Linking Actions for Unmet Needs in Children's Health (Project LAUNCH)

Wheeler Clinic Promising Starts
New Britain, Connecticut

Cumulative Evaluation Report
Years 1-6
May 30, 2016

October 1, 2010-April 30, 2016

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About the Child Health and Development Institute of Connecticut and Lorentson Consulting

The Child Health and Development Institute of Connecticut (CHDI), a subsidiary of the Children's Fund of Connecticut, is a not-for-profit organization established to promote and maximize the healthy physical, behavioral, emotional, cognitive and social development of children throughout Connecticut. CHDI works to ensure that children in Connecticut, particularly those who are disadvantaged, will have access to and make use of a comprehensive, effective, community-based health and mental health care system.

Lorentson Consulting is an evaluation firm specializing in the design and implementation of high quality rigorous mixed method evaluations framed by the theories and practices of organizational change and conducted collaboratively with clients to increase their capacity to conduct evaluations and use evaluation data in program improvement. Lorentson Consulting works with clients in education and health to support them to collect and use information to improve and expand their programs. Our areas of inquiry include early childhood, K-12 and health education, behavioral health, health care and nutrition, and infrastructure development in K-12 and early education organizations.

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Wheeler Clinic has partnered with CHDI to conduct the program evaluation for Promising Starts. The evaluation team at CHDI is comprised of three CHDI staff members: Jason Lang, Ph.D., Jeana Bracey, Ph.D. and Michelle Delaney. Dr. Lang served as lead evaluator from September 2010 through September 2011 and currently serves a supervisory role. Dr. Bracey joined the project in September 2011 as Lead Evaluator, and Ms. Delaney served as a research assistant through March 2014. During 2013, CHDI partnered with a research team at the Center for Program Research and Evaluation (CPRE) at *Education Connection* in Litchfield, Connecticut to strengthen the research dynamic. Mhora Lorentson, PhD (Lead Evaluator), Deserray James-Green, MPH (Sr. Research Associate), and Paget Haylon, MSW (Jr. Research Associate) composed the team of researchers, applying evaluation and assessment methods to the Project Launch initiative for year four. During year five, CHDI contracted directly with Lorentson Consulting to complete necessary evaluation activities through September 30, 2015. Activities completed subsequent to September 30, 2015 were completed by Dr. Lorentson under direct contract with Wheeler Clinic.

Table of Contents

Tables

Figures

Executive Summary

In September 2010, Wheeler Clinic was awarded a five-year Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) grant from SAMSHA to improve services and systems for children birth through age 8 in New Britain, Connecticut. Wheeler Clinic's initiative, Promising Starts, was designed to provide an array of systems improvements and services to improve the lives of young children in New Britain. Promising Starts includes implementation of the evidence-based Child First in-home parent-child intervention model, Circle of Security training for providers and parents to facilitate attachment and improved parenting skills, improvements in early childhood mental health screening and consultation, workforce development among providers of early childhood services, and substance abuse prevention efforts across the New Britain community.

Wheeler Clinic assembled the New Britain Health and Wellness Council (renamed the Blueprint Leadership Team in January 2014) to provide guidance on these and other activities to improve collaboration across systems that serve young children. The council assisted with the completion of an environmental scan of New Britain's services and systems for young children in April 2011. Using the results of the environmental scan, the Council assisted Wheeler Clinic staff with the development of a strategic plan for the Promising Starts initiative in June 2011. Also in June 2011, a detailed five year evaluation plan was completed, together with evaluators from the Child Health and Development Institute of Connecticut (CHDI). The evaluation plan was updated in November 2012, May 2013, and in the summer of 2014 with assistance from the project's evaluation and technical assistance team.

Wheeler Clinic partnered with CHDI, an independent non-profit organization for children's health and mental health, to conduct the program evaluation for Promising Starts for Years 1 through 3 of the funding period. During 2014, CHDI in turn partnered with EDUCATION CONNECTION to complete evaluation activities. During 2015, CHDI partnered directly with Lorentson Consulting. The evaluation report that follows is based upon the mission, vision, goals, and activities in the strategic plan developed by Wheeler Clinic and the Council, and the progress of the initiative during the five years of planning and implementation of this Cohort 3 grantee.

Project Goals and Objectives

The overarching goal of the Promising Starts Project LAUNCH initiative is to promote young child wellness through the integration and coordination of a system of care for children from birth to age 8 in New Britain, Connecticut. Specifically, the following seven target areas for intervention were identified:

- Creation and restructuring of the **New Britain Health and Wellness Council** as a collaborative stakeholder advisory group for Promising Starts activities. This Council was renamed the Coalition for New Britain's Children during Year 3 and the Coalition for New Britain Leadership during Year 5. A Blueprint Leadership Team and Health and Wellness Project Management Team was formed during Year 4. During Year 5, the Health and Wellness

Project Management Team merged with the Health and Wellness Committee of the New Britain Public School District to become the Health and Wellness Strategy Group. This group in turn separated into three working groups focusing on Mental Health, Teen Pregnancy and Obesity.

- Implementation of the **Child First** evidence-based home visiting model of infant-parent attachment
- Implementation of **Circle of Security Parenting (COS-P)** groups to promote parenting skills and family strengthening
- Promotion of the standardized use of **behavioral health and developmental screening and assessment** such as the Ages and Stages (ASQ) Child Development Screening Protocol among pediatric providers
- **Substance abuse prevention** and health promotion strategies for children aged 0-8 and their families, including implementation of the Healthy Alternatives for Little Ones (HALO) curriculum in preschool settings
- Integration of **mental health consultation** in home-based childcare settings using the Center for Social and Emotional Foundations for Early Learning (CSEFEL) model of behavioral health consultation and the Second Step violence prevention curriculum in education settings, and
- Facilitation of **workforce development** through trainings and support for the Connecticut Association of Infant Mental Health (CT-AIMH) endorsement.

Evaluation Questions

A comprehensive series of questions was developed by Promising Starts staff and CHDI evaluators to guide evaluation efforts over the course of this five-year initiative. Evaluation questions are designed to address the *implementation process; systems change* at the state and local levels; and *outcomes for children*, families, and their communities related to the long-term goals of improved access to validated screening and assessment, increased implementation of evidence-based services, development of a skilled workforce trained in child development, and improved coordination and cross-system collaboration. The following questions were addressed at each level of intervention:

<u>Implementation process</u>

- What barriers and facilitators to implementing Promising Starts activities were experienced?
- How many providers were trained in each component?
- Were providers satisfied with the training received through Promising Starts?

<u>Systems change</u>

- Were Promising Starts components implemented as planned?
- Were services implemented in a culturally competent and family-centered manner?
- Did Promising Starts Council influence systems integration and infrastructure improvement across child-serving systems in the community?
- Did Promising Starts Council activities increase awareness of evidence-based practices and available community-based services among providers and caregivers?

- Did the Promising Starts Council activities increase coordination and collaboration among community partners including the use of cross-disciplinary workforce development?

Outcomes for Families, Children, and Communities

- Did children who participated in Promising Starts services exhibit improved behavioral and developmental functioning?
- Did caregivers who participated in Promising Starts services exhibit improved parenting skills and reduced stress?
- Did caregivers report satisfaction with services received?

In addition to these general questions, more detailed probes were evaluated at each level of intervention for all components to gauge and guide progress over the course of the initiative.

Approach and Methods

A detailed evaluation plan was initially developed for Promising Starts activities in June 2011. The plan was designed to measure systems change activities, implementation of services, and outcomes for children and families using a combination of quantitative and qualitative approaches. This plan was updated in November 2012 and again in May 2013 to reflect modifications to the implementation in year 2 and to guide evaluation efforts over years 3-5. The plan is reviewed annually and monitored for necessary revisions throughout the implementation period.

Promising Starts supports to providers include training in evidence-based practices for direct service (e.g., Child First, Circle of Security, HALO, and Second Step), training and support in behavioral health screening and assessment, and workforce development activities. These services are evaluated with quantitative data about the amount of services provided, the number of staff trained, providers' use of new services and skills with families, fidelity of implementation, and changes in provider attitudes and knowledge. Qualitative data are gathered through focus groups and surveys with providers, including barriers and facilitators to use of new services, sustainability of services, satisfaction with training, and provision of culturally-competent, family-centered care. To assess implementation efforts for direct services to families, Promising Starts tracks the number and characteristics of children receiving these services, provider and family satisfaction, and child and family outcomes. Fidelity data on these interventions are assessed and used for continuous quality improvement purposes.

Findings

Results from this reporting period indicate that implementation has progressed across the major program target areas and Promising Starts is on track to meet or exceed 5-year benchmarks for six of seven program areas. Activities successfully completed in Year 1, including the environmental scan, completion of the strategic plan and evaluation plan, and development of the New Britain Health and Wellness Council (renamed Coalition for New Britain's Children and referred to as such within this report), laid a solid foundation for implementation of program activities in Year 2 and ongoing direct service activities and provider supports in Years 3 through 5. A no-cost

extension was received which allowed the project to continue to provide Child First Services and to complete final evaluation of Systems Change Activities through April 31, 2016.
At the systems level of intervention, Promising Starts has maintained engagement of 39 individuals representing 28 different child-serving agencies and caregivers in the New Britain community as members of the Coalition for New Britain's Children. Although specific individuals have changed over time, the overall membership and organizational membership has remained the same. Unfortunately, parent representation has typically been minimal and was generally maintained at 1 to 3 parents per year.

Results indicate that the Coalition is maintaining moderate levels of collaboration among specific activities and is advancing towards higher-level coordination, through trusting relationships and frequent interactions. The Coalition developed a comprehensive plan for improvement of early childhood health, wellness and success and developed a leadership team, named the Blueprint Leadership Team in 2014, to guide and direct plan activities. During the first three project years, these activities laid a foundation for expanding and sustaining Promising Starts' goals and activities at the community level beyond the Project LAUNCH grant period. Similarly, during 2014-2015, the system continued to evolve and the Blueprint Leadership team created three subcommittees including the Health and Wellness Project Management Team (PMT), the Earl Learning PMT and the Family Literacy PMT to further guide program expansion. The Health and Wellness Project Management Team (PMT) was formed as a subcommittee to the Blueprint Leadership Team and focuses solely on community activities related to Health and Wellness. During Year 4 of grant activities, the Health and Wellness PMT served as the coordinating body for Promising Starts activities. During Year 5, the Health and Wellness PMT merged with the school district's Health and Wellness Committee to form the Health and Wellness Strategy Group. A number of individuals on the Health and Wellness Team and the Strategy Group also sit on the Coalition for New Britain's Children and assure ongoing integration of health and wellness into community activities.

During Year 4, a total of 340 children/families received direct services through Wheeler Clinic's *Promising Starts* initiative: *54* families received home-visiting-intervention services from Child First, *108* parents/caregivers were trained through Circle of Security's early intervention program for parents and children (COS-P), *110* children participated in the Healthy Alternatives for Little Ones (HALO) curriculum, and *68* children were screened for developmental delays using the Ages & Stages Questionnaires® (ASQ). In addition to the direct services that were provided to children/families, training services were rendered to a total of 223 early childhood providers: Specifically, providers were trained to implement evidenced-based models associated with Child First (1), HALO (53), Sensory Processing and Early Childhood and Strategies for Effective Interventions (37), and Feelings-Limits-Inquiries-Prompts (FLIP IT) (131).

During Year 5, the Blueprint Leadership Team and the Health and Wellness PMT both restructured. The Blueprint Leadership Team maintained overall leadership but were renamed again to become the Coalition Leadership Group. For the purposes of this report, the term Coalition will be used throughout. The Coalition created replaced the three PMTs with four strategy groups including Connecting Families, Health and Wellness, Early Learning/School Readiness and Youth and Workforce Development. The Health and Wellness Strategy Group

simultaneously merged with the Health and Wellness Committee from New Britain Public School District to become a larger and more diverse group. Additionally, three subcommittees were formed to focus on Advocacy and Marketing, Professional Development and Networking and Data and Evaluation.

During Year 5, a total of 285 children/families received direct services through Wheeler Clinic's *Promising Starts* initiative: *43* families received home-visiting-intervention services from Child First, *69* parents/caregivers were trained through Circle of Security's early intervention program for parents and children (COS-P), *54* children participated in the Healthy Alternatives for Little Ones (HALO) curriculum, and *119* children were screened for developmental delays using the Ages & Stages Questionnaires® (ASQ). In addition to the direct services that were provided to children/families, training services were rendered to 3 early childhood providers associated with Child First (3) and to 116 community providers on Risk and Trauma Prevention.

During the no-cost extension period continuing from October 1, 2015 through April 31, 2016, 34 children and 33 families received services from Child First. Therefore, as of the end of Year 5 of LAUNCH funding, a cumulative total of 38 New Britain providers associated with Wheeler Clinic or partner organizations have received training in evidence-based practices for infants/young children through Child First (7), Circle of Security Parenting (COS-P) (26), and HALO (5). Also, a cumulative total of 1082 children/families have received direct services through Wheeler Clinic's *Promising Starts* initiative: *181* families received home-visiting-intervention services from Child First, *287* parents/caregivers were trained through Circle of Security's early intervention program for parents and children (COS-P), *395* children participated in the Healthy Alternatives for Little Ones (HALO) curriculum, and *341* children were screened for developmental delays using the Ages & Stages Questionnaires® (ASQ).

In addition, during the no-cost extension period Systems Change activities were evaluated through the completion of a focus group with individuals who had been involved with the project for the entire five years of implementation. Results identified a high level of participant satisfaction with project activities.

Summary and Recommendations

Wheeler Clinic's Promising Starts initiative continued to make significant progress in implementation across major program targets in Year 5. Systems change and on-going integration of service provision across systems continued in an ongoing and sustainable manner. The three primary direct services to children and families (i.e., Child First, COS-P, and HALO) continued throughout the final program year. During Year 2 implementation of Second Step began although initial measures of implementation fidelity were not obtained until Year 4 as a result of data collection challenges within the school district. Training in developmental screening and utilization of the ASQ-3 continue in an ongoing fashion in progress, and the New Britain Health and Wellness Project Management Team, renamed the New Britain Health and Wellness Strategy Group is continuing to provide oversight and foster enhanced collaboration among community partners—all of which serve to promote workforce development of early childhood providers in New Britain. Evaluation procedures and timelines capture successes with direct services and are

modified to accommodate implementation delays and challenges in other areas. Efforts are underway to sustain and improve project successes after the end of the grant period. Based upon this evaluation of Year 5 activities and of Child First activities and systems change activities through the no-cost extension year, general recommendations include:

- Continued implementation of activities as resources allow;
- Ongoing efforts to promote buy-in and participation in evaluation activities among community stakeholders;
- Ongoing monitoring of barriers and facilitators to implementation along with outcome data to inform implementation and evaluation procedures;
- Continued flexibility in data collection related to collaboration to support the community's ongoing efforts to increase collaboration through merging of related groups to enhance efficiency of collaboration and networking;
- Maintenance of the current Health and Wellness Strategy Group to provide consistency and minimize continuous disruption in systems integration and coalition-building; and
- Continued expansion of supports and the separation of coordination and clinical roles to sustain evaluation efforts that capture long-term program successes.

Overall, five years of data indicate a high level of program success as well as suggest a number of specific recommendations for policy and program management. Strategies and policies are needed to support family engagement, increased attendance at Coalition/Council and Strategy Group meetings, engagement of primary care providers, and use of COS, HALO and Child First at a statewide level. These strategies and policies are also needed by the state of Connecticut with a variety of activities currently underway to achieve these goals including the Early Childhood Comprehensive Systems Development strategic plan, the Office of Early Childhood's Strategic Plan, the new state level LAUNCH grant, and grant activities underway through the Office of Early Childhood's recently received Preschool Expansion Grant.

The Promising Starts Coordinator is already working very closely with the Connecticut Office of Early Childhood and the ECCS Advisory Committee to develop and implementation recommendations and associated policies at a statewide level. As these recommendations and policies are developed, it is highly recommended that Wheeler Clinic continue to incorporate these recommendations and policies in local activities.

Logic Model

A logic model for the Promising Starts initiative is shown in Figure 1 (on the following page). The logic model summarizes and links the grant resources and activities with anticipated outputs, short-term outcomes and long-term outcomes.

Figure 1. Promising Starts Evaluation Logic Model

New Britain Challenges/ Areas of Need

Children & Caregivers:
- x Poverty/unemployment
- x High rates of child abuse & neglect
- x DCF involvement or risk of involvement
- x Family mental health problems
- x High rates of substance abuse
- x Social-emotional or behavioral concerns

Providers (pediatric, mental health, child care, education, etc.)
- x Shortage of in-home services for infants and young children
- x Limited use of EBPs with young children
- x Inconsistent use of validated developmental screenings by pediatric providers
- x Little training in early childhood development and interventions
- x Limited awareness of available programs for young children (Help Me Grow)
- x Limited awareness about substance abuse among caregivers
- x Lack of training/support for existing programs (Second Step)

Service System:
- x Limited capacity for early childhood mental health consultation
- x Fragmentation in service systems
- x Lack of a systems approach to screening and early identification
- x Limited quality infant/toddler care

Inputs

Promising Starts resources:
- x 1 Program Coordinator
- x 2 Early Childhood Specialists
- x 2 Early Childhood Care Coordinators
- x 1 Administrative Support Specialist (0.8 FTE)
- x 1 Postdoctoral trainee, Early Childhood Specialist (0.5FTE)

Funding:
- x SAMHSA

State/local partners:
- x ECCS (CT Early Childhood Partners)
- x DMHAS Substance Abuse Action Council
- x DCF
- x CT Early Childhood Education Cabinet
- x CHDI, Inc.
- x Child First
- x CT Association for Infant Mental Health
- x New Britain Early Childhood Collaborative
- x HRA Head Start
- x New Britain Public Schools

Existing Wheeler Clinic resources:
- x Early Childhood Services: ECCP® and Birth to Three
- x Congregate and Foster Care
- x Intensive home-based services
- x Behavioral health integration in primary care
- x Partnerships with higher education community

Evaluation/Technical Support:
- x CHDI, Inc.
- x Project LAUNCH TA

Activities and Services (10/1/2010 – 9/30/2015)

Training/Systems Activities

Child First Training
- x Intensive two-year training
- x 15 full days of training
- x Weekly meetings/supervision

Circle of Security Training:
- x Providers (Wheeler & community) trained as COS group facilitators
- x Community providers participate in COS groups (2 groups per year)

Behavioral Health and Developmental Assessment
- x Train child care providers in ASQ
- x Support ASQ use in pediatric settings
- x Developmental screening and consultation for families at NB Family Wellness Center

Child Care Consultation:
- x Consultation (CSEFEL model) to Family Day Care Homes/Kith & Kin providers
- x Integrate Second Step pre-K-3rd classroom curriculum; provide support to center-based providers in monthly ECCP consultation

Child Wellness Council
- x Create & convene advisory group to guide Promising Starts
- x Align strategic plan with local & state EC planning efforts
- x Improve collaboration & coordination across systems

Workforce Development:
- x Support CT-AIMH endorsement for providers, higher education faculty, and family members

Substance Abuse Prevention:
- x Educate providers about parental substance abuse
- x Substance abuse prevention updates/support for the early childhood collaborative website
- x Train providers in HALO

Service Delivery

Child First Services:
- x In-home EBP for high-risk children birth to 6
- x Attachment-based
- x Parenting & psychotherapy
- x Care coordination

Circle of Security
- x Group for parents
- x Attachment-focused
- x Parenting skills

HALO
- x Preschool classrooms
- x 3-5 year olds
- x Substance abuse prevention
- x Health education

Outputs

Children & Caregivers:
- x 240 children screened for developmental concerns (120 Child First, 120 community screenings)
- x 120 families receive Child First intervention
- x 144 parents participate in Circle of Security groups
- x 200 children participate in Second Step curriculum
- x Caregivers comprise at least 15% of attendance at Council for Young Child Wellness
- x 320 children participate in HALO

Providers:
- x 5 Wheeler staff trained in Child First model
- x 5 Wheeler staff trained as COS-P facilitators
- x 5 Wheeler staff trained in HALO curriculum
- x Increased awareness of EBPs for young children

Service System:
- x 15 providers trained as COS-P facilitators
- x 90 providers participate in COS-P overview training
- x 25 family day care/kith & kin providers trained in CSEFEL
- x 80 providers at center-based EC programs receive consultation in Second Step
- x 25 community providers participate in Council for Young Child Wellness
- x 100 providers trained in substance abuse awareness
- x 60 early childhood teachers trained in HALO health education model
- x Enhanced higher learning early childhood curriculum
- x Enhanced network of providers trained in early childhood best practices
- x Improved system-wide collaboration

SAMHSA:
- x Cross-site LAUNCH collaboration

Outcomes

Children & Caregivers:
- x Improved caregiver/child relationships (OCCR)
- x Decreased developmental & behavior problems (BITSEA)
- x Improved child language (IDA/ASQ)
- x Improved parenting skills (COS-P parenting questionnaire)
- x Decreased parent stress and mental illness (PSI; BSI)
- x Increased number of families who use Help Me Grow ASQ program
- x Increased understanding of healthy and harmful behaviors among children
- x Satisfaction with services

Providers:
- x Improved knowledge about early childhood development and services
- x Improved provider awareness and use of EBPs with young children
- x Increased use of validated developmental screenings
- x Increased knowledge about caregiver substance abuse
- x Increased use of Second Step and CSEFEL

Service System:
- x Increase in workforce trained in EC competencies
- x Increased collaboration across providers
- x Integrated approach to screening and early identification
- x Culturally competent, family-centered care

SAMHSA:
- x Knowledge about enhancing a community's EC services
- x Knowledge about Child First in-home EBP

Approach and Methods

Evaluation Questions

The mission of the Promising Starts initiative is "to support young child wellness with a skilled, responsive, integrated system of care for children from birth to age 8 in New Britain, Connecticut that focuses on promoting child physical and mental health, preventing and reducing risk factors, and providing early intervention for vulnerable children and families. The long-term outcomes are to improve access to validated screening and assessment protocols and evidence- based services for young children and their families; to develop a skilled workforce trained in child development; and to improve coordination and collaboration across systems in order to enhance behavioral, emotional, and cognitive functioning for young children and their families.

The specific evaluation questions developed to evaluate the mission and goals of Promising Starts include implementation and outcome evaluation components for both systems enhancement activities with providers and direct services for families. Evaluation Questions include:

- Were Promising Starts components implemented as planned?
- Were services implemented in a culturally competent and family-centered manner?
- Did Promising Starts Council influence systems integration and infrastructure improvement across child-serving systems in the community?
- Did Promising Starts Council activities increase awareness of evidence-based practices and available community-based services among providers and caregivers?
- Did the Promising Starts Council activities increase coordination and collaboration among community partners including the use of cross-disciplinary workforce development?

The methods, measures, and additional details about how each of the evaluation questions is addressed are summarized in Appendix A-1. A detailed outcome evaluation plan was developed with assistance from the project evaluation TA in November 2012 and updated in May 2013 to guide evaluation in year 3 of the grant. The evaluation was again updated in summer, 2014 to guide evaluation in Years 4 and in summer, 2015 to guide evaluation in Year 5. The Year 5 evaluation plan is provided in Appendix A-2. Additional details regarding the psychometric properties of each measure used are provided in Appendix B.

Evaluation Design

The evaluation plan is designed to assess systems change activities, implementation of services, and outcomes for children and families. Both implementation (process) and outcome evaluation are addressed using a combination of quantitative and qualitative approaches. A summary of the methods used to address evaluation questions are provided below. Details regarding each evaluation question and associated outcomes are provided in Appendix A1-2.

The primary systems change activities in Promising Starts are improved collaboration and coordination, workforce development, improved and more consistent developmental screening methods for young children, and increased awareness and availability of evidence-based practices for young children across systems. Promising Starts provides specific services and supports to

providers and families. Services to providers include training in evidence-based practices (e.g., Child First, Circle of Security, HALO, and Second Step), training and support in behavioral health and developmental assessment, and consultation to child care providers. These services are evaluated with quantitative data about the amount of services provided, the number of staff trained, providers' use of new services and skills with families, fidelity of implementation and changes in provider attitudes and knowledge. Qualitative data are gathered through focus groups and surveys with providers, including barriers and facilitators to use of new services, sustainability of services, satisfaction with training, and culturally-competent, family-centered care. Efforts are consistently underway to coordinate activities with Connecticut Association with Infant Mental Health in tracking professionals who have achieved IMH-Endorsement.

Promising Starts also provides four direct services to children and families: the Child First in- home intervention, Circle of Security Parenting groups for caregivers, the Healthy Alternatives for Little Ones (HALO) health education and substance abuse prevention curriculum for preschoolers, and the Second Step social-emotional skills development program for children through grade three. Evaluation data for direct services is collected using both quantitative and qualitative methods including surveys, focus group and collection of outcome data when available. Implementation efforts are assessed by tracking the number and characteristics of children and families receiving these services; community awareness about the availability of services; provider and family satisfaction; and child and family outcomes. Feedback regarding results of fidelity and other implementation data on these interventions is discussed with providers and Wheeler Clinic for continuous quality improvement purposes. Further details are presented in the following sections.

New Britain Health and Wellness Strategy Group

The *Coalition for New Britain's Children* was formed in November 2010 as a collaborative organization of community stakeholders in the early childhood community. During Years 1-3, all systems-level data collection occurred through the Coalition led by the Blueprint Leadership Team. During Year 5, this group was renamed to become the Coalition for New Britain Leadership.

