it may also reflect differences between the communities. As mentioned previously, Tarrant County had higher rates of elevations than Ysleta del Sur Pueblo and Bexar County, likely due to screening occurring in an at risk sample. Children identified as Native American were primarily screened in the Ysleta del Sur Pueblo community. The proportion identified with a developmental concern is not lower than would be expected in the general population.

An examination of the relationship between race and ethnicity on referral to further services was significant (X^2=15.75, df=3, p=.001). Children identified as White, non-Hispanic were more likely to be referred for further services (49.1%), compared to children identified as White, Hispanic (39.1%), Native American (36.8%), and Black or African American (33.5%). There were no statistically significant differences in referrals among Hispanic, Native American, and Black children. The proportion of referrals is illustrated in Figure 12.

Figure 12. *Referrals for Children with Developmental Concerns by Race-Ethnicity*



Summary of Results in Screening. The three communities were successful in implementing the developmental screening strategy. In the two communities that implemented through their partnership with early learning and childcare settings, there was limited reach in the screening activities. In the community that implemented a web-based screening platform, their rate of screening increased dramatically. This has allowed the community to efficiently access screening measures within the home and to expand access to childcare, healthcare, and directly to parents. The developmental screening identified concerns in 45.5% of children, with many experiencing multiple areas of concern. Few concerns were identified on the ASQ Social and Emotional measure.

About one quarter of children were referred for further assessment or services. Referrals to the local school system were the most common, followed by referrals for child or family mental health services. Few children were referred to their pediatrician, suggesting that physicians may be unaware of the identified concerns. This suggests the need for facilitated communication between the agency conducting the screening and the family's physician, perhaps through an electronic platform and procedures for parental consent for release of information.

Male children were more likely than females to be identified with a developmental concern; however, there were no significant gender differences in referral rates once the concern was identified. Native American children were less likely to be identified with a developmental concern than other groups; however, this difference may be due to site differences. The majority of Native American children resided in the Ysleta del Sur Pueblo. Tarrant County, which represented the majority of other children, had higher rates of identification in general. White, non-Hispanic children were more likely to be referred for further services than White, Hispanic, Native American, or Black and African American children.

Strategy 4: Family Strengthening

A. Evaluation Questions

Evaluation questions for this component of the Texas LAUNCH activities are summarized in Table 15. This aspect of the evaluation addressed to what extent the grant was successful in increasing the capacity of family members to promote positive social and emotional development in young children and build resilient families through Incredible Years parenting groups and Parent Cafés.

Table 15. *Summary of Evaluation Questions for Strategy 4 – Family Strengthening*

Evaluation Question	Data Collection Method	Source of Data	Measures
1. How many parents/caregivers are participating in parenting groups?	Teacher report	Sign-In Sheets	Sign-In Sheets
2. What percentage of parents/ caregivers are attending at least three-quarters of the sessions within a group series?	Analysis of existing data	Sign-in Sheets	Sign-In Sheets
3. 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?	Analysis of existing data	Parent interview	Demographic information from NOMS
4. Is there intervention integrity/fidelity to the Incredible Years parenting intervention?	Group Facilitator report	Checklist	Collaborative Process Checklist
5. Are lower levels of intervention integrity associated with attenuated outcomes?	Group Facilitator and Parent report	Checklist and survey	Collaborative Process Checklist; Eyberg Child Behavior Inventory
6. Are there any differences in outcomes based on age, sex, or race/ethnicity?	Administrative analysis of existing data	Surveys	NOMS and Eyberg Child Behavior Inventory
7. Are the IY parent groups associated with changes in levels of parental stress?	Parent self-report	Survey of parents, pre-test and post-test	Parenting Stress Index (PSI-SF)
8. Are the IY parent groups associated with changes in parental depression?	Parent self-report	Survey of parents pre-test and post-test	National Outcomes Measure
9. Are the IY parent groups associated with significant changes in levels of positive parenting behaviors?	Parent self-report	Survey of parents, pre-test and post-test	Parent Practices Interview (LIFT)

10. Are the IY parent groups associated with reductions in problematic child behavior?	Parent self-report	Survey of parents, pre-test and post-test	Eyberg Child Behavior Inventory (ECBI)
11. How many parents or caregivers are attending Parent Café events?	Analysis of administrative data	Sign-In Sheets	Sign-In Sheets
12. How many parents or caregivers are returning for more than one event?	Analysis of administrative data	Sign-In Sheets	Sign-In Sheets
13. How many parents or caregivers are reporting a perceived change in knowledge and confidence following attendance at a Parent Café event?	Parent self-report	Survey following event	Parent Satisfaction Survey

B. Approach and Methods

The Incredible Years evaluation uses a pre-test and post-test design. The impact of the intervention is examined by measuring key variables prior to the intervention and at the end of participation in the group. Although the evaluators planned to examine the extent to which treatment integrity, including dosage and adherence to the model, served as a mediator of outcomes, but the sample size was insufficient.

The evaluation design for the Parent Café strategy was a process-oriented tracking of the number of participants impacted by the Parent Cafés, as well as a post-test design to measure participants' perception of change on knowledge and parenting confidence, as well as satisfaction after attendance at Parent Café activities.

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.

Parent Practices Interview (LIFT; Webster-Stratton, Reid, & Hammond, 2008): The Parent Practices Interview is a 72-item questionnaire focused on parent discipline behaviors. 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).

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.

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 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.

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. Incredible Years group facilitators met with parents or caregivers referred to the program prior to the first group session. During this meeting, facilitators gathered information about the family, explained the program, completed consent forms, and completed baseline instruments. The NOMS form was intended to be conducted by interview, with other measures (i.e., LIFT, PSI-SF, ECBI) completed as self-report, unless literacy issues arose. Follow-up measures were collected at the final meeting of the group, or within one month of completion (i.e., NOMS, LIFT, PSI-SF, ECBI). Incredible Years group facilitators were to complete the Collaborative Process Checklist at the end of each group session. In addition, each facilitator was to submit one audiotaped group session in each year of the project for external review by Incredible Years Trainers or evaluation staff.

Parent Café group facilitators recruited 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 gathered administrative data (e.g., sign in sheets) from the participants, explained 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 were collected at the conclusion of the Café.

C. Data Analysis

The primary analyses measuring the impact of Incredible Years were dependent t-tests, comparing summary measures of parenting behaviors (LIFT Positive Index, Negative Index), parenting stress, and child behavior problems (ECBI total). Missing data on individual scales was imputed, based on the standardized rules for each instrument about allowable missing data. Children or families with missing baseline or follow-up measures were excluded from the analyses, given the limited number of assessment points. Due to the small sample with baseline and follow-up data, outcomes could not be examined for different families from different racial/ethnic groups (Question 6) or for differing level of model adherence (Question 5).