During February, 2014, the New Britain Health and Wellness Project Management Team was formed to serve as a subcommittee to the Blueprint Leadership Team. The Health and Wellness PMT focuses on health and wellness activities within New Britain and operates as an advisory group to provide oversight and support to implementation of the Promising Starts' Project LAUNCH initiative. During 2014, systems-level data collection was directed at PMT activities. During Year 5, the Health and Wellness Project Management Team merged with the Health and Wellness Committee of the New Britain Public School District to become the Health and Wellness Strategy Group which became the focus of systems-level data collection. This group in turn separated into three working groups focusing on Mental Health, Teen Pregnancy and Obesity.

Process evaluation activities. Team activities, representation by community stakeholders, and collaboration among participating providers are tracked through PMT attendance records, meeting minutes, annual focus groups with PMT representatives and attendance of the project evaluator at PMT meetings. Focus group questions address implementation of planned services, barriers to implementation, methods to address these barriers, and barriers and facilitators of interagency

collaboration. Process data was collected at monthly meetings during the current reporting period through June, 2015. At this point, program staff transitioned LAUNCH activities into the control of the Health and Wellness Strategy group as part of the transition out of LAUNCH funding. Data is available for a total of nine of nine scheduled meetings. In addition, an end of project focus group was completed during March, 2016. Approximately twenty individuals who had been involved with the project since project inception attended. Questions were geared to identify participant perceptions of how the project had worked for the community during the five and a half years of implementation.

Outcomes evaluation activities. A survey tool (i.e., New Britain Health and Wellness Collaboration Survey, see Appendix C) was developed by CHDI/Promising Starts evaluators to collect data about the level of coordination and collaboration among New Britain child-serving agencies and providers on a semiannual basis. Surveys include the Levels of Collaboration Survey (Lohmeier, Lee, & Tollefson, 2006) and the Interagency Collaboration Activities Scale v6.1 (Greenbaum & Dedrick) to address the extent to which agencies collaborate with each other based on self-report ratings and aggregate ratings of each agency by the other Council participants. The survey was administered as a hard copy twice in Year 2, once in Year 3, twice in Year 4 and once in Year 5.

In March 2013, the PARTNER Tool (Program to Analyze, Record, and Track Networks to Enhance Relationships, see Appendix D) was introduced as an additional survey tool for tracking of relationships between members of leadership networks through social network analysis, including the direction, strength and focus of those relationships (University of Colorado 2012). The PARTNER tool and the Levels of Collaboration survey were expected to be administered twice electronically during 2014-2015, once during fall 2014 and once during spring 2015 to serve as an assessment of progress made by the Health and Wellness PMT and to augment data collection collected through the hard copy surveys. The PARTNER Tool was successfully administered during 2013 indicating initial coalition-development in line with the results of the hard copy surveys. However, upon the first administration of the PARTNER tool during 2014, a number of data collection challenges inherent to the PARTNER tool itself were experienced resulting in the loss of all data collected. As a result, administration of the PARTNER tool ceased.

Child First Home Visiting

Child First is a locally developed evidence-based model of in-home intervention for children age birth to six and their caregivers. The model is designed to reduce the incidence of serious emotional disturbance, developmental and educational challenges, and abuse and neglect among high-risk families. Interventions include comprehensive developmental/behavioral health screening and assessment, intensive team-based in-home intervention, care coordination, and case management for families, in addition to training and consultation for providers. Evaluation of the Child First component is conducted collaboratively between the Child First and Promising Starts evaluation teams and includes pre-post assessments for providers trained in the Child First model, monthly fidelity and metric data to track implementation and quality improvement, and outcome data for children and families receiving Child First services. Implementation of the model in Promising Starts began with initial staff training in July 2011, with services to families beginning in September 2011 (Year 1) and expansion of the service in New Britain in Years 2-5. A no-cost

extension was received allowing for the provision of services through April 31, 2016.

Process evaluation activities. Implementation data, including barriers to and facilitators of progress, modifications made to the strategic plan with respect to Child First, and collaboration across systems are primarily measured through focus groups and surveys. Appendix A-2 summarizes the schedule of assessments, including provider focus groups and surveys. Focus groups include questions about implementation of planned services, barriers to implementation, methods to address these barriers, and issues related to culturally competent and family-centered practice (see Appendix E for focus group protocol). Focus groups are conducted by a member of the evaluation team, recorded via digital recorder, and transcribed and coded by theme using de-identified data. To assess fidelity to the Child First model as a program-level outcome, a self-report rating tool is administered and analyzed by model developers with results reported to the Promising Starts Coordinator in monthly metric reports.

Outcome evaluation activities.

- Program Outcomes: Child First staff completes monthly implementation metric data as part of their training through the statewide Child First system. Metric data includes basic data about the number and characteristics of families seen, supervision received, and the family engagement process. The Promising Starts evaluation team has a data-sharing agreement with the Child First developers for sharing New Britain's metric data for inclusion in the local and Multi-site evaluations required in LAUNCH. The Promising Starts evaluation team obtains this data monthly and provides summary reports to the evaluation team semiannually.

- Provider Outcomes: A brief survey (i.e., Promising Starts Child First Staff Experience Survey, see Appendix F) was developed by the Promising Starts evaluation team to assess implementation and systems change activities and to track Child First provider knowledge and skill development through Promising Starts. Surveys are administered to providers before and after participation in a Child First training (pre-post design), and with focus groups semiannually to assess sustainability. These surveys include questions about implementation of the Child First model, knowledge and skills related to early childhood mental health, cultural competency and family-centered practice, and the 15-item Evidence-Based Practice Attitude Scale (Aarons, 2004) designed to capture general knowledge about and use of evidence-based practices. Provider training surveys are completed via pencil and paper survey in person before or after their trainings. Semi- annual follow-up surveys to assess maintenance of skills and sustainability are administered in person.

- Parent and Child Outcomes: Outcomes for families that receive the Child First intervention are evaluated using pre-post assessments of the child's developmental functioning and language, child-caregiver attachment, caregiver stress, and caregiver symptoms of mental illness (see Appendix A-2 for specific measures). The Wheeler Clinic Child First staff administers a standard battery of Child First assessments during their in-home visits with families at intake and discharge. Child First staff complete the required baseline assessments within the first three home visits to allow for time to engage the high-risk families seen through Child First and to be consistent with the Child First model guidelines. Child First staff complete the post-treatment assessments in the home with the family prior to the family's discharge from

services. These assessments include direct services data for the Project LAUNCH Multi-Site Evaluation and GPRA/TRAC reporting. Child First staff receives extensive training in the use of assessments during Child First clinical training, including administration, scoring, interpretation, and providing feedback to families about their assessment results.

Data on children and families in New Britain participating in Child First are collected by Wheeler Clinic through their electronic health records system. The Promising Starts evaluation team at receive de-identified child and family data from Wheeler Clinic. The Clinic maintains the key identifying families with ID numbers. This system provides additional protections to child and family data and avoids release of protected health information (PHI). The evaluation team cleans, analyzes, and reports Child First data in the local evaluation, Multi-Site Evaluation, and GPRA/TRAC. Any Child First data required by SAMSHA not entered into the statewide Child First web portal is collected by Promising Starts evaluators from Wheeler Clinic staff through an electronic or web- based form.

Circle of Security Parenting (COS-P) Family Strengthening

Circle of Security Parenting (Cooper, Hoffman, Powell, & Marvin, 2005; COS-P) is an evidence-based program which uses video technology with groups of caregivers to improve parenting skills and promote infant-parent attachment. Interventions include facilitated video- based skills-training for parents of children age birth to 8, which may occur in community-based groups or with individual families in the context of home visiting services over the course of 6-8 sessions. Evaluation of the Circle of Security component includes pre-post assessments for providers trained in the COS-P model, implementation and fidelity reporting, and outcome data for children and families receiving COS-P services. Implementation of the COS-P model in Promising Starts began in September 2011 with the initial provider training. COS-P groups with families began in January 2012 and continued throughout Year 5.

Process evaluation activities. Circle of Security implementation data, including barriers to and facilitators of progress, modifications made to the strategic plan, and collaboration across systems are measured through focus groups and surveys (see schedule in Appendix A-2). Focus groups include questions about implementation of planned services, barriers to implementation, methods to address these barriers, and items related to culturally competent and family-centered practice. Focus groups are conducted by the evaluation team, recorded digitally, and transcribed using de-identified data. A Facilitator Feedback Form (see Appendix S) is used to track and report program data such as number of parents trained, number of sessions attended, and services offered for each group (e.g., transportation, child activities, etc.). A COS Fidelity Measure developed by New York City Project LAUNCH evaluators was implemented in Years 3-5 to track fidelity to the model among providers. The measure has 11 self-report items rated on a 5-point scale (see Appendix T).

Outcome evaluation activities:

- Provider Outcomes: Brief surveys (i.e., Promising Starts Circle of Security Semi-Annual Provider Survey, see Appendix G) were developed by the evaluation team at CHDI to assess implementation and systems change activities and track COS-P provider knowledge and skill

development as a result of Promising Starts. These surveys are administered to participating providers before and after their participation in a COS-P training through Promising Starts (pre-post design), and with focus groups semiannually to assess sustainability. Surveys include questions about implementation of the model, knowledge and skills related to early childhood mental health, cultural competency and family-centered practice, and the 15-item Evidence-Based Practice Attitude Scale (Aarons, 2004) designed to capture general knowledge about and use of evidence-based practices. Provider training surveys are completed via written survey in person before or after their trainings. Follow-up surveys to assess maintenance of skills and sustainability among facilitators are administered semi-annually in person.

- Parent and Child Outcomes: Families that participate in Circle of Security parenting groups are evaluated using multiple standardized assessments, with modifications made in Year 3. The Circle of Security Parent Questionnaire created by COS developers has been consistently utilized to assess parenting skills and attitudes. The Parenting Stress Index (PSI) was used until April 2013 to measure parenting stress at baseline and at the end of the parenting curriculum. At that time, the PSI was discontinued and replaced with two subscales of the Protective Factors Survey (PFS, see Appendix H) as a more appropriate measure of parenting skills, knowledge and parent-child attachment. The PFS was developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention and the University of Kansas Institute for Educational Research and Public Service as a pre-post assessment tool for caregivers receiving child maltreatment prevention services (Counts, Buffington, Chang-Rios, Rasmussen, & Preacher, 2010). Promising Starts uses only the subscales specifically designed to measure nurturing/ attachment behaviors and parenting knowledge and skills. While children are not assessed directly, child-level outcomes included on the parent measures are used to assess improvements in attachment and child behavior. Circle of Security facilitators administer the assessments to caregivers who participate in Circle of Security groups and caregiver satisfaction questionnaires are also administered at the end of the family's participation in services (Appendix I). Circle of Security providers are trained in the administration and use of the required assessments prior to leading their first groups. These assessments include direct service data required for the Multi-Site Evaluation and GPRA/TRAC systems. Demographic and outcome data on families participating in Circle of Security groups are collected by the Promising Starts Project Coordinator, de-identified by Wheeler Clinic, and submitted to the evaluation team on the paper forms completed by caregivers. The Promising Starts evaluation team enters, cleans, and analyzes this data for evaluation reports.

Mental Health in Primary Care (Behavioral Health and Developmental Assessment)

Promising Starts is interested in increasing the use of standardized developmental screenings and assessments across provider agencies in New Britain. Specifically, training of pediatric and child service providers began in June 2011 (Year 1) to prepare these individuals to administer the Ages and Stages Child Development Screening Protocol (Squires, Bricker, & Twombley, 2002; ASQ-3). Trained Promising Starts staff began providing screenings to children and families in other community- based settings including the New Britain Family Wellness Center in September 2011.

During Year 2, training expanded to child care staff from the Hospital for Special Care, child

welfare staff from the Department of Children and Families, providers from the Women, Infants, and Children (WIC) office, and early care and education providers in the community. Training on the ASQ-3 and ASQ:SE child development screening protocols was provided to an additional 38 early care and education providers in Year 3 and another 36 early care and education providers in Year 4. During Years for and 5, no additional ASQ training for providers occurred as all providers have been trained. Screenings are being conducted in an ongoing fashion by trained providers as needed.

During Years 4 and 5, Project LAUNCH activities were coordinated with statewide activities funded by the Early Childhood Collaboration Systems Planning (ECCS) grant being implemented statewide and will be augmented by the state level LAUNCH grant recently received. Statewide data related to the use of the ASQ in early care and education is being collected through ECCS activities and will enhance data collection during upcoming years. There is currently no ability to identify the specific impact of LAUNCH activities in increasing the use of the ASQ. However, the Promising Starts Director sits on the ECCS statewide advisory committee and has been instrumental in statewide efforts to improve screening. It is notable that one of the goals of the statewide ECCS Advisory Committee is to link all project activities and learning for ECCS to activities and learning from the New Britain LAUNCH grant. Additionally, the LAUNCH evaluator is responsible to evaluate the ECCS activities and to incorporate learnings from LAUNCH data collection into ECCS evaluation activities.

Process evaluation activities. Implementation data, including barriers to and facilitators of progress, modifications made to the Promising Starts strategic plan, and collaboration across systems are primarily measured through semi-annual focus groups and a quarterly report form (see Appendix A-2 for specific measures). A Memorandum of Agreement (MOA) is completed for each agency provided with screening materials and training (see Appendix J). A quarterly report form (i.e., Ages and Stages Developmental Screening Agency Implementation Report, see Appendix K) was developed by Promising Starts staff to track the number of children screened and/or referred for additional services, in addition to qualitative data regarding implementation barriers and facilitators. Reports may be submitted by providers electronically or through a web-based survey. To track numbers of children referred to the Help Me Grow screening and monitoring program as a result of early developmental screenings, data from the Help Me Grow coordinating center are obtained on an annual basis for analysis. Coordination with Help Me Grow has been used consistently to support the development of a more effective, streamlined process of screening and appropriate referral in Promising Starts through joint attendance of the HMG representatives and the Promising Starts Director on the ECCS Advisory Committee. Additionally, the founder of HMG, Dr. Dworkin, serves as the Co-Chair of the ECCS Advisory Committee and is responsible to guide all members to implement learnings related to screening and referral supported by HMG in their own communities. Meeting minutes from the New Britain Health and Wellness PMT, the Health and Wellness Strategy Group and the Blueprint Leadership Team are reviewed for information related to relevant policy changes regarding developmental screening and assessment.

Outcome evaluation activities:

- Provider Outcomes: Brief surveys (i.e., ASQ-3 Training Provider Survey, see Appendix F for similar survey) have been developed by the Promising Starts evaluation team to assess implementation and systems change activities and track provider knowledge and skill development as a result of Promising Starts training on the ASQ-3. Surveys are administered to providers before and after their participation in an ASQ-3 training through Promising Starts (pre-post design), and again semiannually to assess sustainability. Surveys include questions about implementation of the ASQ-3 Child Development Screening Protocol, knowledge and skills related to early childhood mental health, cultural competency and family-centered practice, and the 15-item Evidence-Based Practice Attitude Scale (Aarons, 2004) designed to capture general knowledge about and use of evidence-based practices. Provider training surveys are completed via written survey in person before or after their trainings. Semi-annual follow-up surveys to assess maintenance of skills and sustainability are administered via online survey software (e.g. Survey Gizmo). A summary of the survey schedule is included in Appendix A-2.
- Child Outcomes: Help Me Grow enrollment data and counts of children screened and/or referred as collected on the quarterly ASQ Provider Report Form are used to track numbers of children screened with the ASQ-3 in the community. Medicaid claims data are obtained at the community level, including the number of children receiving developmental screenings. This repeated measures assessment will examine annual data, from 2010 (before Project LAUNCH services began) to 2015 to assess whether the Promising Starts activities increase developmental screening of children in New Britain over time for community-wide impact.

HALO Health Promotion and Substance Abuse Prevention

The Year 1 addition of the Healthy Alternatives for Little Ones (HALO) curriculum was an enhancement to the implementation plan. HALO is a 12-session evidence-based substance abuse prevention and health education curriculum for groups of children age 3-6 in educational settings.

Process evaluation activities: Implementation data regarding HALO, including barriers to and facilitators of progress, modifications made to the strategic plan, and collaboration across systems are primarily measured through focus groups and surveys. Qualitative data collected in focus groups/small group discussions and on surveys include questions about implementation of planned services, barriers to implementation, methods to address these barriers, and issues related to culturally competent and family-centered practice. In Years 1 and 2, implementation of the HALO curriculum direct services was provided only by Wheeler Clinic staff with too few facilitators to conduct formal focus groups, therefore individual interviews and small group discussions were conducted. As implementation expanded to additional providers beyond Year 3 (i.e., classroom teachers), focus groups were conducted and fidelity to the HALO model was measured using the self-report HALO Integrity tool provided by model developers. Survey data collection with providers began with the first training of new Wheeler staff in October 2011 and was collected for four HALO cohorts during Years 1 and 2 and 4 as facilitated by trained Wheeler staff. Results are reported in the Promising Starts local evaluation, Project LAUNCH Multi-Site Evaluation, GPRA/TRAC reporting system, and are shared with the National HALO office.

Outcomes evaluation activities:

- Provider Outcomes: Brief surveys (i.e., Promising Starts HALO Provider Survey, see Appendix L) have been developed by the Promising Starts evaluation team to assess implementation and systems change activities and to track knowledge and skill development of providers training in HALO as a result of Promising Starts. These surveys are administered to participating providers before and after their participation in a HALO training through Promising Starts (pre-post design), and again semiannually after training ends to assess sustainability. These provider surveys include questions about implementation of the HALO curriculum, knowledge and skills related to early childhood mental health, cultural competency and family-centered practice, and the 15-item Evidence-Based Practice Attitude Scale (Aarons, 2004) designed to capture general knowledge about and use of evidence-based practices for young children. Provider training surveys are completed via pencil and paper survey in person before or after their trainings.
- Child Outcomes: Child outcome data are collected for HALO using measures provided by model developers. A sample of at least 25% of each cohort of children participating in the HALO curriculum in their preschool classrooms are assessed using the pre- and post-test "Bonita Bunny's Guide to HALO" assessment protocol to determine whether outcomes were met. This percentage was selected a priori based on developer recommendations as required for valid data. The assessment involves a member of the Promising Starts evaluation team reading a story about Bonita Bunny and her friends to a sample of participating children individually, while asking embedded questions about healthy behaviors and substance abuse prevention. Unfortunately, no data was collected during Year 3. During that year, HALO was implemented by classroom teachers, not a Wheeler Clinic intern, and no data collection was possible.

Child Care Consultation

Promising Starts aims to provide mental health consultation for children receiving Promising Starts services or for any adult concerned about the developmental progress of a child while attending an early care or educational setting. Specifically, home-based family day care center staff and kith/kin child care providers are targeted for training in the evidence-based Center for Social and Emotional Foundations for Early Learning model of behavioral health consultation. Additionally, providers at center-based early care and educational/school settings receive training in the Second Step model of support. Implementation of the Second Step model was piloted in Year 3 and enhanced implementation efforts occurred during Year 4. Consultation activities around the CSEFEL model continue to be delayed indefinitely as of the end of Year 5.

Process evaluation activities. Implementation data for the Second Step and CSEFEL consultation models, including barriers to and facilitators of progress, modifications made to the strategic plan and collaboration across systems are measured through semiannual surveys of providers of early care and education consultation when possible (see Appendix A-2).

Outcomes evaluation activities:

- Provider Outcomes: An implementation survey provided by Second Step model developers (Committee for Children, 2011, see Appendix M) was used during Year 4 to assess Second Step implementation and systems change activities among PK-5th grade teachers. This grade span is the grade span for which Second Step is used within the New Britain Public School District. Although provider surveys were developed by CHDI evaluators and were planned to be administered before and after on-line training, as a result of a lack of ability to coordinate data collection with the New Britain Public Schools, no provider data is available.
- Child Outcomes: In addition to counts of providers trained in each model, the number of children receiving CSEFEL/Second Step consultation in each type of setting will be tracked through enrollment and demographic data as implementation allows. In addition, grade-level outcomes for children receiving Second Step in education classrooms will be assessed using pre-post comparisons of school discipline referral and attendance data when data is available.

Workforce Development

Promising Starts activities are designed to broadly impact workforce development for early childhood professionals in New Britain by increasing the awareness of evidence-based practices (EBPs) for young children, training providers in key early childhood mental health competencies, expanding the network of providers trained in early childhood best practices, and promoting sustainability of Promising Starts programs.

Process evaluation activities: Implementation data collected for each direct service forms a picture of the broader Promising Starts initiative at both the local and state level, including barriers and facilitators of progress, modifications made to the strategic plan, and collaboration across systems.

Outcomes evaluation activities:

- Provider Outcomes: As described for each direct service component, pre-post training surveys and biannual surveys and focus groups are administered to track changes in provider awareness and attitudes towards EBPs and training in direct service models (see Appendix A-2). In addition to tracking numbers of providers trained to implement each service component of Promising Starts (e.g., Child First, Circle of Security, ASQ-3, CSEFEL, Second Step, and HALO), data are collected to monitor providers receiving early childhood mental health credentialing through the Connecticut Association of Infant Mental Health (CT-AIMH). Training attendance and CT-AIMH certification records are reported semiannually.

Modifications to Original Evaluation Plan

Minor changes to the original evaluation plan and changes to the timeline of implementation of some Promising Starts components are described below.

- Coalition for New Britain's Children: The PARTNER Tool was added as an annual measure of the direction, strength, and focus of relationships between members of leadership networks participating in the Coalition for New Britain's Children. The PARTNER Tool was expected

to be administered annually in the spring while the Collaboration Survey was expected to continue to be administered once each year to track collaborative activities among participating agencies. During Years 1-3, both the PARTNER Tool and the Collaboration survey were administered to the full Coalition. During Year 4, after the restructuring, the Collaboration Survey was administered to the Health and Wellness Project Management Team. During Year 4, the PARTNER Tool was not administered due to the shift in the organizational structure. Both tools were administered once during fall 2014. However, as a result of difficulties in analysis inherent to the PARTNER Tool, no data was received from the PARTNER Tool administration. As a result, only the Collaboration survey was administered during summer 2015 and was used to track progress of the new Health and Wellness Strategy Group during the final implementation year. An end of project focus group was also planned and implemented to assess progress throughout the five and a half years of implementation.

- Child First: Proposed enhancements to the Promising Starts evaluation plan to incorporate a quasi-experimental study or randomized control trial to assess family outcomes was not pursued in Years 3 through 5, as Child First developers determined it was not feasible due to the demands of the transition period into an independent model and their required completion of an RCT outside of Promising Starts.

- Circle of Security: The use of the Parenting Stress Index (PSI) was discontinued as a component of the evaluation process for Circle of Security Parenting as of April 2013, based on provider feedback that the measure did not appropriately track indicators of interest. To better assess family outcomes, the Protective Factors Survey was introduced as the alternative measure beginning in Year 3. In addition, a Fidelity Measure for COS developed by NYC LAUNCH was introduced in Year 3 to assess provider fidelity to the model.

- Behavioral Health and Developmental Assessment: Data collection and reporting for this component continues to experience challenges due to difficulties identifying pediatric providers willing to implement ASQ-3 screenings, integrate behavioral health into primary care practices and report data back to Promising Starts. Although a number of providers are using the too, those who are not able or willing to consistently report data back to Promising Starts. Enhanced efforts to encourage and monitor participation continue to be developed both within Promising Starts and by the ECCS Statewide Advisory Committee, in partnership with Promising Starts. Efforts include ongoing and statewide parent and provider education, development and use of on-line screening tools, and consideration and/or development of statewide strategies to encourage, support and potentially require screenings to be conducted.

- Substance Abuse Prevention: Efforts in Year 3 focused on supporting staff of early care and education settings to deliver the HALO curriculum in their classrooms as a way to build community capacity and support sustainability for the model through the remainder of the grant period and beyond. During 2013, HALO was provided by four classroom teachers. However, coordination and communication between these teachers and Promising Starts staff was limited, resulting in poor data collection during 2013. Enhanced supports and coordination efforts were put in place during 2014 to increase implementation and evaluation to additional classrooms. Additionally, during 2014 an intern was hired by Promising Starts and provided HALO services directly to enhance data collection and adherence to the program model. These efforts were successful and resulted in the successful attainment of quality data from four

classrooms. During Year 5, the HALO curriculum was utilized in two classrooms by Project LAUNCH staff during Spring 2015 and quality data was received. An additional classroom of children received the program from their teacher and not directly from Project LAUNCH staff. No pre-post data are available from that administration. Substance abuse prevention services for parents/caregivers were not implemented, but plans for training modules are under consideration in collaboration with the Connecticut Drug Endangered Children group.

- Child Care Consultation: Promising Starts provided the Second Step curriculum kits and online training for each Pre-K through 3rd grade classroom in the New Britain public school system during Year 3. Limited coordination and communication between Promising Starts and school officials resulted in inconsistent implementation and limited data collection across the district during Years 3 and 4. Enhanced supports and coordination from Promising Starts began during Year 4 and led to expanded but still incomplete implementation and evaluation in Year 4. During Year 4, the New Britain Public School District received a Safe Schools, Healthy Schools grant from SAMSHA and, through these activities, will be conducting a full implementation and assessment of Second Step throughout the Pre-K through 3rd grade classrooms in the district. School district representatives responsible for these activities sit on the Health and Wellness PMT and are working in close partnership with LAUNCH evaluators to coordinate and evaluate the district wide implementation process. These efforts led to expanded implementation during Year 5. The fidelity of implementation survey was provided to the district coordinator for administration to teacher in both on-line and hard copy form. Data was received from three of the ten elementary schools. Additionally, attendance and disciplinary data were received from all elementary schools during Years 4 and 5. Expansion of consultation activities beyond services currently provided through Child First continues to experience indefinite delays with respect to the CSEFEL model.