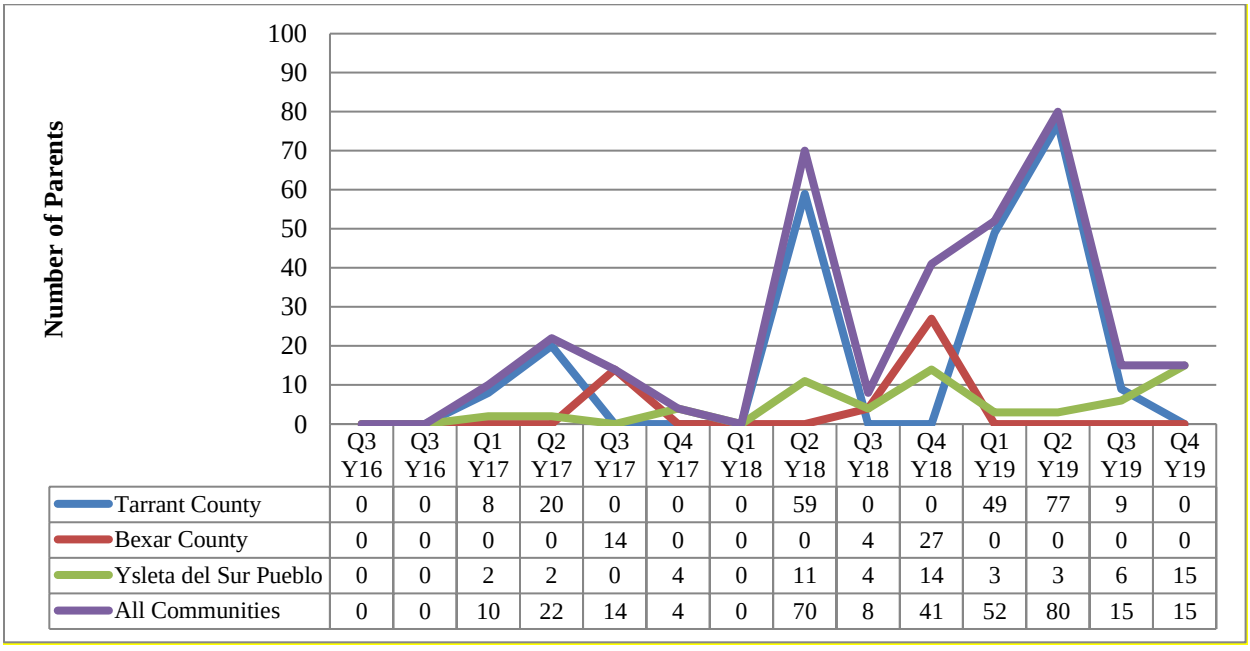
The experience of families participating in Parent Cafes was assessed through a survey, and descriptive analyses were performed. Results were benchmarked against the results demonstrated in initial evaluation studies by BeStrong Families.

Data Barriers or Limitations. The data collection for Incredible Years was considered extensive by many of the community providers. In Ysleta del Sur, the Incredible Years facilitator reported that many parents declined to participate because of the intrusive nature of some of the questions. The questions were felt to be particularly intrusive to the Native American community. In one community, there was significant loss of data from the baseline to the follow-up period. While there were several factors involved, this seemed to be primarily due to the delegation of responsibilities without significant oversight of the multitude of childcare centers involved. Some providers also appeared to not conduct the interview as an interview, but rather to provide the form to the family member, resulting in some confusion. An additional issue arose in the Parent Café evaluation. Following the Training of Trainers for Parent Cafes in the final quarter of the third year, Tarrant County began utilizing a briefer survey. The brief survey consisted of different questions, with only a few maintained from the longer version. Therefore, the results are presented for each measure separately.

D. Findings/Interpretations

Number of Families Served in Incredible Years. All three expansion communities implemented Incredible Years parent training groups. A total of 331 parents or caregivers initiated participation in the Incredible Years parenting program during the grant period. Participants entering the program over each quarter are illustrated in Figure 13. Two hundred and twenty-two caregivers were served in Tarrant County, 45 in Bexar County, and 64 from Ysleta del Sur Pueblo.

Figure 13. *Parents Initiating Incredible Years Groups by Quarter*



	Q3 Y16	Q3 Y16	Q1 Y17	Q2 Y17	Q3 Y17	Q4 Y17	Q1 Y18	Q2 Y18	Q3 Y18	Q4 Y18	Q1 Y19	Q2 Y19	Q3 Y19	Q4 Y19
Tarrant County	0	0	8	20	0	0	0	59	0	0	49	77	9	0
Bexar County	0	0	0	0	14	0	0	0	4	27	0	0	0	0
Ysleta del Sur Pueblo	0	0	2	2	0	4	0	11	4	14	3	3	6	15
All Communities	0	0	10	22	14	4	0	70	8	41	52	80	15	15

Access to Incredible Years by Race and Ethnicity. Demographic data was collected on the National Outcome Measure interview, which was completed on 142 parents. Community information was available for 128 families, including 82 parents or caregivers from Tarrant County, 32 from Bexar County, and 14 from Ysleta del Sur Pueblo. The gender and racial/ethnic breakdown of the sample is presented in Table 16. The sample is fairly small, so no conclusive results are identified. However, there appears to be increased access to Incredible Years for Hispanic or Latino families, Native American families, and Black or African American families. Incredible Years' participants were primarily female.

Table 16. *Demographics of Incredible Years Participants*

	YDSP Expected	YDSP Actual	Bexar Expected	Bexar Actual	Tarrant Expected	Tarrant Actual
Number Assessed	-	64	-	45	-	222
By Race/Ethnicity						
African American	0%	0 (0%)	8.5%	0 (0%)	16.7%	23 (34.3%)
American Indian/Alaskan Native	100%	10 (83.3%)	1.2%	2 (6.9%)	0.9%	0 (0%)
Asian	0%	0 (0%)	3.1%	0 (0%)	5.5%	0 (0%)
White (non-Hispanic)	0%	0 (0%)	28.2%	1 (3.5%)	47.9%	11 (16.4%)
White (Hispanic or Latino)	0%	2 (16.7%)	59.9%	26 (89.7%)	28.4%	32 (47.8%)
Native Hawaiian/Other Pacific Islander	0%	0 (0%)	0.2%	0 (0%)	0.2%	0 (0%)
Two or more Races	0%	0 (0%)	2.3%	0 (0%)	2.4%	1 (1.5%)
Unknown or Refused	N/A	52	N/A	16	N/A	155
By Gender						
Female	UNK	12 (85.7%)	50.7%	27 (84.4%)	51.1%	71 (89.9%)
Male	UNK	2 (14.3%)	49.3%	4 (12.5%)	48.9%	7 (8.9%)
Other		0 (0%)		1 (0.1%)		1 (1.3%)
Missing		50		13		143

Adherence to the Incredible Years Program. Initially, group facilitators were asked to complete the Collaborative Process Checklist, which is an observational tool for Incredible Year's fidelity. However, the tool was time intensive and challenging for facilitators to complete, along with other evaluation duties. Therefore, the evaluation plan was changed to measure adherence to the model by having group facilitators complete the Leader Checklist at the end of each group meeting. This is a "rough" measure of adherence as it is based on the leader's self-report and has no rating of the level of facilitator skill. However, it includes the core tasks that are expected to be completed at each session. Tarrant County was the only site that submitted the adherence checklists. One hundred and forty-seven checklists were submitted. The average adherence score was 89.1% (*SD*=13.2%). Individual session scores ranged from 42% to 100%, with 48.3% of sessions rated at 100%. Some facilitators shortened the overall length of treatment by covering more than one session during a meeting, which likely led to the reduction in adherence on some sessions.