Data Analysis

Focus group, interview, and qualitative survey data are content-analyzed using qualitative research methods borrowed from Content Analysis. Relevant themes are identified, including barriers, facilitators, and modifications made to the originally planned activities.

All quantitative data are checked and corrected for data entry errors, outliers, and missing data. Simple frequencies and percentages are used to determine participation in the Coalition for New Britain's Children during Years 1-3 and in the Health and Wellness Project Management Team and Strategy Group during Years 4 and 5, number of children and families served through direct services, and the number of professionals trained in each of the Promising Starts components. Provider knowledge, skills, and attitudes, assessed through surveys pre- and post- training (and periodically following training), are assessed using paired t-tests (for pre-post assessments) or repeated measures (for assessments with more than two time points).

Paired t-tests are used to examine changes from pre- to post-test on child and family outcome measures when appropriate in Child First (e.g., ASQ, BITSEA, CCIS, PKBS-2, TESI-B, PSI, LSQ, CES-D, YSS- F) and Circle of Security(e.g., PSI, Protective Factors Survey, and Circle of Security Parenting Questionnaire).

In Year 3, social network analysis using the PARTNER Tool was implemented to assess the direction, strength, and focus of relationships among agencies participating in the Coalition for

New Britain's Children. This analysis was expected to be completed twice during Year 5. However, as a result of data collection challenges inherent within the PARTNER Tool, the first administration resulted in the loss of all data and administration was ceased.

Due to the focus in Year 1 on strategic planning, evaluation plan development, and initial development of collaborative relationships with community stakeholders, direct services were implemented late in the reporting period and results were limited to process data regarding the development of the Coalition for New Britain's Children, initial implementation steps for evaluation components, and baseline pre-test training assessments for providers participating in Child First and Circle of Security trainings. Implementation efforts ramped up significantly in Year 2 and continued in Years 3 through 5. Data results provided in this reporting period reflect all direct service components and are presented alongside results from previous years, when available, to provide a longitudinal picture.

Use of Data for Quality Improvement

Implementation data, including information from surveys, focus groups, Coalition for New Britain's Children meeting minutes during Years 1-3, Health and Wellness PMT meetings during Year 4 and Health and Wellness Strategy Group meetings during Year 5, are analyzed, summarized, and reported back to Promising Starts staff during quarterly meetings. Information is used in a continuous quality improvement framework to inform Promising Starts leadership about progress and recommended areas for improvement with respect to systems-level impact, service coordination and delivery, and child/family outcomes. Performance measures, particularly implementation fidelity, service quality, the number and type of services delivered, and provider satisfaction, are integrated with child and family outcome data to monitor the number of youth receiving services, outcomes associated with service delivery, and any factors identified as moderators of treatment outcome.

Additional implementation data are used to monitor and improve Child First services. Monthly implementation data from Child First are collected by the Child First developers as part of Wheeler Clinic's involvement in the statewide Child First system. These data are collected via monthly web-based surveys of each Child First staff member, and are summarized and reported back to the team monthly to inform quality improvement. The Promising Starts evaluation team at both CHDI and Lorentson Consulting works closely with Wheeler Clinic staff (and the Child First developers and their Quality Improvement Coordinator as needed) to interpret and use this data to continuously improve the Child First service. The Promising Starts evaluation team works closely with Wheeler's Child First staff to understand and interpret the data, to identify goals and benchmarks, to develop and use small tests of change for quality improvement, and to assess their own performance improvement strategies with subsequent data. Specific examples include the ongoing use of Child First data to refine program activities by the evaluator in partnership with the Promising Starts Director, and the use of feedback from systems-change data collection to inform planning and coordination activities at Health and Wellness PMT or Strategy Group meetings through attendance of both the LAUNCH evaluator and the Promising Starts Director.

Findings

Results from this reporting period indicate sustained implementation of multiple activities in Year 5 and successful completion of the transitioning process in a the majority of areas. Activities successfully completed in Year 1, including the environmental scan, completion of the strategic plan and evaluation plan, and development of the Coalition for New Britain's Children, laid a solid foundation for intensive implementation of program activities in Years 2 through 5. Results from this reporting period indicate that implementation has been generally sustained across the major program target areas and Promising Starts has met or exceeded 5-year benchmarks for all program areas.

During this reporting period, Promising Starts maintained engagement of 39 individuals representing 28 different child-serving agencies and caregivers in the New Britain community as members of the Coalition for New Britain's Children, renamed the Coalition for New Britain Leadership and membership of 14 different child-serving agencies on the Health and Wellness Strategy Team. As noted previously, individual members of the Coalition changed over time although organizational membership on the Coalition was consistent. Over the life of the grant, training was provided to *223 New Britain providers* in evidence-based practices for infants/young children, including Child First, Circle of Security Parenting, Ages and Stages Questionnaire Developmental Screening Protocol, Healthy Alternatives for Little Ones, and early childhood development competencies. In addition, a large number of trainings were provided to early childhood organizations surrounding New Britain.

A total of *340 children/families* were served through Promising Starts direct services in Year 4, including 54 children who received the Child First parent-child home visiting model, 108 parents who participated in Circle of Security Parenting groups, 110 children who participated in the HALO curriculum in their early care and education settings, and 68 children who were screened for behavioral and developmental concerns in the community using the ASQ-3.

During Year 5, a total of 285 children/families received direct services through Wheeler Clinic's *Promising Starts* initiative: *43* families received home-visiting-intervention services from Child First, *69* parents/caregivers were trained through Circle of Security's early intervention program for parents and children (COS-P), *54* children participated in the Healthy Alternatives for Little Ones (HALO) curriculum, and *119* children were screened for developmental delays using the Ages & Stages Questionnaires® (ASQ). In addition to the direct services that were provided to children/families, training services were rendered to 3 early childhood providers associated with Child First (3) and to 116 community providers on Risk and Trauma Prevention. During the no-cost extension year, an additional 34 children received Child First Services and were screened for developmental delays.

As of the end of Year 5 of LAUNCH funding, a cumulative total of 38 New Britain providers associated with Wheeler Clinic or partner organizations have received training in evidence-based practices for infants/young children through Child First (7), Circle of Security Parenting (COS-P) (26), and HALO (5). Also, a cumulative total of 1082 children/families have received direct services through Wheeler Clinic's *Promising Starts* initiative: *181* families received home-visiting-intervention services from Child First, *287* parents/caregivers were trained through Circle

of Security's early intervention program for parents and children (COS-P), *395* children participated in the Healthy Alternatives for Little Ones (HALO) curriculum, and *341* children were screened for developmental delays using the Ages & Stages Questionnaires® (ASQ).

The New Britain Health and Wellness Council:

Process Outcomes. Wheeler Clinic formed the *New Britain Health and Wellness Council* in November 2010 to provide oversight and guidance to the Promising Starts initiative throughout the duration of Project LAUNCH. The Council began meeting monthly for two hours in January 2011 and moved to quarterly meetings beginning in August 2011 for a total of six meetings in Year 1 and three meetings in both Years 2 and 3. During Year 3, the Council was renamed the Coalition for New Britain's Children and during Year 5 the Council was renamed the Coalition for New Britain Leadership.

In Years 1-5, the membership of the Coalition for New Britain's Children/New Britain Health and Wellness Council/Coalition for New Britain Leadership remained consistent at 39 individual representatives (including 4 family members) across 28 agencies/organizations in the New Britain community, exceeding the benchmark of 25 participating agencies (see Figure 2).

Figure 2. Coalition for New Britain's Children/New Britain Health and Wellness Council Agency Representation: Years 1-3

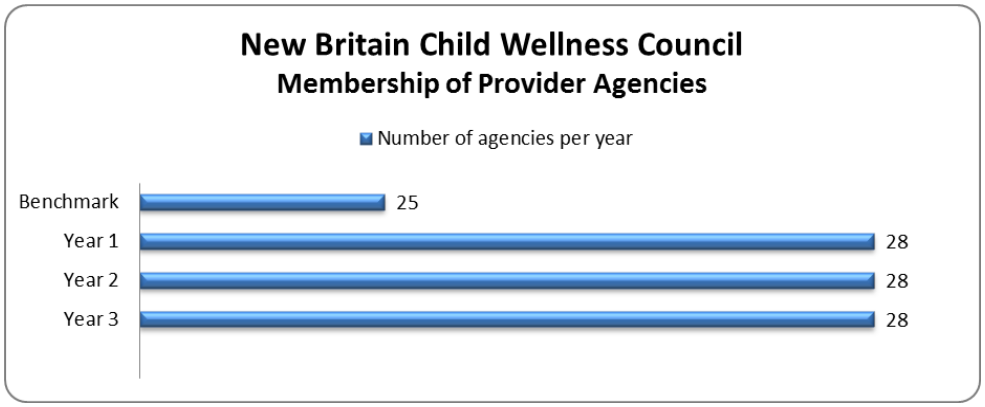
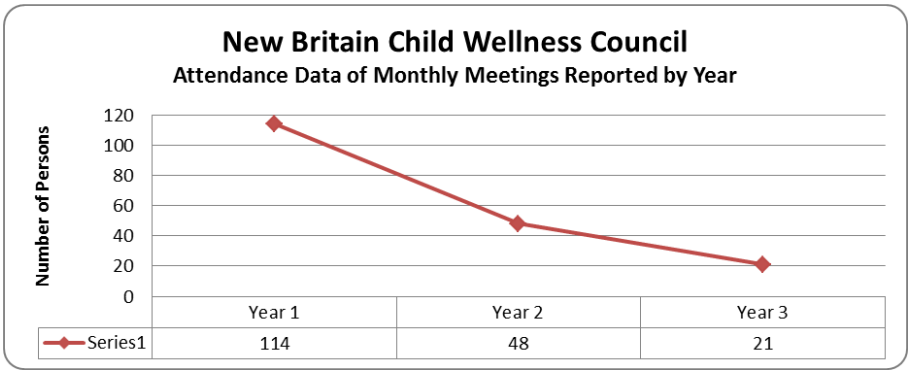


Figure 3 provides attendance data for the Coalition for New Britain's Children/New Britain Health and Wellness Council meetings during Years 1 through 3. It is expected that the decrease in attendance resulted from clarification of the role of the council and corresponding specificity of council membership.

Figure 3. New Britain's Children/New Britain Health and Wellness Council Number of Persons in Attendance: Years 1-3



As a result of the declining attendance of the large Council, during February 2014 the Blueprint Leadership Team was formed to serve as the decision-making body with its subcommittee, the Health and Wellness PMT also formed to focus on health and wellness and provide decision-making related to Promising Starts. During Year 4, membership and attendance at both the Blueprint Leadership Team and the working group, the Health and Wellness PMT was tracked. For each group, agendas were reviewed. Summary data related to the 2014 activities of the Blueprint Leadership Team is located in Table 1.

Table 1. Blueprint Leadership Team Attendance: Year 4

Blueprint Leadership Team
Number of Council Members in Attendance
Year 4

	6-May	3-Jun	1-Jul	5-Aug
TOPICS:	Various reports were presented, and the Summer Learning Program as well as the Coalition's communications, the scorecard, and future commitments to the BLT meetings were discussed.	Various PMT reports and the *Summer Learning Pledge* were presented and discussed. Updates were also presented on the topics of family literacy and early learning.	Various PMT reports were presented and discussed. Issues pertaining to the Coalition's communications, network activities, job descriptions for the data/accountability and communication positions, finances, and grants were addressed.	Reviews were conducted on Results-Based Accountability and roles and responsibilites for committee members. Guidance was provided to the Early Learning Program Management Team regarding their action plan, and roles were distinguished between project managment teams and the
Council (members of various organizations)	11	9	7	7
Staff and Technical Assistance	3	4	3	4
Guests	0	3	0	0
Total	**14**	**16**	**10**	**11**

During Year 4, the newly formed Health and Wellness Project Management Team (PMT) provided oversight and coordination of project activities. The initial membership of this group was 17. This number is reflected in tables below. During late fall of year 2014, the membership list was formalized to include 14 agencies based on ongoing attendance and interest. These 14 agencies continued to be involved in the Health and Wellness Strategy Group during Year 5.

Of the possible 17 attendees initially invited to Health and Wellness PMT meetings during Year 4, 6% attended five meetings, 18% (3) attended four meetings, 12% (2) attended three meetings, 18% (3) attended two meetings, 6% (1) attended one meeting, and 53% (9) attended no meetings (see Figure 5). There was an average of 10 attendees at each meeting. In addition to agency representation, there was one pediatrician who attended the meetings forty percent of the time, attending 2 of 5 recorded meetings; however, there was no parent/caregiver representation, failing to meet the established benchmark of 15%. Overall, meetings were well-attended by key collaborators and primary decision-makers for Promising Starts services and activities.

During Year 4, as a result of the decrease in attendance over time, the Blueprint Leadership Team was formed to provide guidance and decision-making to overall activities and to be responsible for the implementation of the blueprint for improving children's education published by the Coalition. Simultaneously, the New Britain Health and Wellness Project Management Team (PMT) was

formed to serve as a working subcommittee of the Blueprint Leadership Team, focusing solely on health and wellness. During 2014, the PMT provided oversight and coordination of Project Launch activities and reports to the Blueprint Leadership Team.

As a result of restructuring, monthly meetings did not occur during the fall of 2013 but were reinstated in March 2014. Seven meetings of the PMT were held from March 2014 to September 2014, with attendance data collected at five meetings. During 2015, the PMT merged with the Health and Wellness Committee of the New Britain Public Schools to become the Health and Wellness Strategy Group consisting of membership from 14 different organizations. This group met monthly beginning in October, 2014 with one meeting being canceled. Data collection for Year 5 ended in June, 2015. Data is available from 9 out of the 9 meetings held.

Modifications to the infrastructure disallow the direct comparison of collected data between previous years and Years 4 and 5. The discussion will therefore focus on changes over time.

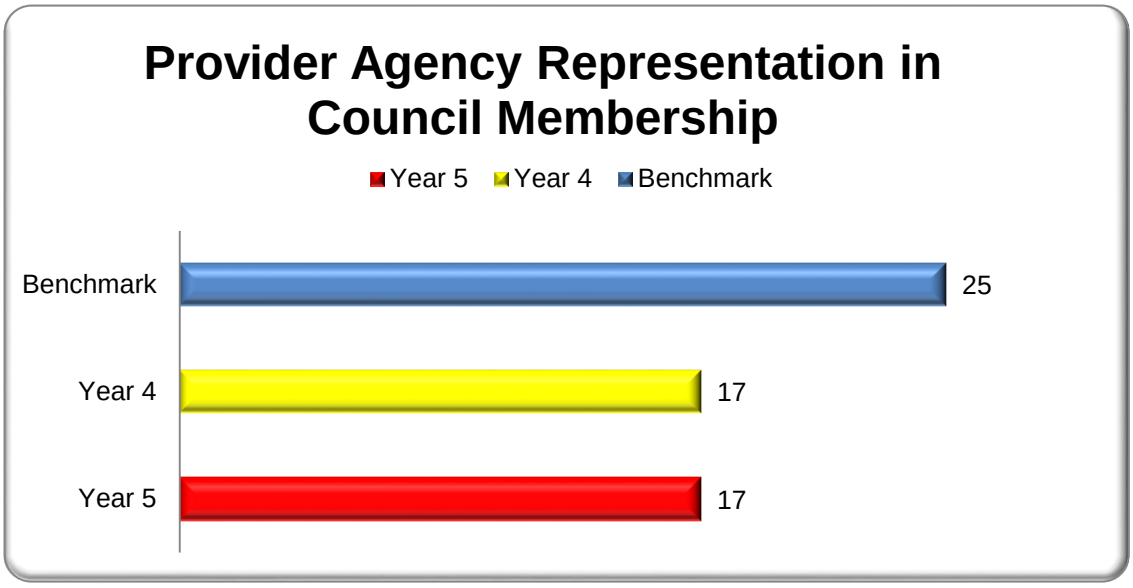
Results indicate that the Coalition is maintaining moderate levels of collaboration among specific activities and is advancing towards higher-level coordination, through trusting relationships and frequent interactions. The Coalition developed a comprehensive plan for improvement of early childhood health, wellness and success and developed a leadership team, named the Blueprint Leadership Team in 2014, to guide and direct plan activities. During the first three project years, these activities laid a foundation for expanding and sustaining Promising Starts' goals and activities at the community level beyond the Project LAUNCH grant period. Similarly, during 2014-2015, the system continued to evolve and the Blueprint Leadership team created three subcommittees including the Health and Wellness Project Management Team (PMT), the Early Learning PMT and the Family Literacy PMT to further guide program expansion. The Health and Wellness Project Management Team (PMT) was formed as a subcommittee to the Blueprint Leadership Team and focuses solely on community activities related to Health and Wellness. During Years 4 and 5 of grant activities, the Health and Wellness PMT serves as the coordinating body for Promising Starts activities. A number of individuals on the Health and Wellness Team also sit on the Coalition for New Britain's Children and assure ongoing integration of health and wellness into community activities.

During Year 5, the Council was renamed the Coalition Leadership Group and restructured. The Blueprint Leadership Team continued to maintain overall leadership. For the purposes of this report, the term Coalition will be used throughout. The Coalition replaced the three PMTs with four strategy groups including Connecting Families, Health and Wellness, Early Learning/School Readiness and Youth and Workforce Development. The Health and Wellness Strategy Group simultaneously merged with the Health and Wellness Committee from New Britain Public School District to become a larger and more diverse group. Additionally, three subcommittees were formed to focus on Advocacy and Marketing, Professional Development and Networking and Data and Evaluation.

As the Health and Wellness Strategy Group became the focus of Promising Starts activities, membership, data collection during Year 5 centered around this group. During Year 5, the Health and Wellness Strategy Group continued to meet regularly. Of the 8 meetings held between October 2014 and June 2015, 35 individuals from 17 participating organizations attended meetings. The average attendance per meeting was 15 ranging from a low of 8 individuals to a

high of 20 individuals. The average number of meetings attended per participant was 3 with 16 participants attending 4 or more meetings. In addition to agency representatives, one parent attended meetings as did two parent or family liaisons representing participating organizations.

Figure 4. New Britain Health and Wellness PMT Attendance: Year 4 and Health and Wellness Strategy Group Attendance: Year 5



Note: Year 4 and 5 data is not comparable to Years 1-3 nor are Year 4 and 5 comparable to each other. During Year 4, the numbers represent membership of the Health and Wellness PMT, a subcommittee of the broader Blueprint Leadership Team which was created to be the decision making body for the full Coalition. During Year 5, the Health and Wellness PMT merged with from the New Britain Public School district creating a new body of 17 organizational members. As a result of the formation of the Blueprint Leadership Team and the Health and Wellness PMT during Year 4 and the Blueprint Strategy Group during Year 5, organizational membership was below the overall benchmark for those entities. However, membership on the Coalition remained at 28 and above the desired benchmark.

Figure 5 provides an overview of agency attendance and representation at meetings of the Health and Wellness PMT by agency during Year 4 and Figure 5a provides an overview of attendance and representation at meetings of the Health and Wellness Strategy Group during Year 5.

Figure 5. New Britain Health and Wellness PMT Agency Representation: Year 4

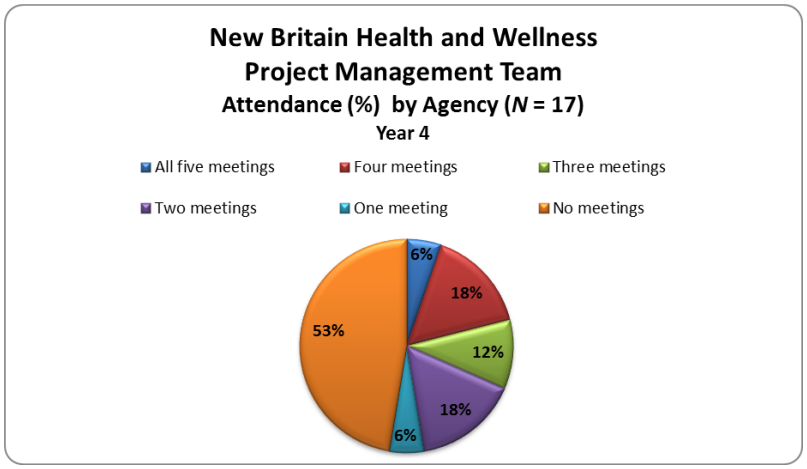
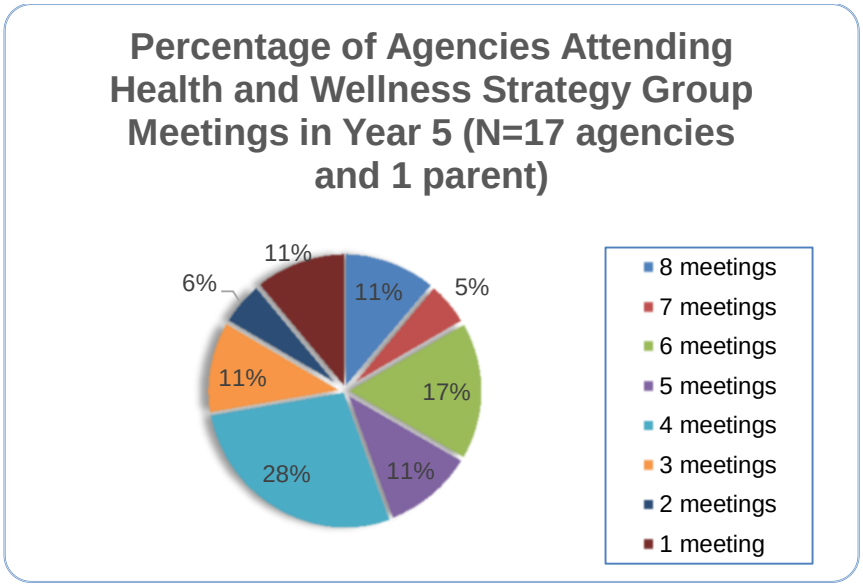
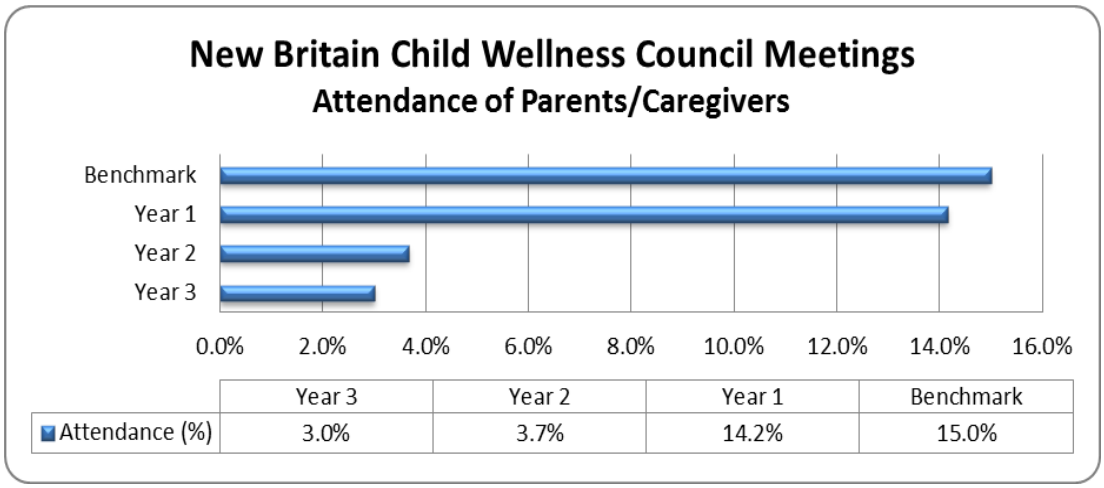


Figure 5a. New Britain Health and Wellness Strategy Group Meeting Agency Representation: Year 5



During Years 1-3, parent attendance occurred at meetings of the Coalition for New Britain's Children/New Britain Health and Wellness Council as summarized in Figure 6.

Figure 6. Coalition for New Britain's Children/New Britain Health and Wellness Council Parent/Caregiver Attendance (%) during Years 1-3



In Year 4, subsequent to the formation of the Blueprint Leadership Team and the Health and Wellness PMT, there was no parent/caregiver representation at meetings held by either the Blueprint Leadership Team or the Health and Wellness PMT. During Year 5, there was one parent attendee at the meetings of the Health and Wellness Strategy Group and representation from two individuals from participating organizations whose were responsible to interact with parents on behalf of these organizations. Parent representation for these two years thus fell below the benchmark of 15%. Although parent/caregiver representation was encouraged during Years 4 and 5 through verbal and written requests and the provision of child care when time and budgets allowed, there was little engagement of parents subsequent to the initial restructuring of the Coalition into PMTs.

It is possible that the lack of parental engagement during later years has resulted from the consistent restructuring and expansion. This restructuring and expansion may have led to an inconsistent message related to the group purpose and activities outside of group members and a lack of an emphasis on immediate parent engagement by group members resulting from the rapid restructuring and ongoing recreation of strategic goals, committees and workplans. The drop-off in parent engagement could also have resulted from a perception that the program is no longer "new" and therefore possibly less exciting. Other potential barriers include time of day of the meetings (mid-day) and lack of incentives to encourage parent participation. However, it is noted that parent engagement has been incorporated as an objective of the Health and Wellness Strategy Groups and will become a focus of the upcoming activities. Additionally, the Promising Starts Coordinator attends meetings of the Health and Wellness Strategy Group regularly and is encouraging the implementation of parent engagement activities as rapidly as possible. It is anticipated that parent engagement will begin to increase again as the Health and Wellness Strategy group goals and objectives are implemented, the new structure stabilizes and shared visions are created and communicated.

Both Blueprint Leadership Team and Health and Wellness PMT meetings were structured with a written agenda and were facilitated by the Promising Starts Coordinator. The Health and Wellness Strategy Group was formed during Fall 2015 and meetings are facilitated by the Community

Health Center. Strategy Group meetings convened monthly beginning in October 2014.

As the Leadership Team no longer provides direct coordination of LAUNCH activities, the discussion will focus on Health and Wellness PMT meetings held from March through September 2015 and the Health and Wellness Strategy Group meetings held from October 2014 through June 2015.

All Health and Wellness PMT meetings included updates on active Promising Starts service components and related activities underway at partner agencies. Meetings provide an opportunity for shared decision-making, networking, and discussion. In the fourth year, meetings were held between March and September, 2014 for a total of 5 meetings (see Appendix N). Initial meetings in March and April examined key data related to health and wellness needs in New Britain. Data were examined related to a variety of health and wellness indicators in New Britain. The Team reviewed data and prioritized for action planning needs according to the degree to which the need was severe, the degree to which necessary data was available to assess the severity of the need, and the degree to which the Team would be able to create change on the indicator.

The PMT defined three primary areas of focus to be addressed in New Britain as follows:

- Focus Area 1: Mothers are healthy and experience a healthy pregnancy,
- Focus Area 2: Children experience healthy growth and development
- Focus Area 3: Children are safe and nurtured.

Potential indicators and strategies were identified. Draft indicators and strategies are below:

Area 1: Potential indicators for Area 1 have been identified as the percentage of mothers who smoke during pregnancy, the percentage of mothers who receive non-adequate prenatal care, the percentage of mothers with a high school diploma (can be correlated with health), the percentage of mothers who receive depression screening and the percentage of births which are low birth rate. Strategies under discussion include the development of a Centering program for prenatal mothers to provide emotional support and guidance through the hospital, the creation of teen smoking prevention programs, and activities designed to improve oral health among pregnant women.

Area 2: Potential indicators for Area 2 include the percentage of four year olds with a healthy Body Mass Index (BMI), the percentage of fourth graders who meet the standard on all four Connecticut physical fitness tests, and the percentage of children with asthma. Potential strategies include the use of community gardens, promotion of breast feeding and enhancement of HALO programming. Consideration is being given to strategies to link results of indicators in Area 2 with indicators in Area 3 including the presence of adverse childhood experiences.

Area 3: Potential indicators include the rate of child abuse and neglect, the rate of domestic violence and the crime rate. Potential strategies include the partnership with ongoing activities underway by the Connecticut Office of Early Childhood, increased emphasis on Circle of Security parenting activities to promote attachment and increased implementation of Second Step through

the community. The PMT reviewed key data and developed draft indicators of progress and strategies for achievement. As a result of the receipt of the Safe Schools, Healthy Students (SSHS) grant by the New Britain public school district, coordination of all data collection and change activities between Promising Starts and SSHS activities began and provides New Britain an enhanced opportunity to leverage funding and community commitment through the existing collaborative process.

During 2014-2015, the Health and Wellness PMT transitioned into the Health and Wellness Strategy Group. Meetings were held monthly and were facilitated by the Promising Starts Coordinator through March 2015. At that time, as part of the transition plan, all meetings were facilitated by the Community Health Center.

The Health and Wellness Strategy Group received training in Results-Based Accountability during February 2015 and subsequently created three separate working groups including Mental Health, Teen Pregnancy Prevention, Obesity and Asthma. Each working group is tasked to examine data from the Community report card, previous work completed by the Health and Wellness PMT and additional sources and to, following the Results-Based Accountability protocol, utilize this data in the development of an action plan. As of June 2015 when data collection was ceased, the development of action plans was well underway. As stated previously, action plans included efforts to increase family engagement in activities.

Structurally, each monthly meeting consists of approximately 45 minutes of working group activities followed by whole group discussion and sharing of information needed by the group. In addition to activities geared toward the development of the action plans, activities completed during Year 5 included the Results-Based Accountability Training, the completion of an introduction to the new Safe Schools Health Students initiative underway by the New Britain Public Schools, celebration of the naming of New Britain as a finalist in the national initiative (SCALE) aimed at accelerating the journey to improve Health and Wellbeing funded by the Robert Wood Johnson Foundation and the subsequent planning for a site visit to be completed by the Foundation.

Systems Outcomes. The New Britain Health and Wellness Collaboration Survey (see Appendix C) was developed to collect data about the level of coordination and collaboration among New Britain child-serving agencies and providers participating in the Coalition for New Britain's Children during Years 1 and 3 and, subsequently, for the PMT during Year 4 and the Strategy Group during Year 5. The survey includes the Levels of Collaboration Survey (Lohmeier, Lee, & Tollefson, 2006) and the Interagency Collaboration Activities Scale v6.1 (Greenbaum & Dedrick) as described in detail below. Data was collected twice during Year 4 and once during Year 5.

The Levels of Collaboration Survey includes one question rating the relationship between each pair of agencies. Respondents rate on a 5-point scale their global level of interaction with another agency to assess their current stage of collaboration. The five stages of collaboration, from most basic to advanced, include: 1) Networking, 2) Cooperation, 3) Coordination, 4) Coalition, and 5) Collaboration as defined in Table 2.

Table 2. Levels of Collaboration Survey: Rating Scale

Networking (1)	Cooperation (2)	Coordination (3)	Coalition (4)	Collaboration (5)
Aware of organization, loosely defined roles, little communication, all decisions are made independently	Provide information to each other, somewhat defined roles, formal communication, all decisions are made independently	Share information and resources, defined roles, frequent communication, some shared decision making	Share ideas, share resources, frequent and prioritized communication, all members have a vote in decision making	Members belong to one system, frequent communication is characterized by mutual trust, consensus is reached on all decisions

Members/agency representatives were asked to provide a "group rating" (an aggregate assessment of the collaborative relationships between members/agencies) and a "self-rating" (a self-reported assessment of an agency's collaborative performance provided by the agency representative) to identify strengths and weaknesses during the collaborative process:

Additionally, the survey uses the *Interagency Collaboration Activities Scale* (IACAS) to provide a self-reported assessment of 17 items across four domains (subscales), enabling the identification of strengths and weakness of collaborative activities between agencies. The four subscales include: (1) Financial and Physical Resources, (2) Program Development and Evaluation, (3) Client Services Activities, and (4) Collaborative Policy. The scaled ratings for interagency activities range from "1.0" (Not at all) to "5.0" (Very much).

During Year 4, the collaboration survey was administered once during spring 2014 and once during fall 2014. Results are reported separately by administration. Both surveys were administered to the Health and Wellness PMT so results are therefore comparable. Data from Year 3 administration to the Coalition for New Britain's Children/New Britain Health and Wellness Council is reported for comparison purposes.

Year 4: Spring 2014:

During the spring of 2014, the survey was administered to the 17 agencies initially participating in the Health and Wellness PMT. There were 7 respondents representing 5 agencies, yielding a response rate of 29%. Although the survey's response rate continued to be low, the responses are representative of the PMTs core and steady membership. Efforts to increase participation continued to be facilitated through constant reminders at meetings, email correspondence, and ongoing, consistent attendance of the evaluation team members at each PMT meeting.

The group's average ratings on the Collaboration scale range from 1.2 to 3.7 (see Figure 6) indicating neither *Coalition* nor *Collaboration* activity. According to the data, the majority of members (65%) were still in the early phases (defined as Networking and Cooperation) of collaborative activities (see Table 2), which compare to the reported ratings of Time 3 (fall 2012, $n = 24$) that range from "1.3 (Networking) to 3.7 (Coordination)"; however, only 27% of these members were seemingly advancing toward Coordination. Statistics indicate that the remaining members (35%) are currently in phase three (Coordination) of the collaborative process. Conversely, the self-reported data reveal much higher averages that range from 2.9 to 3.8, which suggest that individual agencies seem to have a different and greater perspective of their progression during the collaborative process than their counterparts (see Figures 7 and 8).

Figure 7. Health and Wellness PMT Levels of Collaboration: Group Ratings of Agencies Spring Administration (N = 17):

Average Rating Based on Scale from 1-5

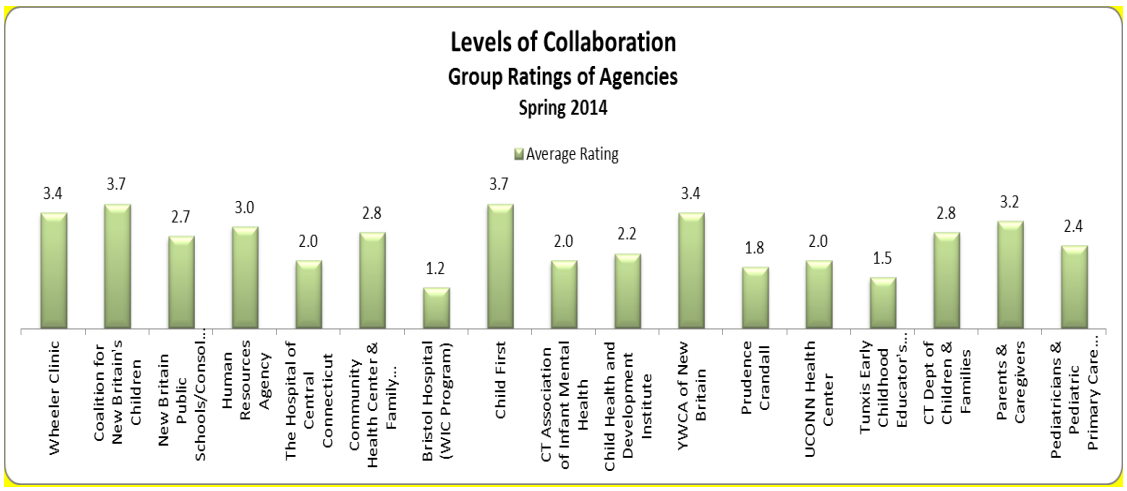
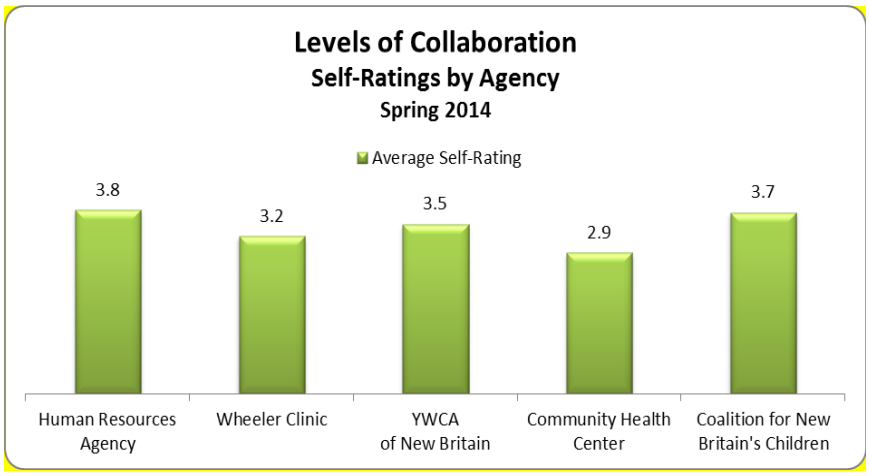


Figure 8. Health and Wellness PMT Levels of Collaboration Spring Administration: Self-Ratings by Individual Agency (n = 5)

Average Rating Based on Scale from 1-5



Fall 2014:

During the fall of 2014, the survey was administered to the 12 current members of the PMT. It is noted that the current PMT membership does not include parents or pediatricians. Of the current members, only 6 agencies (represented by *n* = 9) completed the survey, yielding a response rate of 50%. As in the spring of 2014, the responses are representative of the PMTs core and steady membership, and ongoing efforts to increase participation remain in place and will continue to be employed.

The group's average ratings on the Collaboration scale range from 1.5 (Networking) to 2.9 (Cooperation) (see Figure 9 and Table 2), revealing a slight decline in collaborative activities since

the spring of 2014. It is expected that this decline may be a result of the relatively small sample and the restructuring process to include new members. Members are either in the Networking or Cooperation phases of collaborative activities; therefore, all collaborators (100%) are still in the early phases of collaboration. To this end, in the fall, members are advancing toward the Coordination phase, representing 58% of responding members (7 individuals). As reported during the last reporting period (spring 2014), the self-reported data continue to reveal much higher averages (2.4 to 3.8) than data reported by peer agencies, suggesting a different perspective on personal productivity and collaborative practices (see Figures 9 and 9a).

Figure 9:.Health and Wellness PMT Levels of Collaboration: Group Ratings of Agencies Fall Administration (N = 12)

Average Rating Based on Scale from 1-5

Note: Although the survey was not administered to parents or pediatricians, respondents are asked about their level of collaboration with these entities. As a result, perceptions of collaboration with parents and pediatricians are reported.

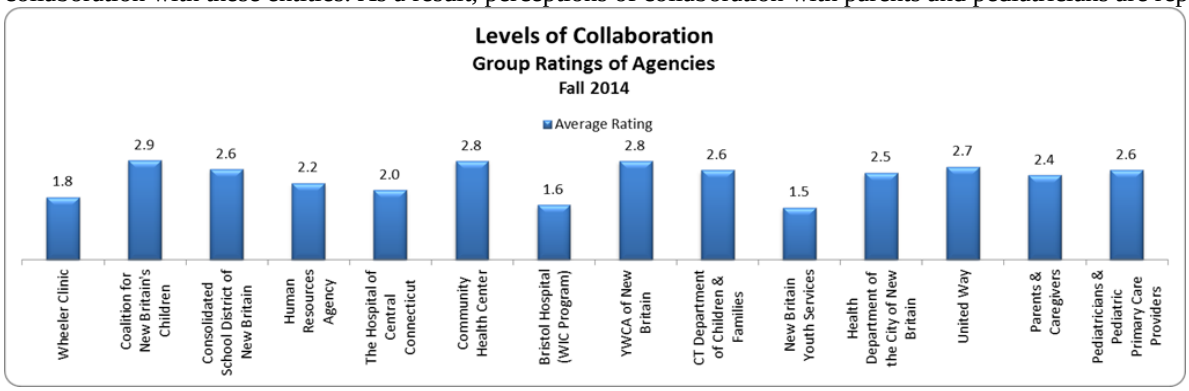
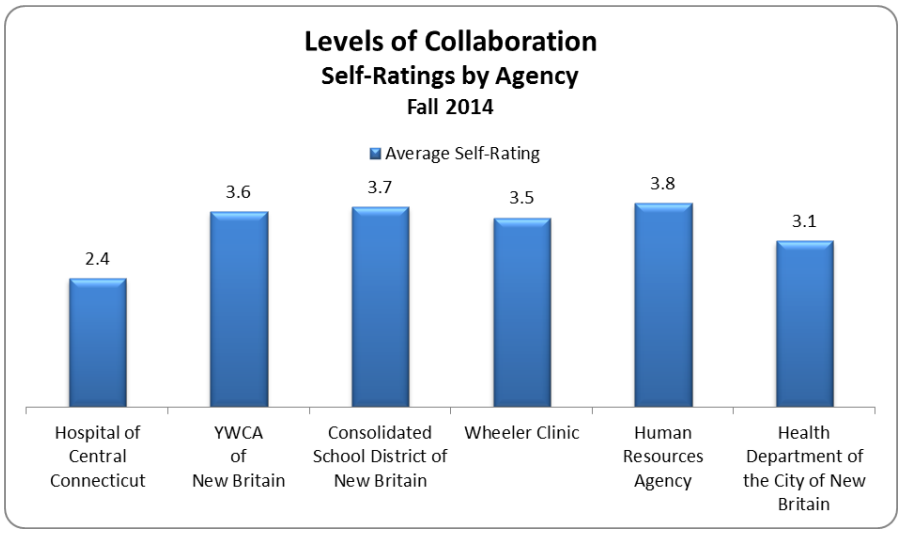


Figure 9a: Health and Wellness PMT Levels of Collaboration Fall Administration: Self-Ratings by Agency (n = 6)

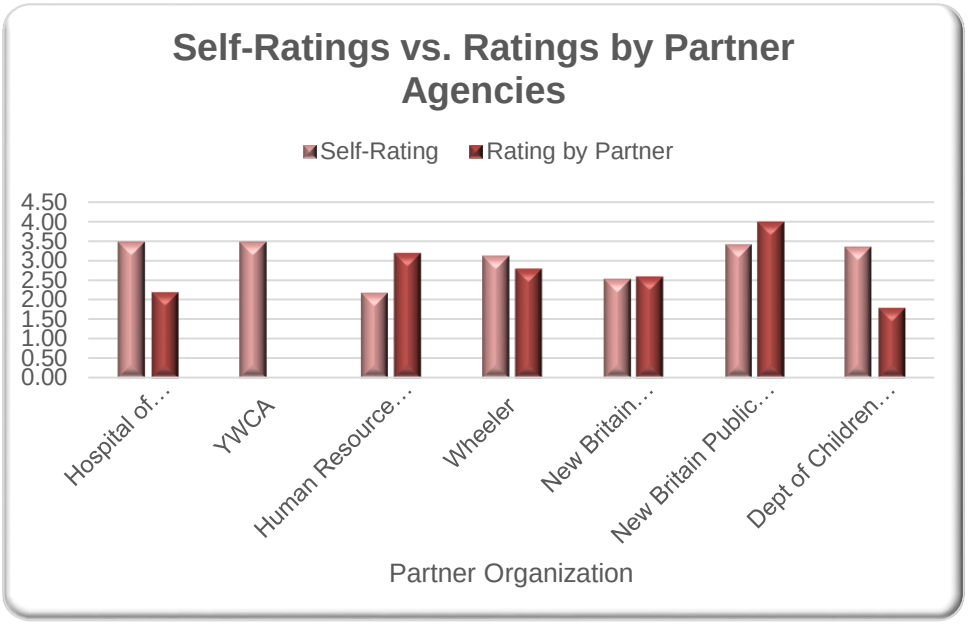
Average Rating Based on Scale from 1-5



Year 5: Summer 2015:

During Year 5, the survey was administered once during summer 2015. The survey was administered to the 17 members of the Health and Wellness Strategy Group formed in 2015, including the original 12 members of the Health and Wellness PMT. Six responses were received. A comparison of the self-rating for each responding agency to the group rating is provided in Figure 10. It is noted that the group rating for the YWCA is missing due to a data collection challenge.

Figure 10: Self-Rating vs. Partner Rating (n = 7): June 2015
Average Rating Based on Scale from 1-5



Results indicate that the self-rating provided by collaborating partners frequently differed from ratings provided by the group with the direction of that difference varying by agency. Both the Department of Children and Families New Britain and the Hospital of Central Connecticut perceived themselves to be collaborating at a higher level than the these organizations are perceived to be collaborating by partners. However, the Human Resources Agency perceived itself to be collaborating at a lesser level than its partners perceived it to be whereas Wheeler Clinic and the New Britain Health Department are perceived to be collaborating at a similar level as they consider themselves to be. It is expected that this variation may be occurring as a result of both the small sample size and the recent merger of the Health and Wellness PMT into the much larger Health and Wellness Strategy Group. It is expected that organizations are exploring their role and the role of others within this new and larger group and that perceptions of collaboration will stabilize as the new coalition solidifies. Due to the large number of collaborating agencies in the overall Health and Wellness Strategy Group, a summary of the group perceptions of collaboration of all agencies is not provided.

The Interagency Collaboration Activities Scale (IACAS) is designed to measure interagency collaborative activities and provides a self-reported assessment of 17 items across four domains

(subscales) (see Table 3), enabling the identification of strengths and weakness of collaborative activities between agencies.

Areas examined include the following: (1) Financial and Physical Resources, (2) Program Development and Evaluation, (3) Client Services Activities, and (4) Collaborative Policy. The scaled ratings for interagency activities range from "1.0" (Not at all) to "5.0" (Very much). Results of the Interagency Collaboration Activities Scale (IACAS) identified relative strengths during the spring and fall of Year 4 and during the summer of Year 5 in *Participating in Standing Interagency Committees*, *Information about Services*, *Developing Programs or Services*, *Program Evaluation*, *Staff Training*, *Informing the Public of Available Options*, *Case Conference or Case Reviews*, and *Informal Agreements*. Although growth was reported in Time 3 on *Informal Agreements* and *Formal Written Agreements* activities, Time 4 (during the spring and fall) and Time 5 reveal both slight and major declines in the respective activities albeit based on a much smaller sample size. It is expected that these declines result from the recent formation of the PMT and subsequently the Health and Wellness Strategy Group and the corresponding newness of collaborative activities.

Moreover, through Time 4, *Common Intake Forms* continue to receive the lowest rating as in previous years, and the subscales show fluctuations since the fall of 2012 (Time 3): By the end of Year 5 (see Summer 2015), *Financial & Physical Resources*, *Client Services*, and *Collaborative Policy* practices had decreased to 2.5, 3.2, and 3.2, respectively, suggesting the collaborative process and ongoing and frequent changes in group structure and management are creating challenges for coalition development. On the other hand, *Program Development & Evaluation* activities are reported to have consistent over time which is indicative of well-coordinated practices. As with previous discussions, data was collected from different although related entities during Years 1-3 and Year 4-5 and are not, therefore, comparable but are provided for understanding and review.

Table 3. Interagency Collaboration Activities Scale: Ratings by Item

***Note*:** Times 1-3 represent the Council/Coalition. Time 4 represents the Health and Wellness PMT, a subcommittee of the Blueprint Management Team. Time 5 represents the Health and Wellness Strategy Group. All calculations based on a scale of 1=Not at All and 5=Very Much.

	Time 1	Time 2	Time 3	Time 4	Time 4	Time 5		Time 1	Time 2	Time 3	Time 4	Time 4	Time 5
	Fall 2011	Spring 2012	Fall 2012	Spring 2014	Fall 2014	Summer 2015		Fall 2011	Spring 2012	Fall 2012	Spring 2014	Fall 2014	Summer 2015
Financial and Physical Resources	3	3	3.3	3	2.9	2.5	Client Services Activities	3.4	3	3.3	3.5	3.1	3.1
Funding	3	3.1	3.6	3.4	3.3	2.6	Diagnosis and Evaluation/Assessment	3.1	2.8	3.3	3.2	2.7	2.4
Purchasing of Services	2.8	2.7	3.2	2.2	2.5	2.4	Common Intake Forms	2.5	2.1	2.7	2	1.6	2.1
Facility Space	3	3.4	3.2	3.6	3.5	3.0	Child and Family Service Plan	2.8	2.4	2.8	3.3	3	2.3

	Time 1 Fall 2011	Time 2 Spring 2012	Time 3 Fall 2012	Time 4 Spring 2014	Time 4 Fall 2014	Time 5 Summer 2015		Time 1 Fall 2011	Time 2 Spring 2012	Time 3 Fall 2012	Time 4 Spring 2014	Time 4 Fall 2014	Time 5 Summer 2015
							Development						
Record Keeping and Information Systems Data	3.1	2.6	3.2	3	2.4	2.1	Participation in Standing Interagency Committees	4.2	4	4.1	4.4	3.8	4.3
							Information About Services	4.2	3.7	3.7	3	3.4	4.1
Program Developme nt and Evaluation	3.5	3.3	3.3	3.8	3.6	3.5	Collaborative Policy	3.4	3.2	3.7	3	3.4	3.2
Developing Programs or Services	3.6	3.6	3.9	4.3	3.6	3.7	Case Conference or Case Reviews	2.9	3.2	3.3	2.8	3.7	3.0
Program Evaluation	3.1	2.9	3.4	3.8	3.4	3.1	Informal Agreements	3.9	3.3	4.2	3.2	4	3.6
Staff Training	3.7	3.3	3.5	3.7	3.6	3.6	Formal Written Agreements	3.4	3.3	4	3.4	3.3	3.1
Informing the Public of Options	3.7	3.4	3.5	3.3	3.8	3.6	Voluntary or Contractual Relationships	3.5	3.4	3.3	2.8	2.8	3.1

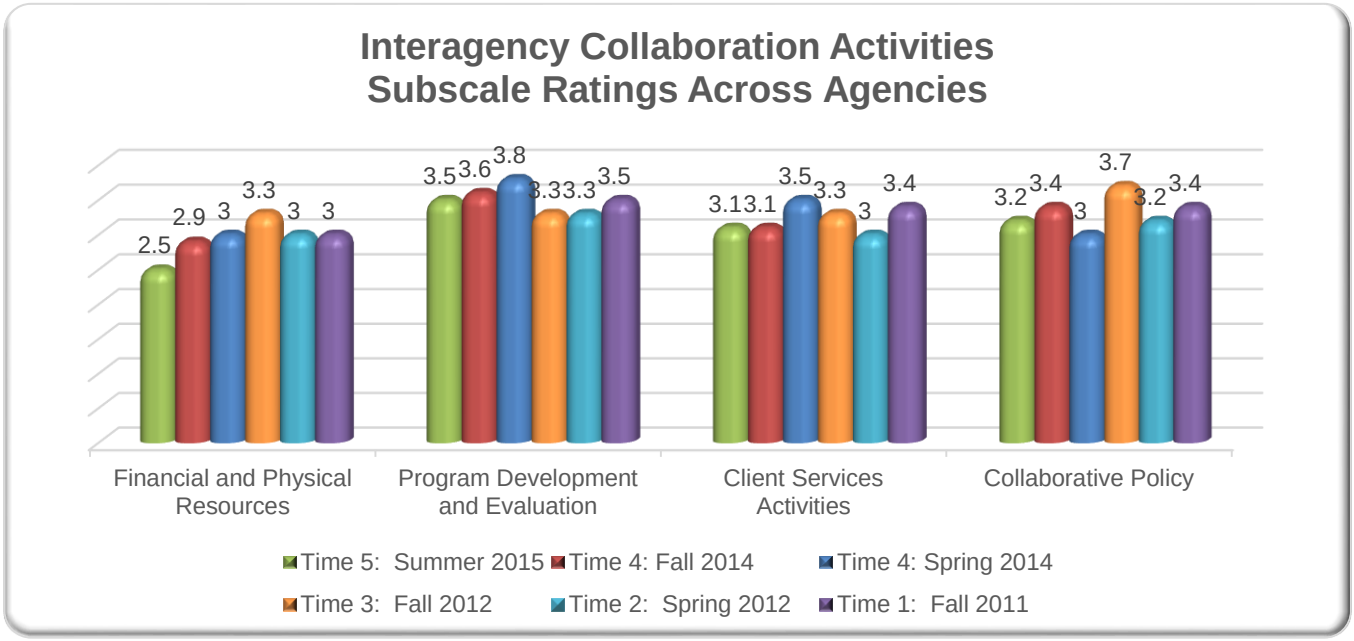
Five-point Scale: **1**=Not at all, **2**=Little, **3**=Somewhat, **4**=Considerable, **5**=Very much

The consistently lower ratings shown within the *Financial & Physical Resources* and *Collaborative Policy* subscales over time suggest that the collaborative process in these areas is challenging. Results indicate that collaboration within the subscales of *Client Services Activities* and *Program Development & Evaluation* are progressive and well-coordinated. It is notable that changes between Year 3 and 4, which—although not directly comparable—show large increases in *Program Development & Evaluation* and *Client Services*. This increase reflects the program focus on these activities within the new PMT and suggests that the creation of the smaller subgroup is achieving desired outcomes.