Behavioral Health Outcomes of Incredible Years Participation. Data around the Incredible Years parenting program was collected prior to the initiation of services and again after service provision was complete. Ninety-nine families completed some baseline measures, but only 38 families had any follow-up information available. Given the very small number of participants at this point, information should be considered exploratory, with no attempt made to generalize.

Information on the baseline functioning of children and parents participating in IY are presented in Table 17. Mean scores on the ECBI Intensity Scale fall below the clinical cut-off of 131. Parents of 24 children (28.6%) had clinical elevations on the Intensity Scale, indicating significant externalizing problems. Similarly, 31.0% (22 out of 71) of parents reached a clinical range on the ECBI Problem Scale, suggesting that parents were significantly bothered by their child's behaviors. The overall total score on the Parenting Stress Index (*M*=74.6) corresponds to the 48th percentile, suggesting that most parents were not reporting significant parenting stress at program entry. Four of the 91 families described total parental stress scores within a clinical range, with up to 11 families having significant elevations on one or more subscales.

Table 17. *Baseline Scores of Child Behavior and Parent Stress*

	Ysleta del Sur (n=13)		Bexar County (*n*=20)		Tarrant County (n=51)	
Scale	*M / SD*	% Elev	*M / SD*	% Elev	*M / SD*	% Elev
ECBI Intensity Scale	110.5 (41.4)	46.2%	101.8 (48.3)	25.0%	100.9 (36.5)	25.5%
ECBI Problem Scale	10.7 (11.2)	40.0%	10.3 (10.9)	42.1%	8.8 (8.8)	23.8%
	(n=11)		(n= 27)		(n=63)	
PSI-SF Total Stress	80.1 (24.9)	9.1%	75.9 (26.7)	11.5%	73.0 (18.1)	0%
PSI-SF Parental Distress	27.8 (11.0)	18.2%	25.0 (11.7)	19.2%	23.2 (7.2)	1.6%
PSI-SF Parent/Child Dysfunctional Interaction	24.1 (8.8)	9.1%	23.3 (9.2)	7.4%	21.1 (6.6)	0%
PSI-SF Difficult Child	28.2 (7.8)	9.1%	28.0 (10.2)	23.1%	27.8 (7.7)	6.9%

Changes to the measures of child and parent functioning are shared in Table 18. The overall trend on the ECBI showed decreases in problem intensity and the number of problems that distressed parents; however, neither indicator reached statistical significance. Examination of clinically significant change (rather than statistical) demonstrates that 10 of 30 children had clinical elevations on the ECBI Intensity Scale at program entry, with 4 children no longer scoring in a clinical range a program completion. Five of the 17 parents with data on ECBI Problems Scale reported a clinical number of problem areas at entry to the program and three no longer reported clinical elevations on the ECBI Problem Scale at program completion. There was minimal parental stress identified within the sample, and minimal change was noted after participation in Incredible Years. This lack of change is likely the result of a "floor effect" on the PSI-SF. Results for Common Indicator 4 were calculated based on the number of caregivers with clinically elevated distress at baseline who reported sub-threshhold levels of distress at program

completion. Results show that 100% of families with elevated distress had sub-threshhold ratings of distress following the IY program for all but the Total Stress scale, where one out of two parents reported reductions.

Table 18. *Change on Measures for IY Participants*

Scale	Baseline *M / SD*	Follow-Up *M / SD*	Mean Change	Statistics
ECBI Intensity Scale (n=30)	109.8 (43.9)	100.5 (41.1)	9.27	t=1.49, p=0.15
ECBI Problem Scale (n=17)	8.7 (10.4)	5.9 (8.0)	2.8	t=1.87, p=0.08
PSI-SF Total Stress (n=33)	70.7 (24.6)	70.0 (23.2)	0.71	t=0.28, p=0.78
PSI-SF Parental Distress (n=35)	23.0 (10.0)	23.0 (10.0)	0.06	t=0.05, p=0.96
PSI-SF Parent/Child Dysfunctional Interaction (n=35)	21.4 (7.8)	21.4 (9.4)	0.06	t=0.04, p=0.97
PSI-SF Difficult Child (n=33)	26.8 (9.8)	26.2 (7.4)	0.65	t=0.49, p=0.62
Common Indicator 4	Scale	Numerator	Denominator	Percent
% of Parents Reporting Reduced Stress	Total Stress	1	2	50.0%
	Parent Distress	4	4	100%
	Parent Child Dysfunctional Interaction	1	1	100%
	Difficult Child	5	5	100%

Changes in Parenting Practices. Parents and other caregivers participating in Incredible Years classes were asked to complete a measure of positive and negative parenting practices (LIFT). The measure results in seven scales reflecting different aspects of parenting behaviors. Each scale is an average of items scored from 1 to 7. For negative parenting scales (Harsh Discipline, Harsh Discipline for Age, and Inconsistent Discipline), higher scores reflect poorer parenting practices. For positive parenting scales (Appropriate Discipline, Positive Parenting, Clear Expectations, and Monitoring), higher scores reflect greater positive parenting approaches. The scores for parents participating in classes are presented in Table 19. Overall, parents reported low levels of harsh discipline and low to moderate levels of inconsistency in discipline. Parents reported a statistically significant reduction in harsh and inconsistent discipline following participation in Incredible Years. Parents showed no change in the use of positive parenting practices. There was also a significant increase in the use of discipline that was harsh for the age of young children (e.g., grounding, extra chores, making discipline unexpected). This suggests that facilitators may need to specifically address the developmental appropriateness of different discipline strategies within the class. Since the primary outcome was decreasing harsh discipline, the Common Indicator 3 was calculated by examining the number of parents reporting decreases of at least 1 standard deviation on the Harsh Discipline scale. Using this methodology, 9 of the 31 participants completing this measure (29.0%) demonstrated improvements in parenting.

Table 19. *Change in Parenting Practices for IY Participants*

LIFT Scales	Baseline *M / SD*	Follow-Up *M / SD*	Mean Change *M / SD*	Statistics
Harsh Discipline (n=31)	2.56 (0.84)	2.00 (0.66)	0.56	*t*=3.09, *p*=0.004
Harsh Discipline for Age (n=31)	2.68 (0.90)	3.07 (1.13)	-0.39	*t*=-2.37, *p*=0.02
Inconsistent Discipline (n=30)	2.90 (0.68)	2.59 (0.63)	0.31	*t*=2.36, *p*=0.03
Appropriate Discipline (n=31)	4.53 (1.11)	4.79 (1.00)	-0.26	*t*=-1.39, *p*=0.17
Positive Parenting (n=29)	4.52 (0.78)	4.52 (0.69)	0.00	*t*=0.02, *p*=0.98
Clear Expectations (n=29)	5.67 (1.01)	5.63 (01.28)	0.03	*t*=0.11, *p*=0.91
Monitoring (n=29)	5.17 (0.78)	5.23 (0.49)	-0.06	*t*=-0.42, *p*=0.68
Common Indicator 3	Scale	Numerator	Denominator	Percent
% of Parents Reporting Improved Parenting	Inconsistent Discipline	9	31	29.0%

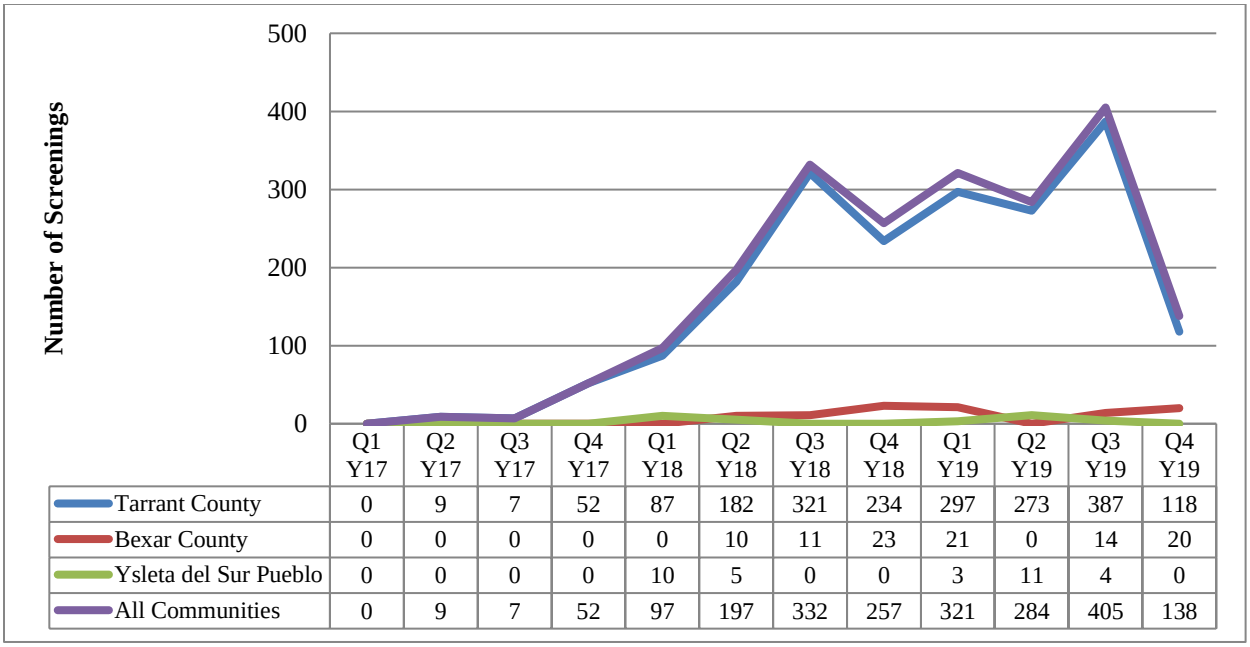
Family Satisfaction with Incredible Years. Thirty caregivers completed the Parent Program Satisfaction Questionnaire, assessed at the completion of the Incredible Years Basics class. Parent responses to select items are presented in Table 20. The neutral and negative responses on the scale were not presented, as no respondents reflected a poor experience on the measure. Parents were asked to rate how useful different components of the parent program are. The highest rated elements were group discussion, practicing at home, and weekly handouts. Parents were also asked about how useful they found different parenting practices taught in the class. The highest rated parenting practices were praise and encouragement, teaching children to problem solve, adult problem solving, and descriptive commenting or coaching.

Table 20. *Responses on the Parent Program Satisfaction Questionnaire*

Question	Slightly Recommend	Recommend	Strongly Recommend
Would you recommend the program to a friend or relative?	0%	17%	83%
	Slightly Confident	Confident	Very Confident
How confident are you in parenting at this time?	7%	40%	53%
How confident are you in your ability to manage future behavior problems in the home using what you learned from this program?	3%	37%	60%
	Slightly Better	Better	Considerably Better
The bonding/attachment that I feel with my preschooler since I took this program is…	3%	50%	47%
My child's behavior problems which I/we have tried to change using the methods presented in this program are…	13%	50%	37%

Number of Families Served in Parent Cafés. Two thousand and ninety-nine parents or caregivers participated in Parent Cafés during the grant period (see Figure 14). Ysleta del Sur Pueblo served 33, Bexar County served 99, and Tarrant County served 1,967. The capacity to conduct Parent Cafes grew exponentially in the Tarrant County community, as the region developed local trainers and expanded to a multitude of settings. Of those completing the longer survey, 42.9% reported that they had never previously attended a Parent Café. Of the parents or caregivers who reported having previously attended a Parent Café, 96.8% reported positive changes in their lives or the lives of their family members as a result of participation.

Figure 14. *Parent Café Participants by Quarter*

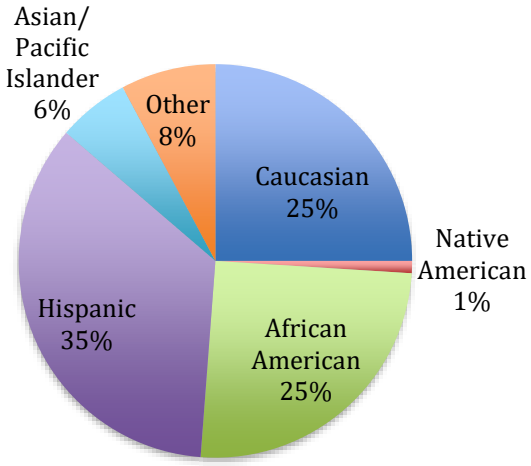


	Q1 Y17	Q2 Y17	Q3 Y17	Q4 Y17	Q1 Y18	Q2 Y18	Q3 Y18	Q4 Y18	Q1 Y19	Q2 Y19	Q3 Y19	Q4 Y19
Tarrant County	0	9	7	52	87	182	321	234	297	273	387	118
Bexar County	0	0	0	0	0	10	11	23	21	0	14	20
Ysleta del Sur Pueblo	0	0	0	0	10	5	0	0	3	11	4	0
All Communities	0	9	7	52	97	197	332	257	321	284	405	138

Characteristics of Families Served. The majority of Parent Café attendees (88.8% of those with data) identified as female. Data was missing on 623 (30.0%) of the participants. The predominant age range of parents or caregivers attending the Parent Cafés was between 31-40 (43%), followed by 22-30 year olds (28.7%), and those over 40 (20.5%). Young parents or caregivers under 22 made up a small proportion of the sample (7.6%). Figure 15 presents the breakdown of race and ethnicity for participants. Data was missing or not provided by 643 parents or caregivers. The sample has a greater proportion of individuals who identify as African American/Black (25.0%) than would be expected. In addition to conducting cafes in underserved communities, the Tarrant county region held events within a primarily African refugee population, which made up a significant proportion of the "Other" category. The average number of children for families attending the Parent Cafés was 1.6. Data was missing or not provided by 1,535 parents or caregivers (73.1%); this question is not asked on the brief survey.