During Year 5, a comparison was conducted to examine differences between the perceptions of the group members throughout the 5 year period. Results are presented in Figure 11. It is noted that as the group changes over time results are not directly comparable. However, trends can be examined.

Figure 11. Interagency Collaboration Activities Scale: Ratings on Subscales: Years 1-5

Average Rating Based on Scale from 1-5



Results indicate that although the original 12 members of the New Britain Health and Wellness PMT are maintaining moderate levels of collaboration among specific activities, the changes in group membership and structure over the past year and a half are creating challenges to collaboration. It is anticipated that the current Health and Wellness Strategy Group will continue to provide networking and collaboration oversite during the upcoming years. As the group solidifies and coalesces, it is expected that the Strategy Group will advance towards higher-level coordination over time.

The focus group discussion held with PMT members during spring of Year 4 revealed a high level of interest in exploring the degree of collaboration between and among PMT members. The results of the initial collaboration survey administered to the PMT were discussed with team members during September 2014. For the majority of the participants, that meeting was the first meeting at which they had observed or discussed the survey. As such, the predominant reactions were a high degree of interest in understanding how the tool measured collaboration and how the results of the survey administration could support the group in their efforts to move forward. Members expressed interest in understanding the actual activities involved in higher-level coordination in terms of shared decision- making, shared resources, and policy development beyond simply attending meetings together. Participants discussed setting benchmarks for measuring collaboration activities and capturing collaboration through other evaluation methods.

The group was interested in administering both the Collaboration tool and the PARTNER Tool during fall 2014 and spring 2015 to serve as a pre-post assessment of progress made during their first full year of implementation as the new Health and Wellness PMT. Based on this feedback, Promising Starts evaluators collected data using both tools during fall 2014 and spring 2015.

However, as a result of a data-collection issue inherent in the Partner Tool, data from the Partner tool was lost in Fall 2014 and use of the Partner Tool was not continued.

The PARTNER Tool (Program to Analyze, Record, and Track Networks to Enhance Relationships, see Appendix D) was used initially during 2013 to provide tracking of relationships between members of leadership networks through social network analysis, including the direction, strength and focus of those relationships (University of Colorado 2012). Results of the PARTNER Tool at that time (presented in Appendix O) indicated that all Coalition members were connected to multiple partnering agencies, although the strength/density of these connections was low. Project LAUNCH/Wheeler Clinic, DCF, and HRA share the role of centralized figures (Appendix O, *Figure 1*), with LAUNCH playing a primary role in facilitation/leadership (Appendix O, *Figure 2*). At that time, all Coalition agencies interacted with at least one other member agency more frequently than the quarterly meetings, with most indicating weekly interaction (Appendix O, *Figure 3*) and levels of trust were high (Appendix O, *Table 1*). Additional service-related outcomes addressed by survey participants (see Appendix O, Table 2) indicated that the Council was ready to improve services, resource sharing, communication, and information sharing across the New Britain provider community and that the most important outcomes to date were improved services and outcomes among the targeted child and family population. Ratings of current success of the Council reaching its goals as of Year 3 indicated moderate success, which was attributed largely to bringing together diverse stakeholders and exchanging knowledge and information.

It is again noted that, as the Coalition was restructured to create the Health and Wellness PMT and then the Health and Wellness Strategy Group, the results from earlier administrations were not expected to be comparable to the results of Year 5 administration of the PARTNER Tool to the Health and Wellness PMT. It is noted that the commitment and dedication of the PMT to assessment of collaboration is extremely high as shown by the interest to participate in both assessments twice during the final project year.

<u>No-Cost Extension, Year 6</u>:

During March, 2016 a focus group was held with twenty individuals who had been involved with Project LAUNCH since inception. Attendees included providers, clinicians, administrators and representatives from partner organizations. Questions were designed to elicit perceptions of project success, project impact on the community, and satisfaction with the infrastructure developed and expanded during project implementation.

Overall, participants expressed a high degree of satisfaction with the implementation and outcomes of Project LAUNCH. The degree to which infrastructure for the provision of services to children was developed, expanded and strengthened during the six years of implementation was enthusiastically described as extremely successful. In the words of one individual. *"I think we are a poster child for the way it has been developed actually! We are one of the few communities that Graustein is now taking out of its early childhood initiatives as we are focusing and developing collaborative support work on our own."*

Project strengths were identified as the existence of a full-time Project Director and the existence of a relatively strong network of agencies prior to project implementation which provided a strong

foundation, and direction, for implementation. Project LAUNCH, and SAMHSA, were described as providing the necessary structure, resources and flexibility of implementation requirements for the project to grow and thrive in a way that met the needs of the community.

Respondents identified the many changes in structure of the coalition and leadership team which occurred during project implementation as critical to allow the collaboration and coalitions to coalesce and strengthen. The networking and partnership ability of organizations within the community were described as stronger and more intact as a result of Project LAUNCH while the shift in community focus from birth to five to birth through Age 24 which occurred through LAUNCH was described as much stronger and appropriate to address the needs of children within the community. The current strength of the coalition was described by one participant as epitomized by, "*Our community coalition health and wellness strategy group now has 35 people on it! And that is just one subgroup!"*

The ability of the community to provide services to children and families was described as much improved as a result of Project LAUNCH. The improvement was attributed to the use of quality indicators to drive topic areas and by strong communication across subgroups that did not exist prior to Project LAUNCH. Respondents described a high degree of communication between pre-school projects, parents and the school system which resulted in the distribution of information to parents regarding brain development that had not previously been distributed and a new emphasis across systems on decreasing chronic absenteeism in the school system, many of which occur as a result of behavioral health issues. The ability of individuals to connect and jointly address these issues was described as resulting from the strong networking and coalition building experienced through LAUNCH.

The need for data and the use of evaluation required by Project LAUNCH and emphasized by Wheeler Clinic was described as "*getting people to the table*" and getting the community to understand and to focus on the use of data. The use of data by and within the community was described as greatly strengthened by Project LAUNCH and as critical to the ongoing ability of the coalition to address the needs of New Britain's children. Respondents described a much greater community awareness of and discussion of the role of quality in service provision which culminated in the adoption of quality standards by the city of New Britain and the adoption of a norm-referred tool to evaluation school programs called the APT tool. These structural changes were attributed to the success of Project LAUNCH and as integral to the ongoing ability of the community to meet the needs of children and families.

Project LAUNCH was also described as providing invaluable resources and information for the provider community across all settings which has allowed, and will continue to allow, providers to more appropriately address the needs of families and children. In the words of one respondent, *"I think many brains have been changed through Project LAUNCH. The training has made more people think about young children in a different way. Because of that, once you understand what infant and child development really is, you begin to look at solutions differently. That is one of the things that has happened.* "

Additionally, the project's ability to bring Child First into the community to serve children and families was described as meeting a critical need. Child First was described by all individuals as

highly needed and highly successful and, as a result of project success, ongoing funding for Child First within the community will be provided by Connecticut's Department of Children and Families.

Participants described the primary weakness of the development of infrastructure throughout the community as the limited success of the project at engaging pediatricians in project activities. Participants described the loss of two pediatricians by the community over the project period resulting in extremely long wait lists for services and the need for families to travel to other communities to receive services.

Child First Home Visiting

Program Outcomes. The Wheeler Clinic Child First team was initiated in June 2011 and included two full-time clinicians, two full-time care coordinators, and the Promising Starts coordinator who served as a part-time clinical supervisor and also provided direct clinical service to families. This team completed initial training with model developers in August 2011 and began serving families in September 2011 (the end of Year 1) with the capacity to serve 16 families. In May 2012 (Year 2), the team joined the Child First Cohort 2 Learning Community with 3 other Connecticut Child First teams for additional training that allowed the team to increase their capacity to serve 22 families. In July 2012, the team added a part-time Wheeler Clinic postdoctoral trainee, who is an Early Childhood Specialist, to provide direct clinical services to families, which increased their service capacity to 24 families. During 2015, Wheeler Clinic was expecting to add one additional Child First Team. Unfortunately, as a result of budget cuts on a statewide level, Wheeler Clinic was unable to achieve this goal. During Year 5, one clinician left the program resulting in a team of 6 staff certified to deliver the program.

Child First developers completed the incorporation process in 2013 (Year 3 of Promising Starts) to distinguish the model as an independent entity. The process included rebranding of the Child First name and logo, accreditation of local sites, expansion of the model's activities and quality assurance processes, and replication to additional sites in Connecticut and nationally. The replication included local expansion to a new Wheeler Clinic Child First team in Bristol, Connecticut, under the supervision of the Promising Starts Program Coordinator. This new team is supported by MIECHV funds and is not included in the Promising Starts evaluation. Proposed enhancements to the Promising Starts evaluation to include a quasi-experimental study of Child First family outcomes in Year 3, as indicated in the previous evaluation plan, was determined by the developers to not be feasible; therefore, modifications to the Promising Starts evaluation plan were not pursued. During 2014, one additional clinician was hired and trained to provide services in Child First, further expanding service provision capacity. During 2015 and most of 2016 two Child First Teams (6 clinicians) provided services. During 2016 (the no-cost extension year) one individual was transferred out of Child First to another location at Wheeler Clinic resulting in the temporary loss of one half time clinician. This individual was replaced resulting in a rapid reimplementation of service provision.

During Fall 2015 it is noted that the Wheeler Clinic site received full accreditation from Child First. Child First noted that their baseline completion rates were low and, as a result, Wheeler Clinic implemented a quality improvement plan including quarterly reviews of data completion

and a rigid timeline for data entry.

Despite programmatic changes, fidelity assessments continue to reflect strong fidelity to the model among Wheeler Clinic Child First providers in Promising Starts. Through April 2013, fidelity checklists were submitted monthly to the Child First quality improvement coordinator and shared with team members. New Britain results were also provided directly to evaluators of Promising Starts. In April 2013, a new process for tracking fidelity was introduced by Child First developers, whereby individual and program level fidelity checklists were collected by the team supervisor and processed in reflective supervision. Given that Child First's clinical supervisor is also the Promising Starts' program coordinator for New Britain, those results are processed internally at both the individual and systems level. Moving forward in Year 4, these results were tracked qualitatively through the coordinator and a revised data-sharing agreement was developed with the Child First developers as the quality improvement contract with CHDI ended in December 2013. To date, results indicate that Promising Starts' Child First providers consistently report feeling "very" to "extremely skilled [in]/comfortable [with]" implementing the model, showing significant improvements made in Care Coordination (see Appendix P). No additional data was available during Years 4 or 5 due to the ending of the contract with CHDI.

Service counts and demographic data are collected, analyzed, and reported regularly for GPRA/TRAC and Multi-Site Evaluation (MSE) requirements. The data indicate that a total of 205 children received Child First's home-visiting-intervention services to date: Children enrolled in the program's intervention service (see Figure 12) during Year 1 (2 children), Year 2 (34 children), Year 3 (35 children), Year 4 (54 children), Year 5 (66 children) and Year 6 (34 children) were all screened for developmental and behavioral delays (see Figure 13); therefore, the program has exceeded the benchmark for the five-year grant period. It should be noted that the figure screened (total 240) is above the figure of enrolled children (total 205) due to the screening of non-enrolled children in participating families. In addition to the provision of service counts, demographic information was provided from MSE, which reveal a unilateral population of children and families: According to MSE data, demographic characteristics, which was collected on 34 of the 54 sampled children, indicate that most of the children served in Year 4 were of the racial and ethnic minority population (82.4%), representing males (52.9%) and females (47.1%) who reside in a single-parent household (55.9%) that receives government assistance (87.9%). Similar results were obtained in Year 5 and were provided to LAUNCH via the MSE.

Figure 12. Number of Children Receiving Intervention Services from Child First

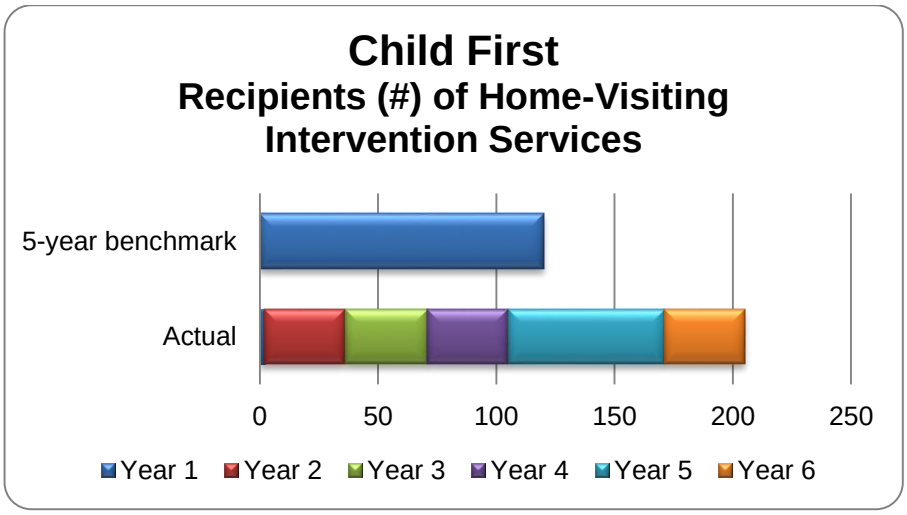
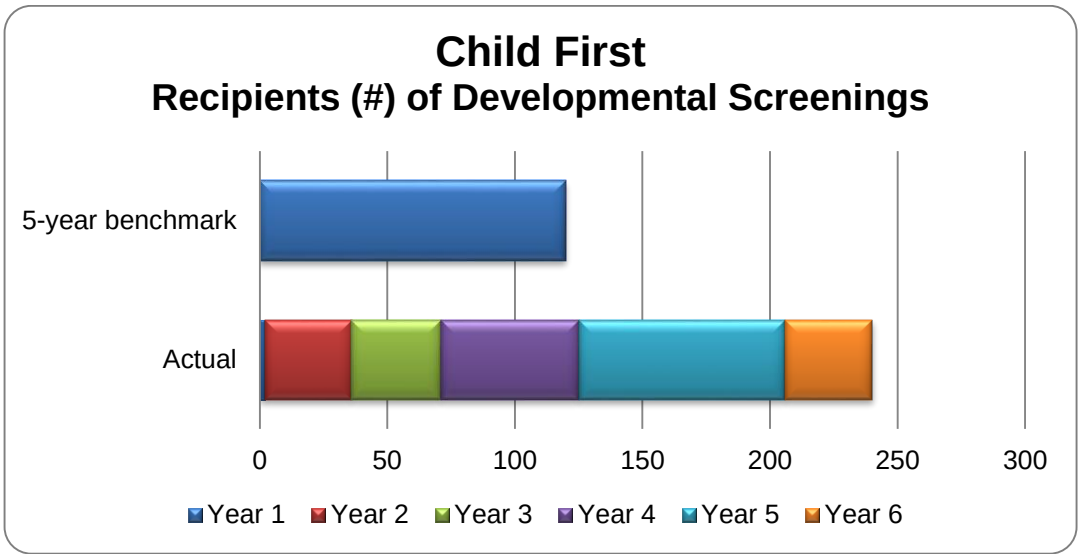


Figure 13. Developmental Screenings through Child First



Provider Outcomes. A total of 6 Wheeler staff members were trained in the Child First model across Years 1 and 2. One additional staff member was trained during Year 4 to provide a total of 7 trained staff. However, one individual was lost during Year 5 returning staff count to 6. The staff continues to receive follow-up training annually and are actively engaged in providing Child First services, exceeding the benchmark of 5 staff for the grant period.

A semi-annual focus group was conducted in May 2013 with six Child First staff from Wheeler Clinic, including four clinicians and two care coordinators. Focus group participants reported a generally high level of satisfaction with service implementation and described a number of

strengths and challenges.

One follow-up focus groups was conducted for Year 5 in October 2015 with 6 Child FIRST staff from Wheeler Clinic, including five clinicians and one care coordinator. Focus group participants reported a high level of satisfaction with service implementation and described a number of strengths and challenges (see Table 4).

Table 4. Child First Focus Group Results Fall, 2014 (Year 5)

Strengths	Outcomes	Challenges	Outcomes
Voluntary program allows self-referrals	Attracts parents with interest and experience in working with home-based services	Time line for treatment	Difficulty engaging families because of "chaos," degree of trauma, and trust factors in the home
Team-based	Supports flexibility among staff and allows staff to attend skill-development trainings	No challenges were described	No outcomes were reported impacted
Reflective supervision	Supports staff decision-making, implementation, and encourages openness and trust	Reflective supervision	Extensive time required. However, continued description as "extremely important"
Learning Collaborative model	Provides opportunities for advanced training	Balancing staff time requirements	Actual clinical work, trainings, and reflective supervision are all needed but create stress
Integration of trauma-informed parent psychotherapy training	Better addresses the needs of families served	Lack of training in substance abuse and child sexual abuse	Difficulty providing necessary clinical care for some family members
Consistent access to CF consultant	Professional access supports clinical outcomes	Assessment tools needed in other languages	Difficulty in not being able to provide needed services to some family members

Strengths of Child FIRST continue to be identified as the voluntary nature of the program which is perceived to allow parents to self-refer and to therefore result in the participation of families interested in working together; the ongoing opportunities provided to support providers to obtain and maintain needed skills; participation in the learning collaborative; the integration of trauma-informed child-parent psychotherapy trainings; consistent access to a Child FIRST consultant for the duration of the program; the emphasis of ongoing reflective supervision for clinicians and care coordinators in both group and individual sessions; and the use of clinician-care coordinator teams which support flexibility in services for families. **Challenges** are described as the length of time needed to address the needs of families effectively, typically longer than the suggested 6-12 months because of "chaos," degree of trauma, and trust factors in the home; the absence of training for providers in supporting families dealing with substance abuse, working with children who have been through sexual abuse or working with families from generational poverty situations; a lack of assessment tools for families who do not speak English and a lack of practical suggestions for self-care in the trainings. Additionally, the need for providers to balance time

requirements across work, trainings, and reflective supervision related to Child First program continues to be challenging.

Participants described a number of changes which have occurred throughout the Child FIRST implementation process. **Modifications to the model** include revisions to assessments to improve usability and cultural success for individuals speaking languages other than English; incorporation of the Circle of Security curricula into the model; adjustments to Child First recommendations for hiring clinical staff which have resulted in 100% staff retention; and expansion of the locations where families are met by providers. **Changes in work practices** were described as incorporation of newly learned skills from Child First trainings directly into practice with families and other work situations; an increase in the confidence of Child FIRST care coordinators in working with trauma-related issues; and increased trust among Child First team members. C**hanges in work settings** were incorporated last year and continue currently. These changes include the availability of an office with a door within the Head Start program to support privacy; an increase in provision of transportation for families; and the use of private spaces in local libraries to meet with families as needed.

Focus group participants discussed the possible incorporation of the Healthy Mothers-Healthy Babies, self-empowerment curricula for women, into the Child First Program. Participants stated this program could be an appropriate strategy to use to increase mothers' ownership for their health. It is noted that focus group responses and program descriptions from year to year have been extremely consistent. This consistency illustrates the degree to which the program has been continually implemented with fidelity and the high degree sense of satisfaction and support which the program receives from providers.

Outcomes for Children and Families. Available child and family outcome data were initially limited as the typical length of treatment is 6-12 months and only 18 families had successfully completed the intervention and discharged from the program as of the end of Year 3. An outcome summary report for all 18 families (including the 4 families who discharged in Year 2) prepared by the Child First evaluation team is presented in Appendix Q. Baseline data problem rates range from 21-87% indicating the percentage of those assessed meeting the problem rate for intervention (Appendix Q), consistent with qualitative reports by staff who describe the service population as having "very high level needs" with respect to child and family services. Comparisons of baseline and discharge data reported by Child First evaluators indicate significant improvements on two measures—the Center for Epidemiologic Study-Depression (CESD) and the Caregiver-Child Interaction Scale (CCIS). Improvements on the CESD indicate reduced self-reported symptoms of caregiver depression and reduced CCIS scores indicate that caregivers exhibit better quality relationships and interactions with their child as observed by the Child First team (see Appendix Q).

In Year 2, Child First developers introduced bi-annual follow-up measures to track client progress between baseline and discharge to facilitate additional data collection and analysis in future reporting periods; however, limited availability of outcome data continued to be a challenge through Years 3 and 4. As reported in provider focus group data, some families did not fully complete the required evaluation measures during the termination process, due to perceived resentment towards the termination process and other factors. In addition to limited availability of data, receiving comprehensive data reports in a timely manner has been an ongoing challenge for

Promising Starts evaluators. Additional attempts to streamline the data sharing process between the local Child First team, Child First evaluators and quality improvement coordinator, the Child First clinical supervisor, and Promising Starts evaluators were pursued in Year 4. Evaluators met with the Child First supervisor/Promising Starts coordinator early in 2014 to establish agreement on a clear data reporting schedule and timeline, which shall improve data collection efficiency in future reporting periods. This meeting was helpful in facilitating data collection but increases in the efficiency of data collection are still needed.

Detailed outcome data was obtained for New Britain children discharged from Child throughout the five year period of the grant and including the no-cost extension year. Results are summarized in Table 5.

Table 5. Child First Child Outcome Data Years 1-5 including No-Cost Extension Year

	All Cases					Cases Within Baseline Positive				
measure	**N**	**Baseline Mean**	**Post Mean**	**P value**	**Cohen D**	**N**	**Baseline Mean**	**Post Mean**	**P value**	**Cohen D**
ASQ Communication	35	-0.83	-0.90	Not Significant	0.05	10	-2.39	-2.24	Not Significant	0.11
ASQ SE	4	76.25	38.75	Not Significant	1.13	4	76.25	38.75	Not Significant	1.13
CCIS	32	60.97	48.47	P<.01	0.65	28	65.11	51.39	P<.01	0.78
CESD	44	23.93	18.11	P<.01	0.42	31	30.48	22.52	P<.01	0.64
Child Problem Behavior	26	1.95	1.05	P<.01	0.62	19	2.72	1.26	P<.01	1.15
Child Social Skills	28	-1.10	-0.41	P<.01	0.53	17	-1.97	-0.99	P<.01	1.03
HOPE	34	10.00	10.00	Not Significant	0.00				P<.01	
PSI-3	25	89.08	79.40	Not Significant	0.33	11	116.55	94.00	P<.01	0.91
PSI-4	26	100.12	84.62	P<.01	0.58	11	127.18	99.45	P<.01	1.44
PSSI	18	19.11	13.28	Not Significant	0.37	9	32.56	20.78	Not Significant	0.75

Statistical comparisons of pre-post differences were conducted for all measures in which the number of pre-post pairs was five or more using a paired t-test and Cohen d. The results of the analysis of all cases are presented in conjunction with the analysis of cases in which an initial concern was identified (Cases Within Baseline Positive).

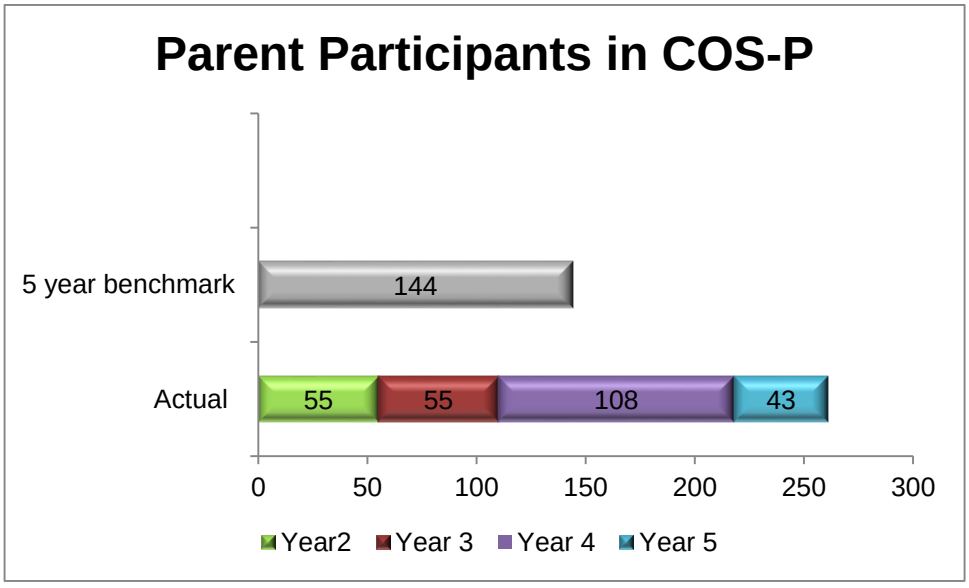
It is important to note that the most appropriate measure to use for assessing pre-post change is to assess differences for which cases are within baseline positive as these cases are cases in which a concern was initially identified. For these cases in which a concern was initially identified, significant improvement was observed for all measures assessed.

When all cases were examined, it is noted that fewer significant differences were observed. This is expected as examination of all cases includes assessment of pre-post differences in areas in which there was no concern identified.

Circle of Security Parenting (COS-P) Family Strengthening

Program Outcomes. As indicated in the previous reporting periods, training was conducted in Year 1 to provide an overview of the Circle of Security Parenting model. A total of 74 participants attended this training, including 15 providers from New Britain who received additional training as a COS-P facilitator, of which 9 were from Wheeler Clinic. An additional ten New Britain providers were trained as COS-P facilitators in Year 3 (see Appendix R for training benchmarks). Facilitators began offering COS-P groups to 55 families in Year 2, 55 parents/caregivers participated across the 5 COS-P groups in Year 3, and 108 parents/ caregivers participated in COS-P groups held during Year 4 (see Figure 14). Also in Year 3, providers expanded participation in Circle of Security to parents participating in home visiting programs so that services could be provided in the home, outside of a group setting. Evaluation data is not consistently collected for home-based COS participants; however it is estimated that at least 20 families participated in these services as provided by multiple New Britain trained facilitators. In Year 4, demographic information was provided for 65 of the 108 caregivers participating in COS-P groups facilitated by Wheeler Clinic. Data show that many participants had a child born to a teenage mother (35.4%) and were participating in at least one government assistance program (87.7%). Additional demographics are presented in the Multi-Site Evaluation report. During Year 5, an additional 43 parents and caretakers participated in COS-P. Summary data is shown in Figure 14.

Figure 14. Parent Participants in COS-P Program



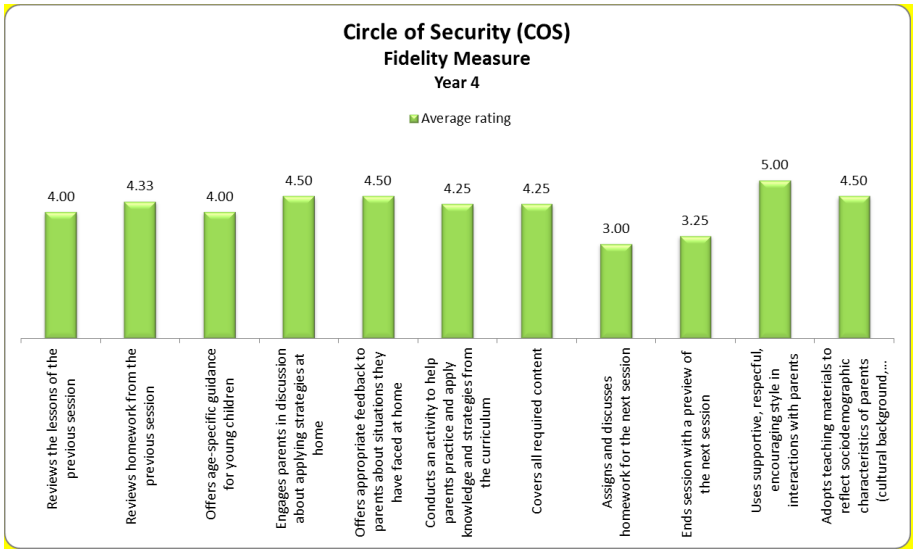
A Facilitator Feedback Form was developed by the Promising Starts' Coordinator for co-facilitators to track the number of sessions offered during each group, the total number of

participants attending all or half of sessions, logistical information about the groups such as whether childcare or food were provided, and any barriers and facilitators to group facilitation (see Appendix S). Facilitators from 3 of the 4 groups in Year 2 completed the form and results indicate that the average number of sessions per group was 6 and all groups provided childcare and food. A total of 28 caregivers attended at least one group session, 78.57% of those attended at least half of the sessions, and 53.57% successfully completed all sessions in their group. Data from one group was available for Year 3, due to incompletion by group facilitators and/or failure to submit data to Promising Starts evaluators upon request. Results indicate that the group met for a total of 6 sessions, had 15 parents participating at least once, with 5 parents completing the program. A total of 28 children were impacted by participants in this group, which did offer childcare, but not meals. To address the poor data completion by facilitators and ensure ongoing and positive program implementation and positive communication, during Years 4 and 5 the use of the facilitator feedback form was incorporated into reflective supervision and discussed in an ongoing manner. No additional data was available to evaluators.

A Circle of Security (COS) Fidelity Measure, which was developed by New York City Project LAUNCH evaluators, was implemented in October 2014 (Year 4) to track fidelity to the COS attachment-based intervention model (COS-P) among trained providers (N = 10). The measure has eleven (11) self-report items that are rated on a five-point scale (see Appendix T). The results are based on four, surveyed responses and during Year 4, continue to indicate that facilitators had both *moderately* and *strongly* maintained fidelity to the intervention model while practicing the specific, itemized activities related to group facilitation (see Figure 15). To review the COS Fidelity results for Year 3, please refer to Appendix Y. Results from Year 4 are provided below. During Year 5, the COS Fidelity Survey was not administered and fidelity assessment was incorporated into the supervision process.

Figure 15. Circle of Security (COS) Fidelity Measure: Year 4

Average Rating Based on Scale from 1-5



Results indicate that COS is being implemented with fidelity.

Provider Outcomes. Previous evaluation reports provide pre and post-test training data collected on COS-P trained providers and facilitators, offering an assessment of changes in knowledge and attitudes towards evidence-based practices and changes in experiences subsequent to the implementation of COS-P protocols within group settings. Additional data was collected from a follow-up survey that was disseminated to ten (10) COS-P facilitators in Year 4. The demographic statistics of trained providers in Years 4 and 5 (see Appendix U) are similar to those in Years 2 and 3, indicating that most providers are from Wheeler Clinic (60% in Year 4 and 100% in Year 5) and have worked in child-related professions within the New Britain community for a significant length of time, average number of years (7.3 in Year 4 and 7.2 in Year 5). Demographic statistics also reveal that providers represent a bilingual (60% in Year 4 and 57% in Year 5) and racially and ethnically diverse population with a mean age of 38 years in 2005. (Comprehensive results of pre and post-assessments for Years 1-4 can be viewed in Appendix V.)

Moreover, data from the pre and post-assessments have been consistent over time and show that providers increased in knowledge and gained experience in key early childhood competencies after exposure to COS-P training and practices (Appendix V, *Figure 1*). Responses to the Evidence-Based Practice Attitudes Scales (EBPAS) indicate that attitudes are both positive and generally consistent toward *evidence-based practices* (EBPs) (Appendix V, *Figure 2*) and the *willingness to adopt new EBPs* (Appendix V, *Figure 3*) such as the *COS-P model* (Appendix V, *Figure 4*). Furthermore, providers reported positive results that are consistent with previous years; however, results indicate growth in the utilization of both *mental or behavioral health consultation* services and *behavioral health screening* tools over time (Appendix V, *Figure 5*).

A focus group was conducted in Year 2 with 11 COS-P group facilitators in New Britain, who reported the following strengths and challenges to implementation. **Strengths** included positive engagement of parents—particularly fathers, offering make-up sessions to allow for increased completion rates for parents, and providing child care during sessions, which increased attendance and in some instances facilitated group learning by example. **Challenges** included fostering engagement of parents referred by DCF and maintaining parents' privacy when coordinating with DCF staff; adapting content for participants with cognitive limitations and incorporating them into discussions; covering multiple chapters in one session; delayed completion and reporting of enrollment and demographic data by group facilitators; and limited completion of pre-post surveys by participants.

A follow-up focus group was conducted in July 2013 with 12 COS-P group facilitators, including five facilitators newly trained in Year 3. All participants again reported overwhelmingly positive feedback about the COS-P service and their personal experiences as facilitators of the program. As one provider stated, "I'm ready to quit my job to do this full time." Eight of these facilitators indicated that they provide COS-P with individual families in a home or office-based setting, as an alternative to the group format. **Strengths** of the program included the ability to provide a common language to use with parents to discuss the importance of relationships and attachment and to help parents become more reflective; enhancement of parent-support skills and relation-based practice in the work settings and personal lives of providers; increased confidence among providers regarding effectiveness of interventions, particularly with complex families; and

increased providers' tools to assist families dealing with trauma. In addition, participants reported that enhanced success rates with families participating in COS-P has enhanced the work of other Promising Starts services (particularly Child First) and the increased morale among staff has led to a more supportive, nurturing, and cohesive work setting that incorporates the principles of COS-P in day-to-day staff relationships and interactions. **Challenges** included scheduling make-up sessions for cancelled classes or families who miss multiple sessions; the need to separate foster parents from families with active DCF involvement whose children may be removed from the home; managing negative communication patterns between couples receiving COS-P services in the home; and the lack of any trained male facilitators in the New Britain community.

Focus group participants discussed several strategies for enhancing and sustaining COS-P across New Britain, through activities such as seeking funding for 1-2 full-time home visitors to provide COS-P, particularly for DCF-involved families; developing COS-P graduates as parent facilitators of parent support groups; and recruiting male COS-P facilitators to offer groups specifically for fathers.

A subsequent follow-up focus group was conducted for Year 4 in April 2014 with 10 COS-P facilitators and for Year 5 in March 2015 with 9 COS-P group facilitators. Participants again reported very positive feedback about the COS-P program with one provider stating, "*It's a beautiful fit for the work we're doing in New Britain. Parents are not going to argue about working together to be a better parent*." Additionally, providers continue to emphasize the importance of COS activities and training on their personal and professional success. In the words of one provider, "*I can take everything I have learned through the program to work with families and apply it to my own life, my own families, and families I work with in all aspects of my work It really just applies to everything*."

Reported **strengths** of the program were many and continue to include the flexibility of using COS-P in group settings as well as with individual families in home visits. Participants stated that the use of home visits has been especially effective with families who continue with the Child First home visiting program since follow-up on COS-P can be conducted. Additional reported strengths include the ability of the COS-P to create a safe environment; quality visuals, DVDs, and short clips in the curricula; the use of straight forward concepts such as "the Circle" and "Shark Music," which serve to provide a common language for parents and caregivers. Participants stated that the use of COS-P in a group setting is helpful for parents who find it comforting to realize that other families are struggling with the same issues. Respondents emphasized that as parents learn about the importance of their relationship and attachment to their child their reflective capacity increases. Respondents unanimously stated that COS-P has enhanced the other Promising Starts program such as Child First. **Challenges** identified by participants included difficulties using the program with non-English speaking parents, especially those who speak Polish; transportation difficulties for parents due to lack of transportation and intermittent bus service in New Britain; a continued need to separate intact families from foster families and families with active DCF involvement within group settings; and a need to identify opportunities for constructive involvement for families after the program ends.

The primary **modification to the COS-P model** continues to be a change in number of weeks of the group from 8 weeks to 6 weeks. The facilitators stated that chapters are combined to support

the shorter time span. Another adaptation was described as being created for use in the home with families who do not have English as their first language. In these homes, translation of the program occurs simultaneously through the involvement of an English speaking family member.

Focus group attendees discussed potential strategies to sustain COS-P. These strategies included the identification of clinicians who could be trainers of the model and also provide supervision, development of activities to reach out to outpatient facilities to incorporate COS-P into ongoing support group programming, use of additional pre/post data and an appropriate assessment tool to look at parent reflective capacity, and the collection and summary of success stories. Participants emphasized that if success stories can be told by the parents themselves sustainability would be greatly enhanced Additionally, participants emphasized the role of Connecticut as a state and other programs throughout Connecticut in sustaining COS-P. Participants described a large number of activities and efforts throughout Connecticut as occurring in an effort to sustain COS-P as well as interactions with New York City LAUNCH which is also working to sustain COS-P. Through these various activities and efforts, COS-P training is occurring throughout Connecticut and the program is expected to continue to expand throughout the state.

A number of **positive family outcomes** were described by the focus group participants. One participant explained to the care provider that "*I didn't know how to be a parent until I looked at this road map for how to be emotionally available for my child and how to read my child's emotional cues."* A number of providers described parents as connecting current parenting struggles with their childhood experiences and emphasizing the importance of having made that connection to increased comfort with the parenting process.

Outcomes for Children and Families. In Year 2, outcome data was collected only for families participating in the COS-P group facilitated by Wheeler Clinic as a part of the Promising Starts Initiative. While facilitators from other agencies had agreed to participate in outcome data collection in Year 3, limited outcome data was available for this period as the evaluation procedures were enhanced.

A total of 14 caregivers from the October 2012 group facilitated by Wheeler Clinic completed the Parenting Stress Index (PSI) at the beginning and end of the COS-P group. The 36-item PSI Short Form includes three subscales: Parental Distress (PD), Parent-Child Dysfunctional Interaction (PDI), and Difficult Child (DC), in addition to the Total Stress Score. Results from Year 3 show consistent patterns with results from Year 2; however differences were significant in Year 3 and not in Year 2 (see Appendix W). Specifically, parents reported *higher* ratings of distress on the Difficult Child Characteristics and Parent-Child Dysfunctional Interactions subscales at the end of the program compared to baseline. Overall, parents in Year 3 presented with lower parental stress upon entering the COS-P program compared to Year 2. These results may be explained by several factors. First, the small sample size limits reliability of results. In addition, those participants who completed the full six sessions and evaluation measures may not accurately reflect positive changes experienced by other participants who did not complete the group. For example additional participants completed at least half of the sessions, but may not have completed the final session and data collection due to significantly improved parental experience. Moreover, parents new to a program may underreport baseline distress, while parents who do complete the program may learn to better assess their own levels of distress and report more accurate ratings at the end of the

program, which would account for higher post-test ratings. Alternatively, the PSI subscales may not accurately capture subtle changes in parenting stress and parental experiences attributed to the brief COS-P intervention, which may be better captured by individual items or qualitative data. For these reasons, coupled with feedback from providers that the PSI content and results were not useful for assessing progress, the PSI was discontinued as a screening measure in April 2013 within the COS-P service. However, the Parent Feedback Questionnaire continues to be used to gain additional data from parents regarding their experience in COS-P.

The Parent Feedback Questionnaire (see Appendix I) was administered to parents/caregivers (*N* = 14) who participated in the COS-P program facilitated by Wheeler Clinic. The questionnaire included open and closed-ended questions that solicited ratings from participants on the program's effectiveness (see Appendix X). Overall, participants rated COS-P as an "excellent" intervention model (see Figure 16), and approximately 92% indicated that they would recommend the program to others. All (100%) participants learned new parenting skills through the COS-P protocol and almost all (92%) reported an increased ability to view and respond to their child's challenging behaviors. Eighty five percent reported that their child's behavior was "much better" and nearly 93% indicated that their stress levels had been reduced as the result of successfully implementing COS-P intervention strategies, reporting positive endorsements.

Additionally, each year the percentage of parents reporting an increase in skills as a result of COS-P increased until by Year 5, 100% of parents reported an increase in skills (Figure 16a).

Figure 16. COS-P Parent Satisfaction

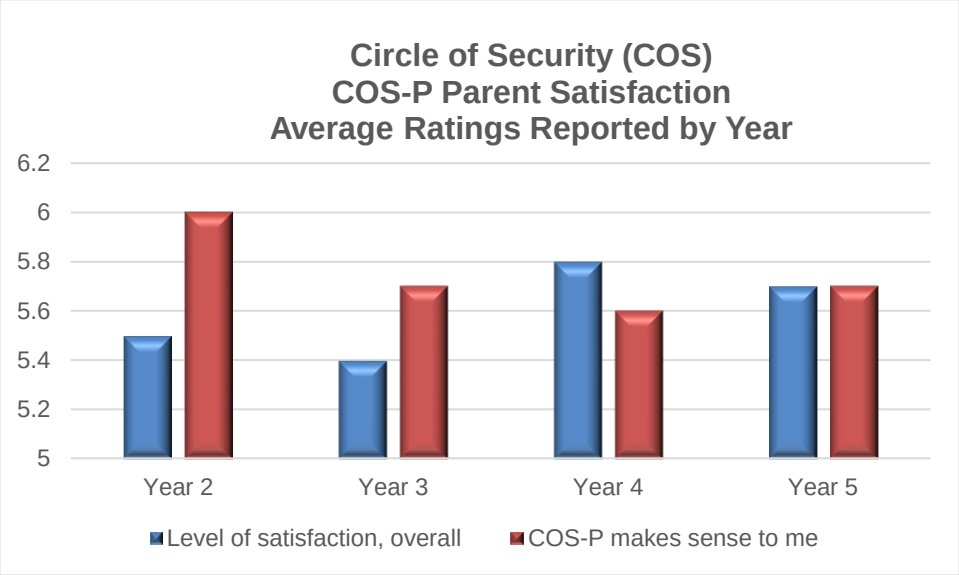
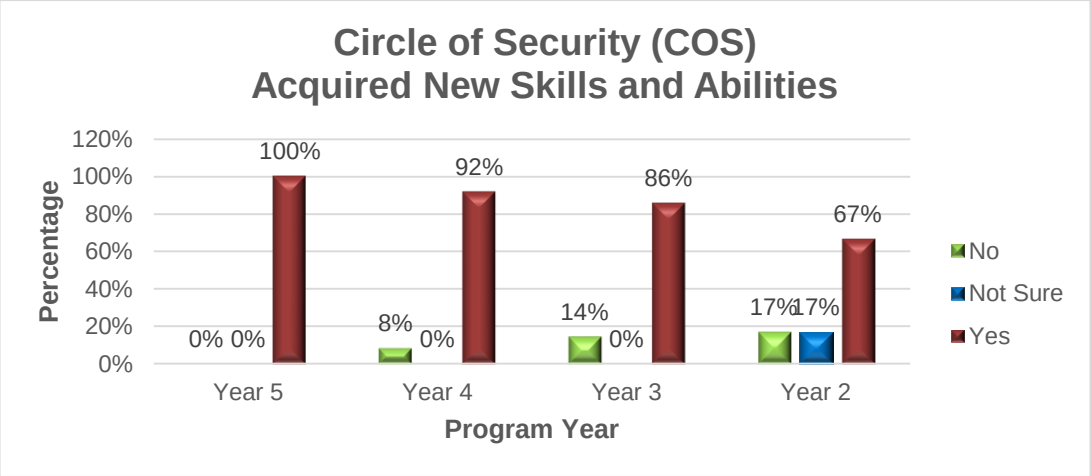


Figure 16a. COS-P Parent Acquired Skills and Abilities



Mental Health in Primary Care (Behavioral Health and Developmental Assessment)

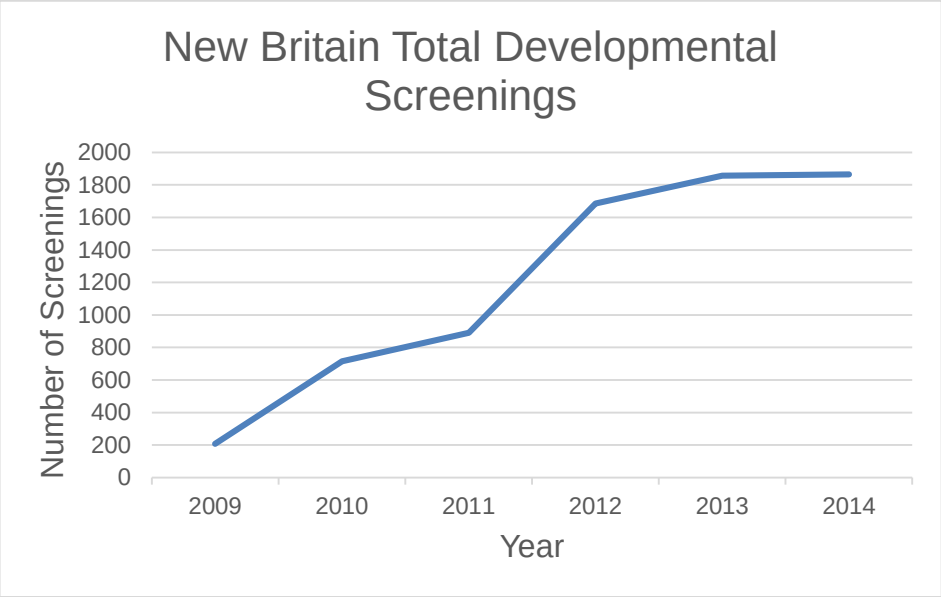
Systems Outcomes: In Year 1, Promising Starts provided training on the Ages & Stages Developmental Screening protocol (ASQ-3) to 47 providers across 9 child and family-serving agencies in New Britain. As reported in Year 1, Promising Starts planned to partner with CHDI to promote the EPIC (Educating Practices in their Communities) training modules, which provide education and guidance to providers in implementing developmental screening and assessment, as a way to address barriers to buy-in and participation of primary care providers. As described in an earlier section, the EPIC presentation occurred during the March 2012 meeting of the New Britain Health and Wellness Council, attended by one primary care provider and 10 other participants. Although attendance of primary care providers was low, providers of other participating agencies expressed interest in hosting EPIC presentations on-site, to expand the impact of the ASQ screening efforts in the New Britain community. Engagement of primary care providers in Promising Starts activities remained low in Year 3 and efforts to engage them in focus groups or interviews were unsuccessful due to limited access to providers.

A total of 113 community providers in New Britain were trained on the ASQ-3 through three separate trainings in Year 2, representing child welfare staff, early care and education center staff, family service workers, and staff from a primary care agency. During Year 4, an additional 38 early care and education providers were trained in ASQ-3 and ASQ: SE child development screening protocols. During Year 5, no additional providers have been trained as all existing providers have been trained. Screenings are being conducted in an ongoing fashion.

Pre-post training surveys for providers were developed by Promising Starts evaluators in Year 2, in addition to the ASQ-3 Developmental Screening Agency Report Form developed by the Promising Starts Coordinator; however, data collection continues to be a challenge. No additional provider data is available for Years 3 through 5. Several barriers have been expressed by the Promising Starts coordinator regarding data collection, including lack of buy-in from providers, lack of accountability for data collection, and limited implementation of ASQ screenings. Several strategies have been implemented to address these barriers, including electronic surveys as an

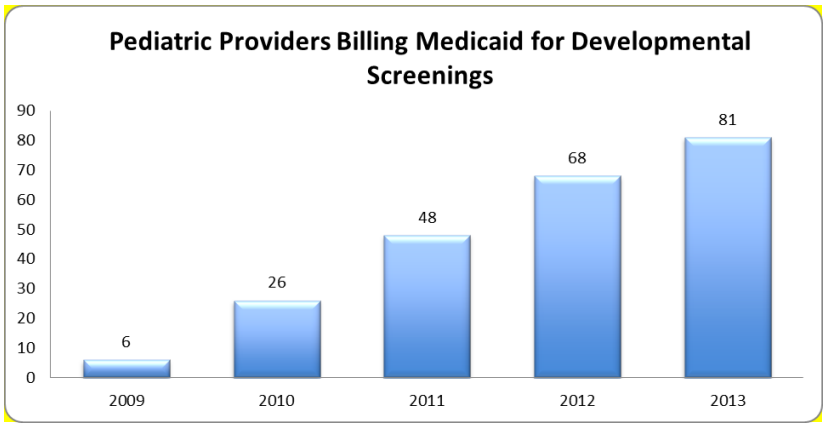
alternative to paper surveys; emphasis on data collection as a requirement for receiving LAUNCH-funded ASQ-3 screening materials through Promising Starts Memoranda of Agreement with participating agencies; and utilization of the Council as a vehicle for promoting training and screenings. Despite these challenges, Medicaid billing data shows significant increases in developmental screenings among New Britain providers and also in the number of pediatric providers billing to Medicaid following Promising Starts activities (see Figure 17, 18 and 18a). Years 4 and 5 resented additional opportunities for engaging provider in ASQ screening activities through collaboration with Connecticut's new Office of Early Childhood (OEC), responsible for implementing policy and support developmental screening practices statewide.