Perceptions of Parent Cafés. Participants in the Parent Cafés were generally very positive about all aspects of the program. Tables 21 and 22 present the results of Parent Café surveys at each community. Participants almost unanimously endorsed that participation in the Parent Café was helpful to them and that they would recommend the Parent Café to friends and/or family members. Additionally, 96% of respondents indicated they intended to participate in Parent Cafés in the future. The vast majority of participants indicated that they made a plan to change something about their parenting practices, such as listening to their child more or changes in discipline strategies (79% or greater). Notably, 16% of attendees in Tarrant County did not feel that they came away with a personal connection with whom they intended to stay in touch and 24% did not identify a community specific program or resource that would be of benefit to them or their family. Participants in Bexar County and Ysleta del Sur Pueblo had higher results on these items. The Texas survey results are similar or better than those described by Be Strong Families in their Illinois evaluation.

Figure 15. *Race and Ethnicity of Parent Café Attendees*



Café Participant:
I enjoyed being able to open up about things that I keep bottled up daily.

Table 21. *Participant Perceptions of Parent Cafes*

	Tarrant *% Agree N=512*	Bexar *% Agree N=93*	YDSP *% Agree N=13*	BSF* % Agree *N≈4700*
Participating in the Parent Café was helpful to me.	99%	98%	100%	99%
I would recommend Parent Cafes to my friends and family.	98%	98%	100%	98%
I plan to participate in Parent Cafes in the future.	96%	98%	100%	97%
I learned something that will help me as a parent.	97%	99%	100%	97%
I realized something that will help me in my relationship with other people who are helping me raise my children.	94%	97%	100%	-
I learned a new way to handle stress or challenges in my life.	95%	97%	100%	95%
I plan to take better care of myself.	97%	98%	100%	97%
I met a person (or people) I plan to stay in touch with.	84%	90%	92%	83%
I learned about a program or resource in my community that will be good for me and my family.	76%	95%	92%	-
I will be more willing to ask for help when I or my family needs it.	96%	100%	92%	95%
I plan on changing something about my parenting.	89%	97%	100%	88%
I plan to change how I listen to my children.	92%	99%	100%	-

I plan to change how I talk to my children.	90%	99%	100%	-
I plan to change how I discipline my children.	79%	95%	100%	80%
I plan to spend more time with my children.	91%	98%	100%	90%
I plan to make sure I understand my children's feelings.	95%	99%	100%	94%

Note: *Results from on-going evaluation by Be Strong Families for comparison purposes.

Table 22. *Participant Perceptions of Parent Cafes – Brief Survey (Tarrant County only)*

N=891	*% Strongly Disagree*	*% Disagree*	*% Agree*	*% Strongly Agree*
I felt comfortable sharing with the other participants in the Café.	1%	1%	17%	82%
I learned something through somebody else's story/ experience.	1%	0%	21%	78%
The experience helped me reflect on my strengths and challenges as a parent.	1%	0%	21%	78%
I learned a new way to handle stress or challenges in my life.	1%	4%	35%	61%
I met a person (or people) I plan to stay in touch with.	1%	10%	42%	47%
The Protective Factors are a useful way for me to keep my family strong.	1%	0%	26%	73%
I learned something that will help me deal positively with a challenge I'm currently having with my child/children.	1%	2%	31%	66%
I learned about a program or resource that might be helpful to me, my family, or people in my community.	1%	5%	34%	60%
I practiced ways to talk with others that will reduce conflict in my life.	1%	2%	30%	67%
The Cafe made me feel valued as a parent and community member.	1%	3%	31%	65%
I see myself being able and willing to be part of a parent Cafe team.	2%	5%	29%	64%

Summary of Results in Family Strengthening. The three expansion communities each implemented Incredible Years and Parent Cafes. While evaluation of Incredible Years had some challenges, results suggested that families were satisfied with the program and would recommend participation to others. Only one-quarter of families participating in Incredible Years reported concerns with their child's behavior and very few parents had elevated levels of parental distress. This suggests that the commuities primarily recruited from a general parent population. Parents in the Incredible Years program reported significant changes in their use of harsh and inconsistent discipline strategies; however, there was no noticeable increase in positive parenting practices. Parents reported fewer problem behaviors and less intensity of problems following the intervention, but the differences did not reach statistical significance. Parents expressed resounding satisfaction with their participation in Parent Cafes and almost unanimously indicated a plan to make changes as a result of their participation.

Strategy 5: Mental Health Consultation

A. Evaluation Questions

This component of the evaluation explored the implementation of Mental Health Consultation within the expansion communities. This was an optional strategy and a novel service in the state and the evaluation was exploratory in nature. Evaluation questions for this component of the Texas LAUNCH activities are summarized in Table 23.

Table 23. *Evaluation Questions for Mental Health Consultation*

Evaluation Question	Data Collection Method	Source of Data	Measures
1. How does the racial and ethnic distribution of children served compare to the community?	Parent Interview	Parent report	National Outcomes Measure (NOMS)
2. Do teachers and child care providers participating in mental health consultation change the classroom climate following the intervention?	Teacher report	Pre- and post-survey	Preschool Mental Health Climate Scale (PMHCS)
3. What percentage of parents or other primary caregivers report reduced stress?	Parent report	Pre- and post-survey	Parenting Stress Index (PSI)
4. What percentage of providers report decreased stress levels?	Teacher report	Pre- and post-survey	Professional Quality of Life Scale (ProQoL)
5. Are there any differences in outcomes based on age, sex, or race/ethnicity?	Analysis of existing data	Existing surveys	NOMS, PSI, DECA-C
6. What percentage of children whose teacher or parent participates in mental health consultation demonstrate improved social-emotional skills/functioning?	Parent report	Clinical assessment	Devereaux Early Childhood Assessment Clinical Form (DECA-C)
7. What percentage of children are suspended/expelled from programs serving children birth to age eight prior to and after mental health consultation?	Agency expulsion/suspension rates	Gathered by Consultant	Agency reporting

B. Approach and Methods

The mental health consultation evaluation used a single group, pre-test and post-test design. For child-focused consultation, pre-test and post-test measures were used to 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 focused 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 were also planned 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.