Figure 17. Developmental Screenings Billed to Medicaid in New Britain



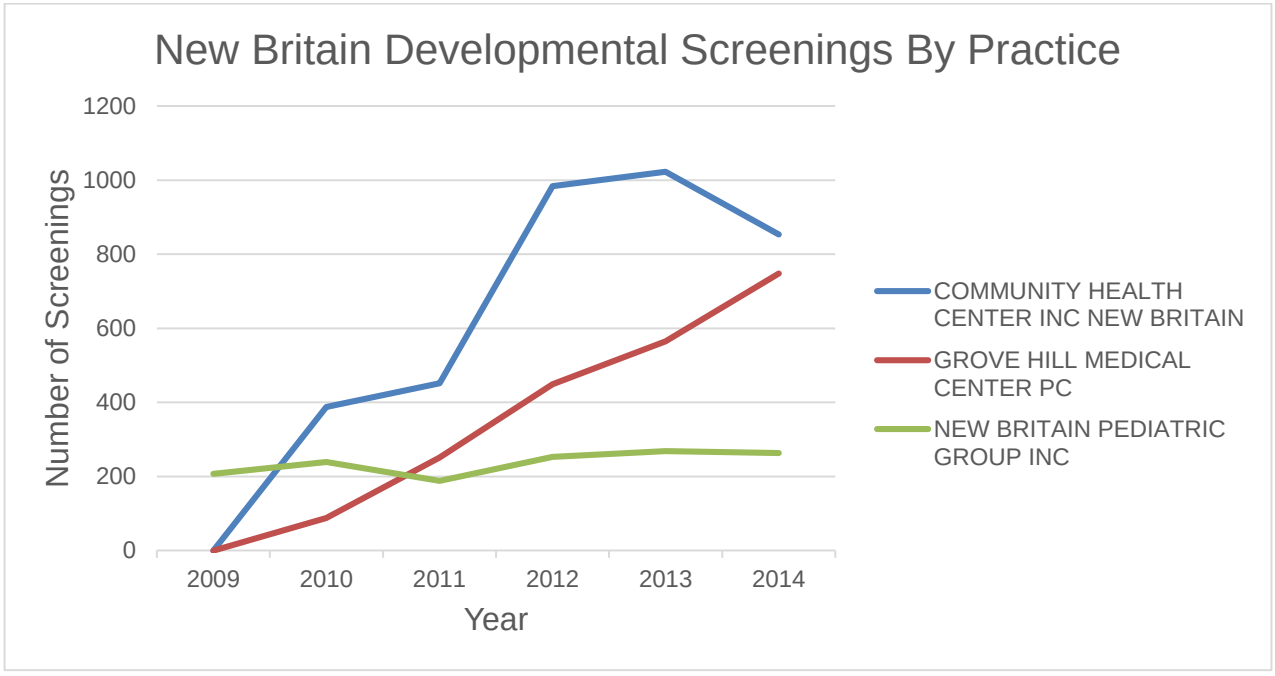
This data represents children in New Britain screened up to age 3. A single child may be in the counted twice if they received screening twice in one calendar year. The percentage of children screened and billed to Medicaid out of all children in New Britain up to age 3 is not known due to the aggregate number not being currently available.

Figure 18. Number of Pediatric Providers in Connecticut Billing Medicaid for Developmental Screening



During 2014-2015, data was available from New Britain providers only who billed medicaid for developmental screenings over a 6 year period. That data is shown in Figure.

Figure 18a. New Britain Developmental Screenings by Practice



Additionally, in partnership with United Way of Connecticut, the OEC continues to implement the Early Childhood Comprehensive Systems Planning (ECCS) grant received in 2014. The grant focuses on increasing the degree to which children from age 0-5 receive appropriate surveillance and screening to identify and address developmental and health challenges. Connecticut has completed the second year of project activities for that program including approximately 20 focus groups with early childcare providers and development, initial administration of a survey to early care providers and parents to assess processes by which children are screened statewide and the

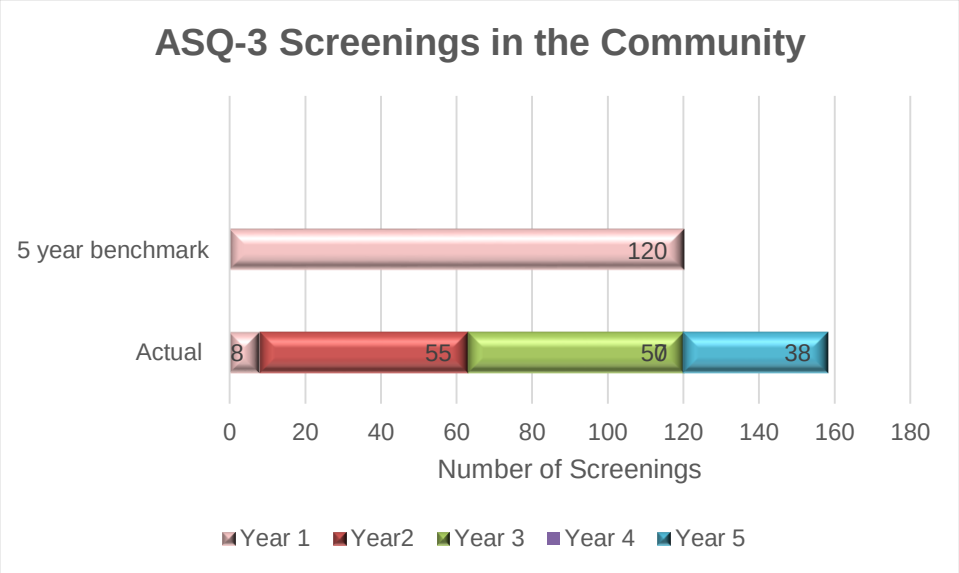
development of a state level strategic plan based, in part, on the results of the statewide needs assessment. The evaluator for Promising Starts is also responsible for the evaluation of ECCS activities and integrates knowledge and processes between the two programs as appropriate.

It is noted that through the Help Me Grow Campaign Implementation Committee, which is chaired by the Promising Starts Child Wellness Coordinator, Connecticut has set a goal of screening every two-year-old in 2014 and expanding the service over time to all young children. Help Me Grow registered 1000 children during 2014 and 2314 children during 2015.

Child and Family Outcomes. In Year 3, 57 additional children were screened in the community using the ASQ-3 through Promising Starts efforts, for a total of 120 children screened in New Britain to date (not including children screened through Child First or another service), which meets the 5-year benchmark of 120 children screened in the community (see Figure 19). In Year 4, no additional children were screened through community activities although children were screened through Child First as reported previously. During Year 5, in addition to screenings which occurred through Child First, 38 children were screened within the community setting.

Promising Starts' efforts are considered a model for statewide implementation, and staff seek to increase community-level participation in the Help Me Grow developmental screening program through the Campaign Implementation Committee.

Figure 19. ASQ-3 Developmental Screenings in the Community

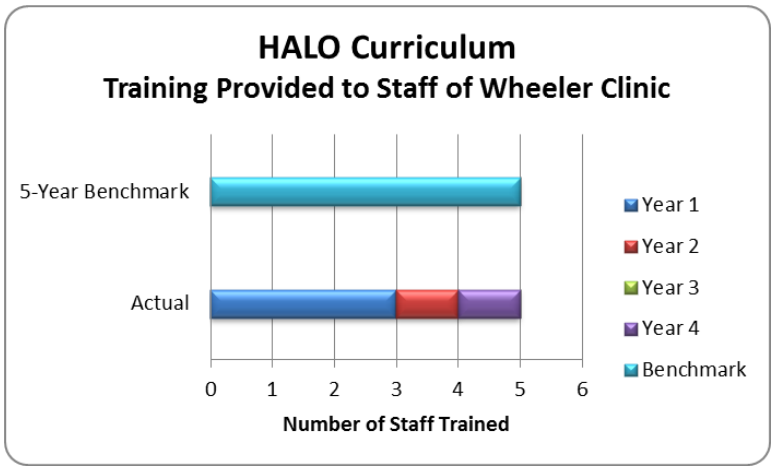


HALO Health Promotion and Substance Abuse Prevention

Program Outcomes. In previous years, four staff members (i.e., doctoral-level interns and the Promising Starts coordinator) of Wheeler Clinic were trained as facilitators of the *Healthy Alternatives for Little Ones* (HALO) curriculum (*Bonita Bunny's Guide to HALO*). During this time, both the curriculum and the assessment were successfully administered to preschoolers of the Human Resources Agency's Head Start and School Readiness programs by three (3) staff members in Year 1 and one (1) staff member in

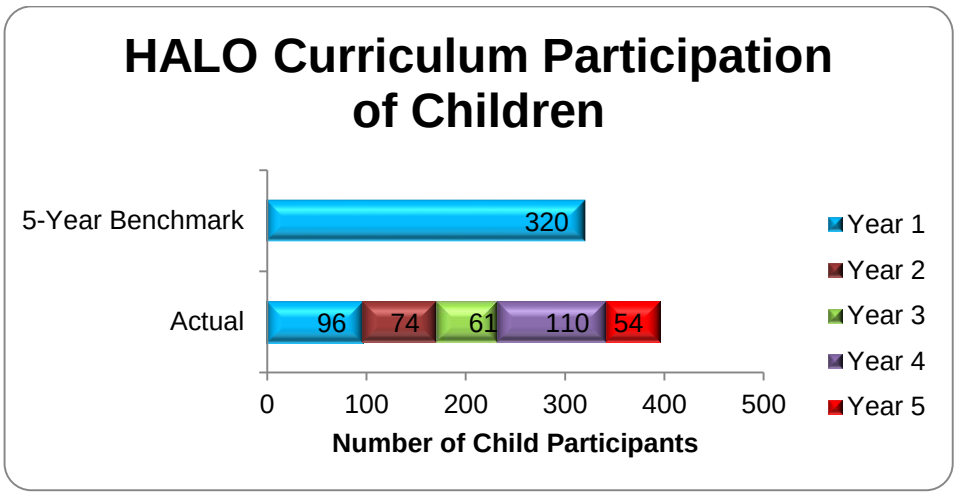
Year 2. Although there were no Wheeler staff trained in Year 3 (see Figure 20), training was provided to five external personnel of early care and education providers by a trained facilitator of the Wheeler Clinic. These external personnel were classroom teachers who implemented HALO within the classroom. However, the use of external personnel resulted in a lack of data and an inability to control implementation fidelity. As a result, during Year 4, Wheeler Clinic hired one intern who was trained to administer the HALO curriculum. In Year 4, this intern provided instruction to 110 children across four classrooms within the Head Start and School Readiness settings. However, of the 110 children who completed the curriculum, only 70% (77) of the sample were targeted for pre and post-test data results. During Year 5, an additional 38 children completed the HALO curriculum. During the five years of LAUNCH funding, the HALO curriculum has been administered by 5 trained staff members (see Figure 20) to 395 children through Head Start and School Readiness programs, exceeding the 5-year benchmark of 320 children (see Figure 21).

Figure 20. Wheeler Staff Trained in HALO



Note: No additional staff were trained during Year 5.

Figure 21. Number of Children Participating in HALO during Years 1-5



Note: During Years 1, 2 and 4, HALO was implemented by Wheeler Staff. During Year 3, HALO was implemented by classroom teachers. During Year 5, 38 children received HALO from Wheeler staff and

an additional 16 children received the program from classroom teachers.

The assessment results collected by Promising Starts in Year 2 were used to further the expansion and implementation of the HALO curriculum across the New Britain community. The necessary resources and support were provided to all facilitators by Promising Starts across the educational continuum. The New Britain School Readiness Council promoted the curriculum by training four preschool teachers to facilitate HALO's twelve learning units, which were implemented within Head Start and School Readiness programs in Year 3 with 110 additional children served in Year 4. All child participants of the HALO program were personally served in their assigned classrooms by trained teachers and or "specialty" interns during years three and four. During spring 2014, an intern was trained as a HALO facilitator. This individual provided the HALO curriculum to children between the ages of three and six years during summer of 2014 and throughout 2015. In addition to the trained preschool teachers of the Head Start and School Readiness programs, an aggregate of teachers and administrators were trained in the HALO curriculum at the *Bristol Early Childhood Conference* in August 2014. A total of 53 providers received HALO training, funded by Project LAUNCH. No additional providers received HALO training during 2015.

Provider Outcomes. No additional provider data is available during this reporting period.

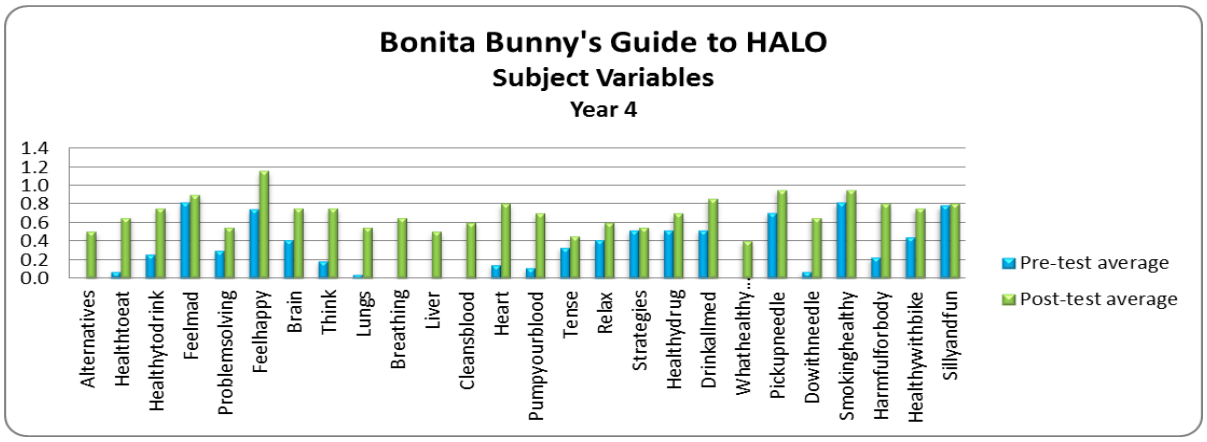
Child and Family Outcomes. Limited data was collected during Year 3, as groups were facilitated by early care and education providers and not by Wheeler Clinic providers. Classroom level demographics for the 61children participating in HALO during Year 3 were similar to previous cohorts and indicate that children ranged in age from 3-5, included slightly more females (57%) than males and were predominantly Hispanic. No pre-post data was collected using the "Bonita Bunny's Guide to HALO" during Year 3. Previous results indicated significant improvement across each domain, although minimum competency scores, as determined by program developers, were only attained for the Feelings and Healthy Choices subscales. Individual item analyses also indicated significant improvement across each question; particularly on items relating to the identification and function of body organs. Additional outreach and support were provided to early care and education providers to implement HALO in Year 4 and resulted in an additional 110 children receiving the curriculum.

During Year 4, demographic information was collected on 77 of the 110 child participants, revealing similar characteristics to cohorts of previous years. Participating children were between the ages of three and six years, representing a predominance of female (52%) and Hispanic/Latino (47%) participants (see Appendix Z for complete demographic information). Demographic information collected on children (n = 20) who were successfully assessed on "Bonita Bunny's Guide to HALO" included that these children were three or four years old and consisted of 60% (12) males and 40% (8) females. The ethnic representation of Hispanic/Latino, African-American, Caucasian, and Other was 45%, 25%, 20%, and 10%, respectively.

Overall, children scored poorly on the pretest primarily in the subjects of general health, healthy lifestyles, and body organs (see Figure 23). However, children demonstrated a significant improvement in every subject (see Figure 22) during the post-test assessments but failed to meet the established minimum levels of competency (see Figure 24) in two *Areas of Attention*.

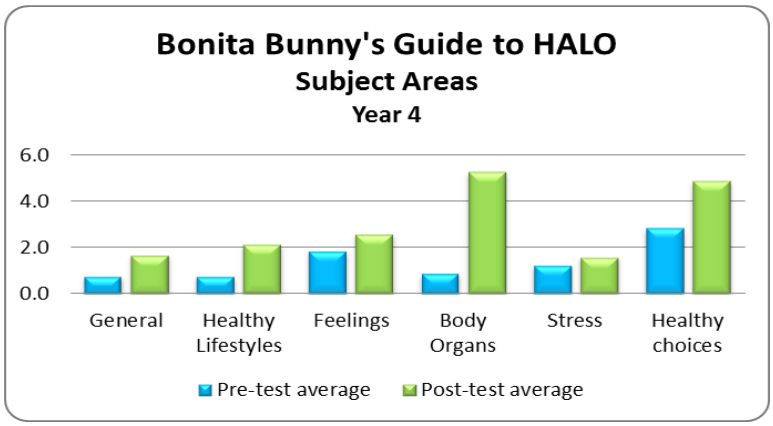
Specifically, average scores for *General Health HALO Information* and *Stress and Relaxation* fall slightly below the threshold of "2," yielding the respective results of 1.7 and 1.6. A summary of results of Year 4 is provided in Figures 22 through 25.

Figure 22. Bonita Bunny's Guide to HALO: Categorical Variables: Year 4
n=20



Results indicate that on each subject tested, the child's score increased between the pre and post test. A lack of a bar for the pre-test score indicates an average of 0 on that item.

Figure 23. Bonita Bunny's Guide to HALO: Areas of Attention: Year 4
N=20



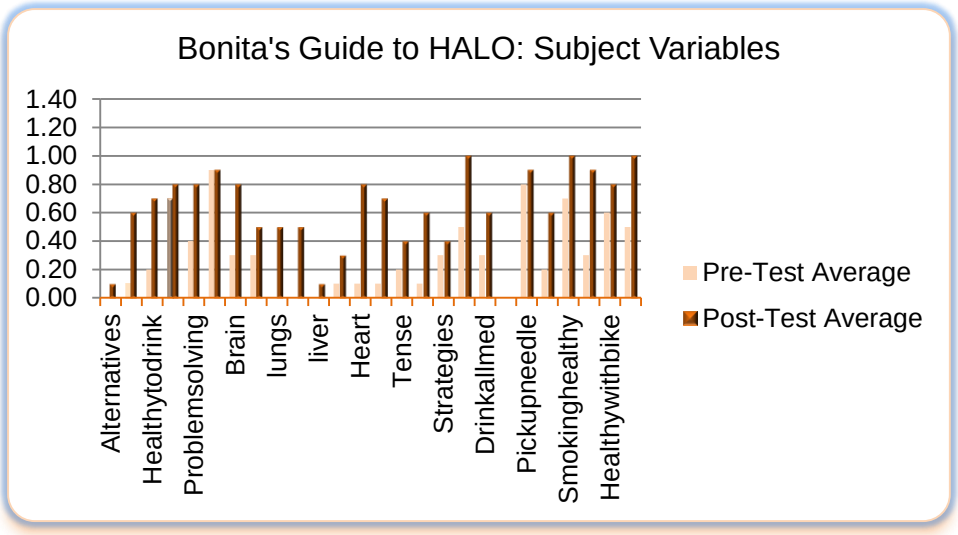
Results indicate that on each concept tested, the child's score increased between the pre and post test.

A paired-samples *t* test (based on an alpha of .05), revealed a statistical and reliable difference between mean numbers of pre and post-test assessments in the following subject areas: *General Health HALO Information*, $t(19) = -3.596$, $p = .002$; *Healthy Lifestyles*, $t(19) = -4.034$, $p = .001$; *Body Organs*, $t(19) = -5.661$, $p < .001$; and *Healthy Choices*, $t(19) = -3.486$, $p = .002$.

During Year 5, an additional 38 children received the HALO curriculum and an additional 10 children (26%) received both the pre and post assessment. Figures provided below represent

averaged, comparative data of pre and post-test results administered during the fall of 2014. The assessment was randomly administered to children within each of two classrooms.

Figure 22a. Bonita Bunny's Guide to HALO: Categorical Variables: Year 5 N=10



Results show improvement in each concept area between the pre and post test. All results were significant at a level of $p<.05$.

Figure 23a. Bonita Bunny's Guide to HALO: Areas of Attention: Year 5 N=10

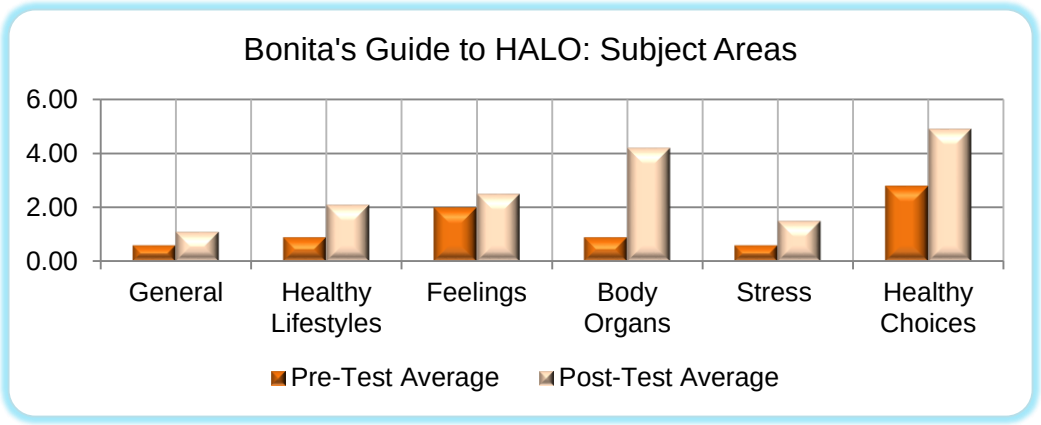


Figure 24. Bonita Bunny's Guide to HALO: Competency Levels

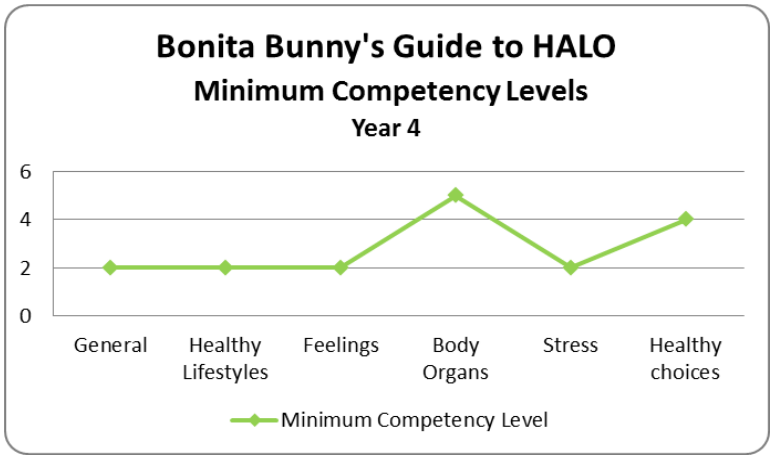


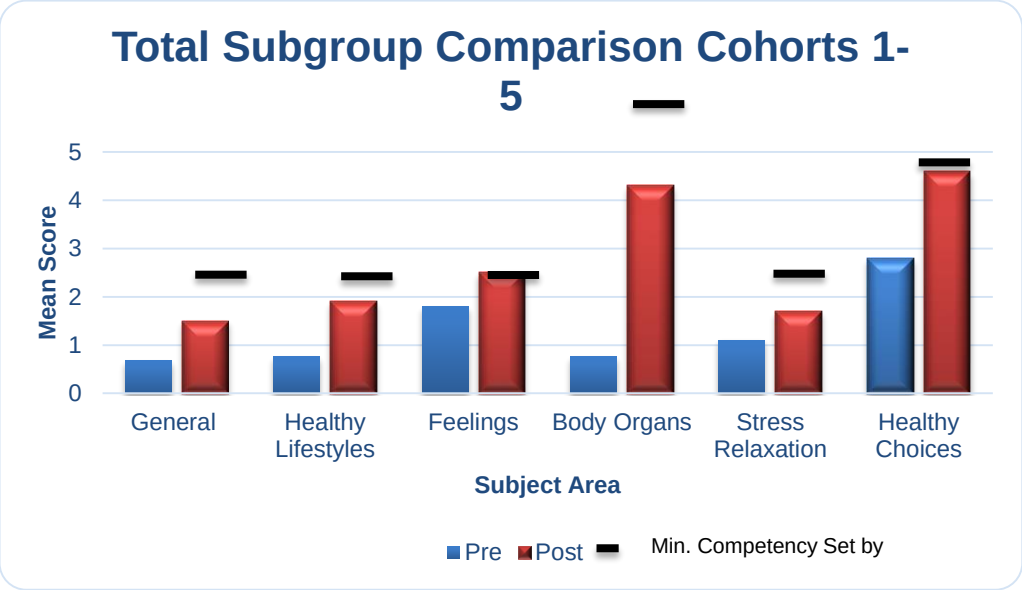
Figure 24 provides the competency levels set by the developer for each concept tested.