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).

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).

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.

Procedures. Following child referrals to the mental health consultant (MHC), the parent met 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 conducted the NOMS using an interview format, with additional measures completed by the parent or other caregiver, unless literacy issues suggested an interview for all scales. Follow-up assessments were completed at the end of the intervention by the parent or other caregiver, with the interview led by the MHC. Follow-up assessments were only conducted if the family participated in at least five meetings with the MHC. If the family

left the setting prior to the end of the intervention, staff attempted to contact the parent to complete discharge assessments. For agency and classroom interventions, the MHC met with administrators interested in being involved in the service. Administrators were to 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 was to support the completion of the job stress survey with all early childhood teachers in the facility. The survey was to be completed again after one year of collaboration. When the MHC was asked to provide support to one or more classrooms, he or she was to conduct the PMHCS through an observation of the class. The instrument was to be repeated after 6 months.

Barriers and Limitations. The Mental Health Consultation evaluation was initiated in Year 3 and had multiple challenges. While communities were trained at the beginning of the third year, providers did not initially begin the evaluation activities. They reported that the evaluation was unclear and complex. Based on this feedback and experiences with Incredible Years, the evaluation was modified to exclude the NOMS interview and add a case summary form to gather information on all consultations, even those that were briefer than five interactions. Two additional trainings were provided to strengthen the understanding of the evaluation. No communities were able to obtain child care policies and no MHCs conducted any formal measures of classroom climate. The Bexar County community collected the DECA-C and PSI-SF on families with more lengthy involvement.

C. Data Analysis

The number of children or families who received child-focused mental health consultation were documented by the expansion communities. Demographic information was gathered on the case summary and described below. Referral problems, consultant response, and referrals were coded from the narrative data. Parent measures of child-related stress were examined with a dependent t-test.

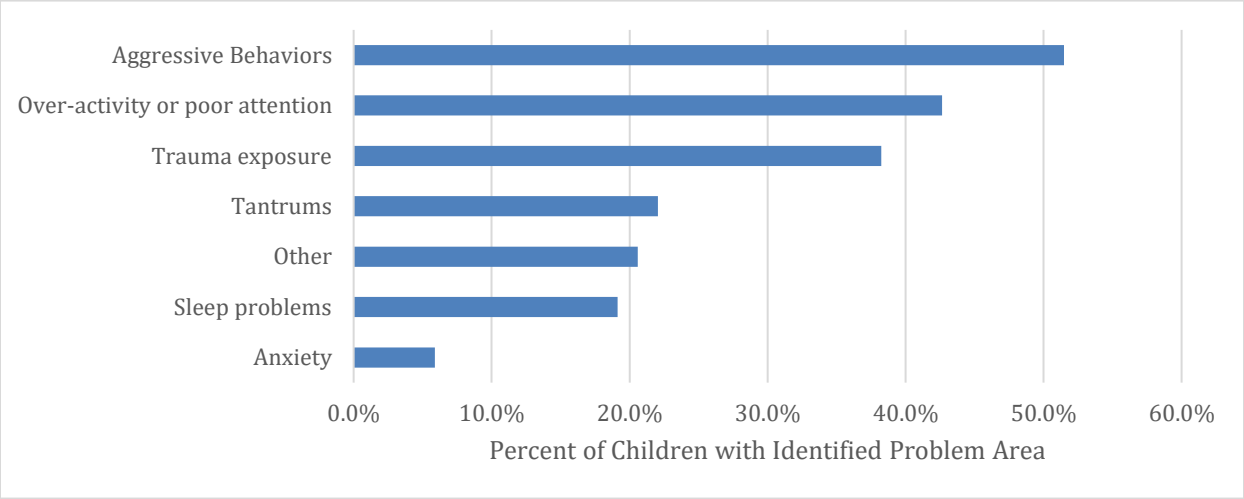
D. Findings/Interpretation:

A total of 142 children or families were served through mental health consultation, with 17 children served in Ysleta del Sur Pueblo, 52 in Bexar County, and 73 in Tarrant County. The sites provided case summaries on 68 children, representing the majority of children served after April 2018. Only one two-year-old was involved in MHC (1.5%). About one-quarter of the children were three years old; with the majority either four years old (38.5%) or five (35.4%). Ages were missing for six children. Male children were much more likely to be referred for MHC than female children (74.6% versus 25.4%), with one child having missing data. The sample included children identifying as the following: 24 as Black/African American (35.8%); 18 as White, Hispanic (26.9%); 13 as White, non-Hispanic (19.4%); 9 as Native American, Hispanic (13.4%); 1 as Asian, non-Hispanic (1.5%), and 2 as more than one race (3.0%). Two children with case summaries were missing information on race and ethnicity. The majority of referrals resulted in only one meeting (87.3%). The remainder of the children were seen either two, three, or four times. No children were seen more than five times. Parents were involved in 96.6% of all consultations.

Referral Problems. The types of referral issues identified in mental health consultation are summarized in Figure 16. The most common issue leading to referral was aggressive behaviors towards parents, siblings, and peers. Complaints related to overactivity, failure to follow

directions, and difficulty attending to tasks was also very common. Over one-fifth of children had clear histories of trauma exposure, including many children with child welfare involvement and family violence. There were also a number of referrals due to concerns about developmental delays, including speech delays and potential autism. Caregivers reported multiple incidents of expulsion from previous child care settings.

Figure 16. *Referral Problems for Mental Health Consultation*



Consultative Activities. The mental health consultant conducted a psychosocial evaluation with all children, sometimes utilizing developmental screenings or mental health assessments. In two instances (2.9%), the consultant conducted a classroom observation to further assess problem areas. In some instances (11.8%), the consultant provided psychoeducation to the caregiver, helping them to understand some of the factors that are impacting a child's behaviors. In 29.4% of the summaries, the mental health consultant provided the caregiver with specific skills to reduce problem behaviors or increase the child's coping. Examples of skills training include instructing the teacher on ignoring tantrum behavior and providing positive attention when the child quiets and using a calendar to help a child predict transitions in custody.

The predominant activity of the mental health consultants was to assess the adequacy of current services and supports and provide additional referrals. Mental health consultants provided additional referrals to 55.9% of families. The most common referral was to a psychiatrist or behavioral healh organization to explore psychiatric medications (23.5%). Referrals for child counseling were also very common (22.1%). About 10 percent of children were referred for further assessment of a developmental concern, and 2.9% were referred for services through ECI. One family (1.5%) was referred for family therapy. Mental health consultants were asked to identify whether the issue was positively resolved on the case summary. Positive resolution was indicated for 91.1% of cases. However, given the limited nature of most reported consultations and the significant proportion of referrals, this is more likely to indicate a positive interaction with a caregiver and not the overall resolution of the referral problem.

Outcomes of Mental Health Consultation. One community, Bexar County, collected the Parenting Stress Index – Short Form and DECA-C on families involved in mental health consultation. There was an inadequate number of DECA-C measures at baseline and follow-up for examination. However, there was a small number (n=19) of families with parenting scales at baseline and follow-up. Missing values resulted in a smaller sample on the Difficult Child

subscale and Total Stress Scale. Results of the analyses are presented in Table 24. Analyses demonstrated reduced levels of stress at follow-up for the Total Stress score and the Difficult Child subscales. Other subscales also trended towards improvement, but were not statistically significant. Only a small proportion of the sample had any subscales on the measure within a clinical range. Of the four parents reporting elevations on the Difficult Child subscale, three (75%) were below the clinical level at the follow-up assessment.

Table 24. *Change on Parenting Stress for Mental Health Consultation Participants*

Scale	Baseline *M / SD*	Follow-Up *M / SD*	Mean Change	Statistics
PSI-SF Total Stress (n=13)	73.1 (22.3)	57.4 (18.3)	15.65	t=2.35, p=0.04
PSI-SF Parental Distress (n=19)	22.2 (6.8)	19.2 (7.6)	2.99	t=1.74, p=0.10
PSI-SF Parent/Child Dysfunctional Interaction (n=19)	20.0 (6.4)	17.3 (5.2)	2.71	t=1.44, p=0.17
PSI-SF Difficult Child (n=13)	31.0 (10.2)	23.9 (8.9)	7.06	t=2.66, p=0.02
Common Indicator 4	Scale	Numerator	Denominator	Percent
% of Parents Reporting Reduced Stress	Total Stress	0	0	N/A
	Parent Distress	0	0	N/A
	Parent Child Dysfunctional Interaction	0	0	N/A
	Difficult Child	3	4	75%

Summary of Findings. Mental health consultation proved the most difficult strategy to fully evaluate. Since the intervention is relatively brief, an extensive assessment of parent and child functioning seemed unwarranted. It was difficult for consultants to predict the extent of the consultation needed at the outset. However, some key qualitative findings were gathered from the case summaries. Most children were referred for mental health consultation due to disruptive behavior, primarily aggression, hyperactivity, and tantrums. Many of these children were experiencing significant disruption in their lives, including parental divorce, incarceration and foster placement, and had prior exposure to trauma, including family violence, sexual and physical abuse, and death in the family. Mental health consultants primarily served as an expert to examine the adequacy of existing services and provide referrals for additional assessment or services. Although limited, initial outcome data suggests families report lower levels of stress related to children's temperment or behavioral issues following mental health consultation.

The three communities had different models for mental health consultation, reflecting the lack of standardization present in the state. In Ysleta del Sur Pueblo, the mental health consultant primarily supported capacity building of early childhood teachers, providing professional development, classroom observations, and supporting classroom approaches to social and emotional learning. In Fort Worth, mental health consultants evaluated children with more significant mental health issues within home visiting and prevention programs, primarily serving in an assessment and referral capacity. In Bexar County, mental health consultants were embedded in early learning or child care settings, providing both consultation and mental health interventions with children and families. These very different approaches suggest the need to provide some standardization to the model prior to additional evaluation studies and wide-scale expansion in the state.

V. RECOMMENDATIONS

Workforce Development

1. Childcare professionals are interested in receiving information on social, emotional, and behavioral health. Topics of special interest for workforce development included addressing challenging behaviors, the impact of trauma on children, and self-care for teachers. Future workforce development should include providing resources that aid in the use of the new skills (e.g., screening kits, manuals, flashdrives, children's books) and role playing challenging skills.
2. Developing local trainers in practices allowed for greater reach and sustainability. Practices that did not allow for local or regional training (e.g., Incredible Years) were more challenging to disseminate and sustain. The capacity for regional/local trainers should be considered as a factor when selecting evidence-based practices.
3. Training to support implementation of new practices should plan for booster sessions or coaching to ensure that individuals are comfortable implementing the practice to fidelity. For example, some child care organizations failed to implement the ASQ screening tools without further support. Communities can strengthen the implementation of practices by developing community champions who maintain contact with trainees, problem solve barriers to implementation, and provide booster trainings or coaching to move to mastery of the skills.
4. Providers attending one of the two workshops on Georgetown University's Mental Health Consultation framework were positive, but frequently expressed the desire for more in-depth skill building training targeting consultants. The Tarrant County workshop on mental health consultation was rated highly by participants and provided more concrete tools. The state should continue to examine opportunities to strengthen the available workforce training for this relatively new provider role.

Developmental Screenings

5. Tarrant County has been successful in expanding the community's capacity for developmental and social-emotional screening through an online platform. Project leaders have supported its use through memoranda of understanding with community agencies, regular staff training in the use of the system, and staffing to engage families interested in additional community resources. Tarrant County is exploring a more robust reporting system, that allows the community to track referrals and the resulting services. The state should use these "lessons learned" in the development of a state web-based platform for early childhood screening, ensuring it supports a universal approach to screening and access to referral resources.
6. Communities should monitor potential disparities in referral rates by racial and ethnic subpopulations. While differences in the identification of risk was not evident in the evaluation, White, non-Hispanic children were more likely to be referred for further services than youth of color.

Family Strengthening

7. The outcome evaluation of the Incredible Years program is limited by the small sample sizes, but initial results are positive and suggest decreases in harsh parenting practices and potential reductions in child behavior problems. However, there was an overall small reach for this intervention. Given the level of intensity required by this parenting program, communities may benefit from having it available for families at risk for poor parenting or experiencing child behavior problems. Rather than implementing as a universal program, within childcare or schools, Incredible Years may better serve as a targeted intervention with families at risk of child welfare

involvement or young children identified with disruptive behaviors.

8. The Parent Café intervention was well-liked by families and participants reported changes to their parenting practices. The intervention provides an opportunity for engaging families in community and discussing parenting practices in a non-judgmental manner. The evaluation did not allow for an assessment of the impact on family or child outcomes and further research is needed. However, the high acceptability of the model is promising for a universal approach that descreases stigma related to parenting programs. Texas should consider conduting a pilot study of Parent Cafes in one or more communities.

Mental Health Consultation

9. There was no universal agreement on the definition of mental health consultation in Texas, and this was evident in the different approaches taken by each community. Texas should continue to work to develop a greater consensus on the role of mental health consultants within different systems and raise awareness of this role within early childhood systems.
10. Additional research and evaluation is needed in Texas to document the impact of mental health consultation on teacher retention and stress, classroom climate, family stress, and child social, emotional, and behavioral health. Texas could continue to advance the model through a well-designed, cross-site pilot study inclusive of rural, urban, and suburban communities.

VI. APPENDIX 1

Disparities Impact Table

The direct services provided to children and families are presented in the table below. The disparities impact statement initially proposed a relatively even distribution of males and females. However, this was based on the assumption that service information would focus on the child. Since family strengthening is a significant proportion of the data presented, females (mothers) make up a disproportionate share of the sample.

	Screening	Incredible Years	Parent Cafes	Mental Health Consultation	Expected Texas Child Population
Direct Services: Number Served	3,661	331	2,099	142	
By Race/Ethnicity (List Sub-Populations individually)					
African American	949 (32.2%)	23 (21.3%)	367 (25.2%)	24 (35.8%)	12.6%
American Indian/ Alaskan Native	192 (6.5%)	12 (11.1%)	15 (1.0%)	9 (13.4%)	0.5%
Asian	98 (3.3%)	0 (0%)	86 (5.9%)	1 (1.5%)	5.4%
White (non-Hispanic)	1177 (40.0%)	12 (11.1%)	364 (25.0%)	13 (19.4%)	42.6%
Hispanic or Latino	787 (26.7%)	60 (55.6%)	511 (35.1%)	18 (26.9%)	37.1%
Native Hawaiian/Other Pacific Islander	0 (0%)	0 (0%)	0 (0%)	0 (0%)	<1%
Two or more Races	215 (7.3%)	1 (0.1%)	113 (7.8%)	2 (3.0%)	1.8%
Unknown	236	223	643	75	n/a
By Gender					
Female	1404 (38.4%)	110 (88.0%)	1,311 (88.8%)	17 (25.4%)	49%
Male	2255 (61.6%)	13 (10.4%)	165 (11.2%)	50 (74.6%)	51%
Transgender	0 (0%)	2 (1.6%)	UNK	0 (0%)	<1%
Unknown	2 (n/a)	206	623	75	n/a

VII. APPENDIX 2 SAMPLE MEASURES

WILDER COLLABORATION SCALE

Statements about the Texas LAUNCH Early Childhood Committee:
1=STRONGLY DISAGREE, 2=DISAGREE, 3=NEUTRAL / NO OPINION, 4=AGREE, 5=STRONGLY AGREE

1.	Agencies in our community have a history of working together.	1	2	3	4	5
2.	Trying to solve problems through collaboration has been common in this community. It's been done a lot before.	1	2	3	4	5
3.	Leaders in this community who are not part of our collaborative group seem hopeful about what we can accomplish.	1	2	3	4	5
4.	Others (in this community) who are not a part of this collaboration would generally agree that the organizations involved in this collaborative project are the "right" organizations to make this work.	1	2	3	4	5
5.	The political and social climate seems to be "right" for starting a collaborative project like this one.	1	2	3	4	5
6.	The time is right for this collaborative project.	1	2	3	4	5
7.	People involved in our collaboration always trust one another.	1	2	3	4	5
8.	I have a lot of respect for the other people involved in this collaboration.	1	2	3	4	5
9.	The people involved in our collaboration represent a cross section of those who have a stake in what we are trying to accomplish.	1	2	3	4	5
10.	All the organizations that we need to be members of this collaborative group have become members of the group.	1	2	3	4	5
11.	My organization will benefit from being involved in this collaboration.	1	2	3	4	5
12.	People involved in our collaboration are willing to compromise on important aspects of our project.	1	2	3	4	5
13.	The organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts.	1	2	3	4	5
14.	Everyone who is a member of our collaborative group wants this project to succeed.	1	2	3	4	5
15.	The level of commitment among the collaboration participants is high.	1	2	3	4	5
16.	When the collaborative group makes major decisions, there is always enough time for members to take information back to their organizations to confer with colleagues about what the decision should be.	1	2	3	4	5
17.	Each of the people who participate in decisions in this collaborative group can speak for the entire organization they represent, not just a part.	1	2	3	4	5
18.	There is a lot of flexibility when decisions are made; people are open to discussing different options.	1	2	3	4	5
19.	People in this collaborative group are open to different approaches to how we can do our work. They are willing to consider different ways of working.	1	2	3	4	5

20.	People in this collaborative group have a clear sense of their roles and responsibilities.	1	2	3	4	5
21.	There is a clear process for making decisions among the partners in this collaboration.	1	2	3	4	5
22.	This collaboration is able to adaptto changing conditions, such as fewer funds than expected, changing political climate, or change in leadership.	1	2	3	4	5
23.	This group has the ability to survive even if it had to make major changes in its plans or add some new members in order to reach its goals.	1	2	3	4	5
24.	This collaborative group has tried to take on the right amount of work at the right pace.	1	2	3	4	5
25.	We are currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	1	2	3	4	5
26.	People in this collaboration communicate openly with one another.	1	2	3	4	5
27.	I am informed as often as I should be about what goes on in the collaboration.	1	2	3	4	5
28.	The people who lead this collaborative group communicate well with the members.	1	2	3	4	5
29.	Communication among the people in this collaborative group happens both at formal meetings and in informal ways.	1	2	3	4	5
30.	I personally have informal conversations about the project with others who are involved in this collaborative group.	1	2	3	4	5
31.	I have a clear understanding of what our collaboration is trying to accomplish.	1	2	3	4	5
32.	People in our collaborative group know and understand our goals.	1	2	3	4	5
33.	People in our collaborative group have established reasonable goals.	1	2	3	4	5
34.	The people in this collaborative group are dedicated to the idea that we can make this project work.	1	2	3	4	5
35.	My ideas about what we want to accomplish with this collaboration seem to be the same as the ideas of others.	1	2	3	4	5
36.	What we are trying to accomplish with our collaborative project would be difficult for any single organization to accomplish by itself.	1	2	3	4	5
37.	No other organization in the community is trying to do exactly what we are trying to do.	1	2	3	4	5
38.	Our collaborative group had adequate funds to do what it wants to accomplish.	1	2	3	4	5
39.	Our collaborative group has adequate “people power” to do what it wants to accomplish.	1	2	3	4	5
40.	The people in leadership positions for this collaboration have good skills for working with other people and organizations.	1	2	3	4	5

To What Extent was the Committee Able to:

To What Extent was the Texas LAUNCH Committee Able to:					
Create a shared vision for early childhood mental health.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Increase collaboration among state partners involved in early childhood.	Disagree	Neutral	Agree	Strongly Agree	Strongly Agree
Foster a communication channel between LAUNCH local communities and state partners	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Provide opportunities for problem solving barriers at the state and local levels	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
To What Extent was the Texas LAUNCH Initiative Able to:					
Increase access to developmental and social-emotional screening	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Strengthen the ealy childhood workforce	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Provide additional opportunities for family strengthening	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Enhance opportunities for mental health consultation provided toearly childhood caregivers.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Please identify the biggest accomplishment for TLECC (or its workgroups) over the past year.

Please identify the biggest barrier to the TLECC reaching its goals over the past year.

Thank you for your participation!

TEXAS LAUNCH MHC Case Summary

Consultant: _____ Referral Date: _____

Community: _____ Center: _____

Number of Interactions with Child, Teacher, or Parent: _____
(count only once per day)

Parent Involved: YES NO Positive Resolution: YES NO

Referral Problem:

Case Summary (intervention and resolution):