During both Years 4 and 5, evaluators were able to identify areas of consistent difficulty during the pre-test assessments: Children could frequently not define specific terms such as *alternatives* and *healthy* nor identify healthy lifestyle choices and bodily organs (i.e., brain, lungs, liver, and heart). As with previous years, children during Year 5 scored poorly on the pre-test, which reflected primarily in the subjects of general health, healthy lifestyles, and body organs. However, children demonstrated a significant improvement in every subject during the post-test assessments. It is noted however that during the post-test, children failed to meet the established minimum levels of competency in three areas. Specifically, average scores for *General Health HALO Information* and *Stress and Relaxation* fall slightly below the threshold of "2" and the average score for *Body Organs* fell below the threshold of "5, yielding the respective results of 1.1, 1.5 and 4.2.

Children were able to successfully recite definitions of terms by which they were previously challenged as well as identify *healthy* and *harmfu*l food and lifestyle choices. The results are supported by a paired-samples *t* test (based on an alpha of .05), which reveal a statistical and reliable difference between mean numbers of pre and post-test assessments in the following subject areas: *General Health HALO Information*, $t(9) = -3.00$, $p = .02$; *Healthy Lifestyles*, t(9)=-3.67, p=.005; *Body Organs*, $t(9) = -5.36$, $p = .000$; *Stress and Relaxation*, t(9)=-5.01, p=.001 and and *Healthy Choices*, $t(9) = -11.70$, $p = .000$.

Additionally, data from Years 1-5 were combined to obtain an aggregate pre-post assessment for all children from whom pre and post assessments were available. Results are presented in Figure 25.

Figure 25. HALO Cohorts 1-5 Mean Totals of Subscale Items
N=70



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

The HALO pre-assessments identified areas of difficulty in general health, healthy lifestyles, and knowledge of body organs. Children demonstrated a significant improvement in four of the six areas during the post-test but failed to meet the minimum levels of competency in *General Health*, *Healthy Life Styles*, *Body Organs* and *Stress and Relaxation*. It is recommended that any future implementation will increase emphasis on teaching content in these two areas. Based on these promising outcomes, the community has scaled up curriculum delivery across school readiness programs and developed strategies for sustainability.

Child Care Consultation

Program Outcomes. During Year 2, Wheeler Clinic entered into an agreement with New Britain Public Schools to provide the Second Step violence prevention curriculum to all pre-K, 1st, 2nd, and 3rd grade classrooms in the district beginning in the 2012-2013 school year. Through Promising Starts, Wheeler Clinic provided curriculum resource kits to each classroom, with access to online training for teachers; however to date no teachers have accessed the online training portal. Based on an interview with the Director of Pupil Services in New Britain Public Schools held in December, 2013 and subsequent discussions with two elementary school principals, the Second Step program is being implemented in all K-3 classrooms within the district and is described by the Director of Pupil Services as an excellent program. Additionally, the Coordinator of New Britain's Safe Schools Healthy Students grant, funded by SAMSHA, sits on the Health and Wellness Strategy Group and states that the program is being implemented in the majority of preschool classrooms in New Britain.

However, both the Coordinator of Safe Schools Healthy Students and the Director of Pupil Services cite consistent challenges between district, school and project personnel as resulting in limitations in data collection. These challenges include a lack of centralized authority which

prevents the Director of Pupil Services from mandating to schools that data be completed, communication challenges between the Director of Promising Starts, the Coordinator of Safe Schools Healthy Students and the Director of Pupil Services, and a generalized lack of communication throughout the school district. An additional barrier to completion of the on-line training programs is that district staff state that the program is clear and well-organized and that, therefore, training for teachers is not needed to implement the program.

Despite these challenges, during 2013-2014 interactions with the Coordinator of Safe Schools Healthy Schools has resulted in the successful administration of the Second Step Fidelity survey to district staff and preschool programs throughout New Britain. The survey was completed in the fall of 2014 by sixteen (16) educators in New Britain from the following early childhood education programs: Hospital for Special Care (WIC), HRA Head Start, YWCA of New Britain, and Boys and Girls Club of New Britain. Results are provided in Table 4 below. It is noted that to date there has been no data received from providers in grades K-3. This data is necessary to determine whether teachers are actually implementing the program with fidelity.

Table 6. Year 4 Second Step Implementation Survey Results Percent Response

	Strongly Disagree/ Disagree	Neither Disagree nor Agree	Agree/ Strongly Agree
1) I understand the goals and objectives of the Second Step program.	0.0%	0.0%	100.0%
2) I am committed to helping my students achieve the goals of the program.	0.0	0.0	100.0
3) I understand my role in the implementation process.	0.0	0.0	100.0
4) I know which implementation tasks I'm responsible for and how to carry them out.	0.0	0.0	100.0
5) I have a specific time scheduled for delivering the lessons.	0.0	0.0	100.0
6) I believe it is important to implement the Second Step program fully.	0.0	0.0	100.0
7) I am aware of the overall implementation plan for our school.	0.0	6.7	93.3
8) I teach the lessons in order.	0.0	7.7	92.3
9) I reinforce the lesson skills and concepts as explained in the Using Skills Every Day sections.	0.0	7.7	92.3
10) I believe my students are benefiting from the Second Step program.	0.0	13.3	86.7
11) I do the Daily Practice Activities with my students.	7.1	7.1	85.7
12) I feel confident in my ability to reinforce lesson concepts and skills as explained in the Using Skills Every Day sections.	0.0	15.4	84.6
13) I know where and how to get resources to help improve my practice (for example, support from individuals or online resources).	14.3	7.1	78.6
14) I have adequate time to prepare for lesson delivery.	21.4	7.1	71.4
15) I feel adequately trained to deliver Second Step lessons.	7.7	23.1	69.2
16) I have or know how to get the materials I need to teach and/or reinforce Second Step program skills and concepts (for example, program kits, DVDs, CDs, posters, and handouts).	0.0	35.7	64.3
17) I have adequate implementation support (for example, from my administration, coordinator, and/or district).	14.3	21.4	64.3
18) I have access to all the equipment I need to implement the program (for example, DVD player, CD player, and LCD projector).	21.4	28.6	50.0
19) I understand how I can help monitor the implementation process (for example, by using the Lesson-Completion Checklist or Lesson Delivery and Reinforcement Checklist).	30.8	23.1	46.2
20) I use implementation process monitoring tools to assess my implementation of the Second Step program.	50.0	8.3	41.7

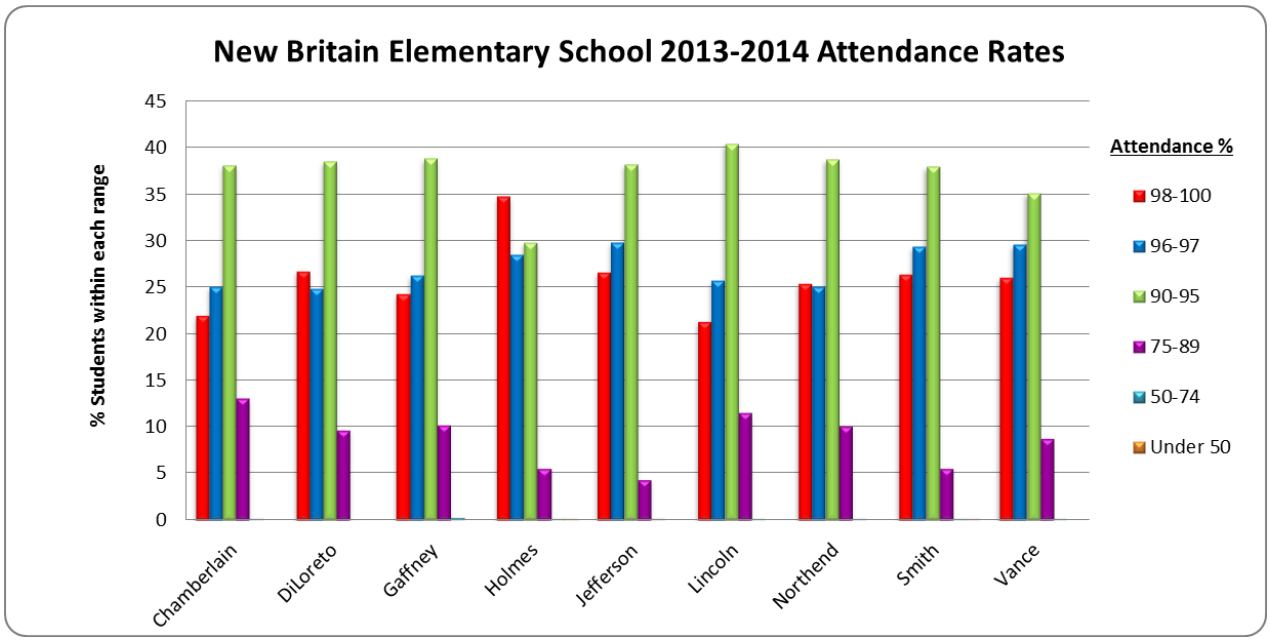
	Strongly Disagree/ Disagree	Neither Disagree nor Agree	Agree/ Strongly Agree
21) I use the Second Step program's formative and summative assessments to monitor student progress.	45.5	18.2	36.4
22) I send Home Links to my students' families.	33.3	41.7	25.0

All respondents "agree or strongly agree" that they understand the goals and objectives of the Second Step program and their role in the implementation process, are committed to helping their students achieve the goals and believe in the importance of implementing the program. Overall, the program is identified as strong with over 70% of respondents answering "agree or strongly agree" to 14 of the 22 questions posed. Data indicate that many users of the Second Step program are not consistently utilizing the monitoring tools, Home Links for families, or the student assessments.

Additionally, through the Safe Schools Healthy Students grant, New Britain has committed to intensive implementation of Second Step, and required data collection, throughout the district. However, there is no accountability between Promising Starts Project LAUNCH and New Britain. The Safe Schools Healthy Students Coordinator states that although they are required to implement data collection, this data collection is not necessarily the same data collection that Promising Starts Project LAUNCH is requesting. Ongoing efforts to strengthen implementation and coordinate data collection and reporting between Promising Starts activities and the Safe Schools Healthy Students activities are underway through the Health and Wellness and Health and Wellness Strategy Group.

In anticipation of more rigorous data collection for the Second Step program in Year 5, attendance data for nine of the ten New Britain elementary schools is provided in Figure 25 from the 2013-2014 school year as a baseline for comparison. At this time, there is no information available as to which schools are implementing Second Step with fidelity although anecdotal data from district administrators indicate the program is being implemented at the majority of schools. There was no data available from Smalley School.

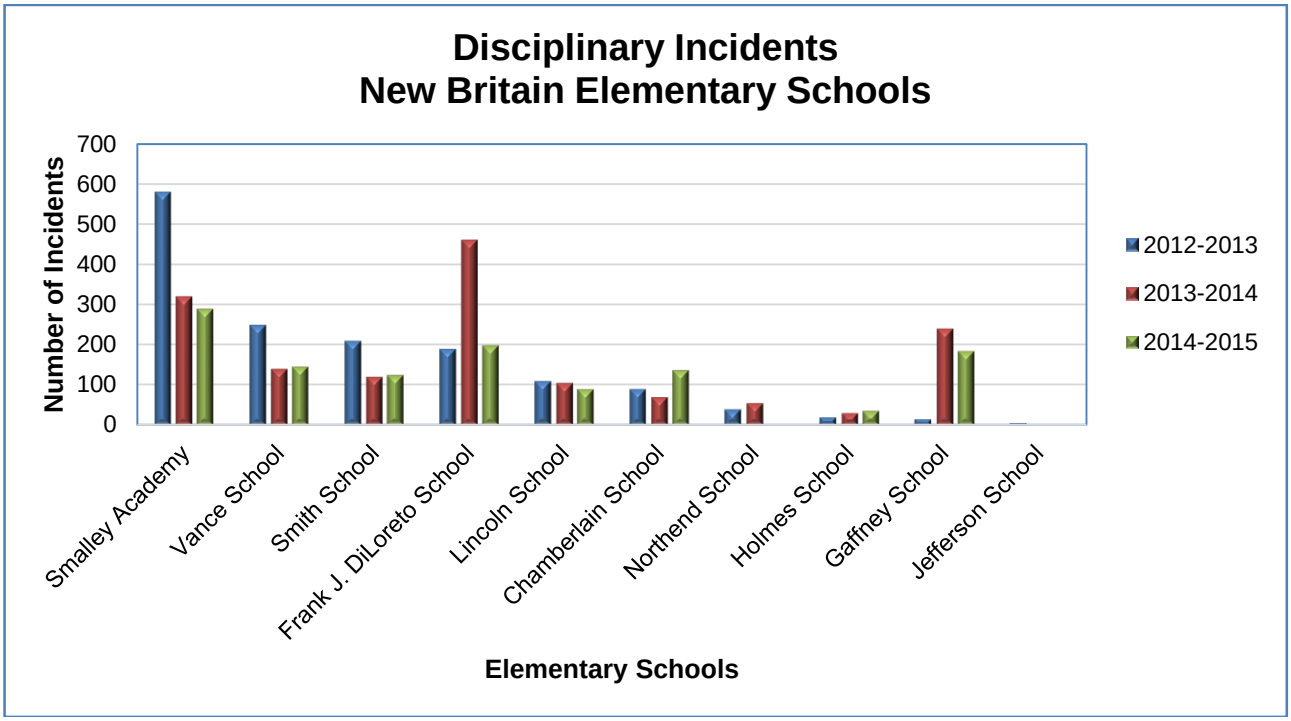
Figure 26. New Britain Elementary School 2013-2014 Attendance Rates



Aggregate attendance measures for schools may not adequately address individual absenteeism. As defined by the Connecticut State Department of Education, a student is classified as ***chronically absent*** if his/her attendance rate is less than or equal to 90%. The nine elementary schools listed in Figure 26 have overall attendance rate averages between 94-96%. However, 4 of these schools have chronic absenteeism rates of over 10%. It is also important to note that a student is classified as ***at risk*** if his/her attendance rate is between 90 and 95%, the largest category for all but one of the schools listed. It is noted that two students from Holmes and one student from Smith fell into the "Under 50%" category.

Additionally, a listing of disciplinary incident counts (which include in-school suspensions, out-of-school suspensions, expulsions, as well as other disciplinary incidents) were received from the district for the past three school years (2012-2013, 2013-2014 and 2014-2015) and are reported to provide ongoing process information (see Figure 27).

Figure 27. Disciplinary Incidents – New Britain Elementary Schools



Five of the schools reported a positive change with reductions of 20% to 60% from 2013 to 2014. During 2014-2015, decreases occurred in four of the eight schools providing information (there was no 2014-2015 data available from either Jefferson or Northend). These changes occurred during the time Second Step was expected to be implemented. However, negative changes occurred at both Gaffney School (increase of 648.48%) and Frank J. DiLoreto Magnet School (144.92%) during 2013-2014 and at Chamberlain and Northend during 2014-2015. It is noted that DiLoreto Magnet is a K-8 school. There is nothing currently available to provide insight into potential reasons for the increases in disciplinary activities at these schools.

During Year 5, in ongoing efforts to initiate data collection and obtain quality data, the fidelity survey was shared with the Safe Schools Healthy Students Coordinator to distribute to each school in both on-line and hard copy form. No surveys were received as a result of this distribution. Consequently, the Director of School Services and the Assistant Superintendent were approached during Summer 2015 and asked to administer the survey to teachers during the Fall professional development week. Promising Starts evaluators and project staff offered to go to each school and administer the surveys in person. The Assistant Superintendent informed each principal through an e-mail that Promising Starts staff required access to distribute the survey. However, no permission to do so was received from the school district. Three schools provided completed surveys to Promising Starts. In these three schools, Second Step appears to be being implemented with fidelity. As a result, although anecdotal data indicates that the Second Step curriculum has been administered by teachers throughout the 5 year period, thus exceeding the 5-year benchmark of 200 children participating in the Second Step curriculum, only limited data is available to support this.

Additionally, Promising Starts staff again reached out to both the Director of Pupil Services and the Attendance Coordinator to obtain attendance and discipline data. It was anticipated that if both attendance and discipline data for schools AND the fidelity survey could be obtained, results could be examined for connections and linkages. Intensive communication efforts and requests were initiated by both CHDI evaluators, Lorentson Consulting evaluators and the Promising Starts Director. All data received is reported below.

Completed fidelity surveys were received from 3 of the 10 elementary schools in New Britain during Year 5. Surveys were completed by teachers in grades pre-K through 5th grade who attended the obligatory professional development day during August, 2015.

To allow comparisons between the schools, the mean response per item was calculated on both an aggregate basis and separately for each school (Table 7). All but four items have an aggregate mean response of 3.0 or higher indicating a high degree of fidelity for that time. Teachers most frequently responded that they understood the goals and objectives of the Second Step program and were least likely to use the formative and summative assessments provided by the program.

Table 7. Year 5 Second Step Implementation Survey Results Mean Response

	Aggregate (N=51)		Vance (N=19)		Lincoln (N=18)		Chamberlain (N=15)	
	Mean	Std. Deviation	Mean	Std. Deviation	Mean	Std. Deviation	Mean	Std. Deviation
1) I understand the goals and objectives of the Second Step program.	4.2	1.0	**4.1**	1.1	**4.5**	.7	**4.1**	1.1
2) I am committed to helping my students achieve the goals of the program.	4.1	1.0	**4.1**	1.0	**4.4**	.7	**3.8**	1.3
3) I am aware of the overall implementation plan for our school.	3.8	1.1	**3.5**	1.3	**4.2**	.6	**3.6**	1.2
4) I understand my role in the implementation process.	3.9	1.1	**3.6**	1.3	**4.3**	.7	**3.8**	1.0
5) I know which implementation tasks I am responsible for and how to carry them out.	3.8	1.0	**3.6**	1.3	**4.3**	.6	**3.6**	.9
6) I have or know how to get the materials I need to teach and/or reinforce Second Step program skills and concepts.	3.9	1.1	**3.5**	1.2	**4.3**	1.0	**3.9**	.8
7) I have access to all the equipment I need to implement the program.	3.8	1.3	**3.4**	1.7	**4.3**	.8	**3.6**	1.0
8) I have adequate time to prepare for lesson delivery.	3.4	1.2	**3.0**	1.2	**3.8**	.9	**3.2**	1.3
9) I have a specific time scheduled for delivering the lessons.	3.0	1.3	**2.3**	1.3	**3.6**	1.0	**3.3**	1.2

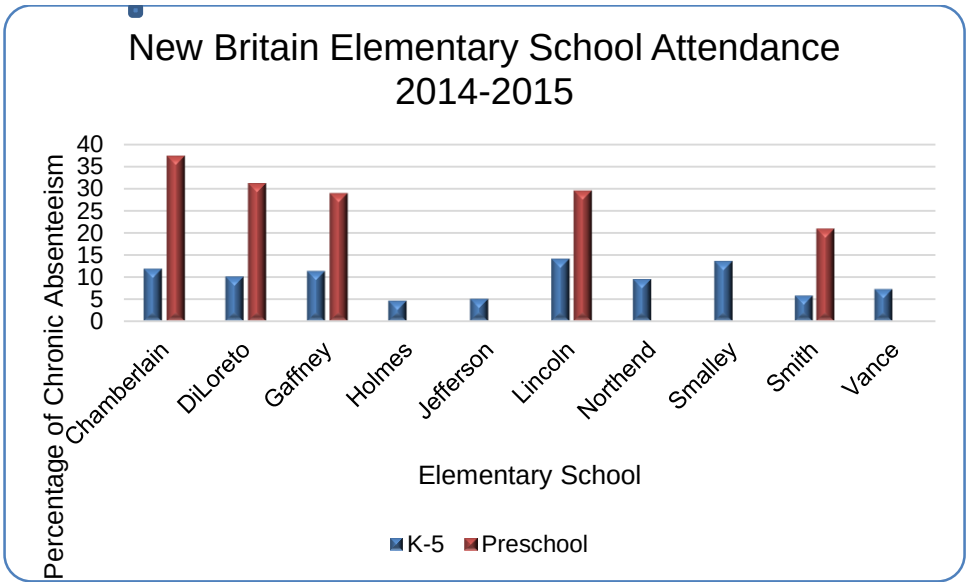
	Mean	Std. Deviation	Mean	Std. Deviation	Mean	Std. Deviation	Mean	Std. Deviation
10) I believe it is important to implement the Second Step program fully.	3.7	1.1	**3.0**	1.3	**4.0**	.8	**4.1**	.6
11) I understand how I can help monitor the implementation process.	3.4	1.2	**2.7**	1.3	**3.8**	1.0	**3.7**	.8
12) I feel adequately trained to delivery Second Step lessons.	3.4	1.2	**2.9**	1.5	**3.8**	.9	**3.6**	.7
13) I feel confident in my ability to reinforce lesson concepts and skills as explained in the Using Skills Every Day sections.	3.6	1.0	**3.4**	1.4	**3.8**	.7	**3.7**	.7
14) I know where and how to get resources to help improve my practice.	3.6	1.0	**3.2**	1.4	**3.8**	.6	**3.9**	.8
15) I have adequate implementation support.	3.8	1.1	**3.4**	1.4	**4.0**	.7	**3.9**	.8
16) I teach the lessons in order.	3.1	1.4	**2.2**	1.6	**3.8**	.7	**3.5**	1.2
17) I do the Daily Practice Activities with my students.	2.9	1.5	**1.7**	1.3	**4.0**	.7	**3.1**	1.2
18) I reinforce the lesson skills and concepts as explained in the Using Skills Every Day sections.	3.0	1.4	**2.0**	1.6	**3.7**	.6	**3.6**	1.2
19) I send Home Links to my students' families.	2.6	1.4	**1.6**	1.4	**3.2**	1.0	**3.1**	1.2
20) I use the Second Step programs' formative and summative assessments to monitor student progress.	2.5	1.4	**1.4**	1.0	**3.2**	1.0	**3.2**	1.2
21) I use implementation process monitoring tools to assess my implementation of the Second Step program.	2.6	1.3	**1.6**	1.0	**3.2**	.8	**3.3**	1.2
22) I believe my students are benefitting from the Second Step program.	3.2	1.2	**2.4**	1.4	**3.6**	.7	**3.6**	1.2

Note: Scale based on scale from 1=Strongly Disagree to 5=Strongly Agree

A between-school comparison reveals that, of the three schools, means of almost every item for teachers in Lincoln school are higher than the means of the other two schools, indicating that Lincoln appears to be implementing the program with more fidelity than the other two schools.

During 2014-2015, the percentage of chronic absenteeism from each elementary school in New Britain was received from the district. As some schools have pre-schools and some do not, data for preschool and K-5 is reported by school in Figure 28.

Figure 28: 2014-2015 New Britain School Attendance for K-5 and Preschool Percentage of Chronic Absenteeism



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In general, schools with a preschool have much higher chronic absentee rates than those without a preschool. As a result of the lack of fidelity data from 7 of the 10 schools, it is not possible to assess the impact of the use of Second Step on chronic absenteeism.

In addition to Second Step, local providers trained to administer the ASQ in early care and educational settings are able to provide mental health consultation based on screening results. Child First teams are also trained to provide mental health consultation to families they serve, both in their homes and in community-based settings where children are experiencing difficulties, and Wheeler employs an experienced mental health consultant who is directly involved in all direct services, representing additional capacity for consultation across the community. Expansion of services to include the CSEFEL model continues to be delayed indefinitely.

Workforce Development

Together, Promising Starts activities in Year 4 have broadly impacted workforce development for early childhood professionals in New Britain by increasing the awareness of EBPs for young children, training providers in key early childhood mental health competencies, expanding the network of providers trained in early childhood best practices, and promoting support and sustainability of Promising Starts programs. In addition to training and support previously described as provided through Child First, COS-P, HALO, and ASQ-3 screenings, Promising Starts sponsored training to 37 providers in Sensory Processing and Early Childhood and Strategies for Effective Interventions, 53 providers in the HALO curriculum, 1 provider in Child Parent Psychotherapy, 2 providers in Hoarding Assessment, 116 providers in Risk Prevention and Trauma, and 131 providers in FLIP IT.

Promising Starts also continues to partner with Help Me Grow to offer a quarterly provider breakfast lecture series with presenters from local agencies to increase competencies in mental health-related topics for family service providers and to encourage professional networking. Three breakfasts were held during Year 3 (February, June, and August 2013) with an average of 16 participants at each representing multiple provider agencies and systems, down from an average of 26 participants in Year 2. Updated training satisfaction survey data was requested but not received from the Help Me Grow coordinator and are not available for this report. Previous demographic and satisfaction data from Year 2 are provided in Appendix AA, which reflect high satisfaction with training content and all participants agreed the training was useful. There was no additional data available for Years 4 or 5.

In Year 2 the Promising Starts coordinator from Wheeler Clinic earned the Infant Mental Health Endorsement from the Connecticut Association for Infant Mental Health (CT-AIMH) and accepted the invitation to serve on their Board of Directors. Promising Starts continues to partner with CT-AIMH to develop infant/toddler mental health professionals and promote eligibility for those seeking endorsement. During 2014 the Coordinator from Wheeler Clinic accepted an award for the Child First Program from Prudence Crandall, the domestic violence organization in New Britain. The award was the *Rev. Davida Foy Crabtree Community Service Partnership Award* and was provided for "generously partnering with us to provide hope, healing and inspiration to those affected by domestic violence and exemplifying service excellence in this important work." In keeping with this goal, in Year 4 CT-AIMH began a partnership with Central Connecticut State University to help develop an interdisciplinary certificate program in Infant and Early Childhood Mental Health in their Social Work graduate/professional studies department. During Year 5, the Promising Starts coordinator from Wheeler Clinic became the President of the Board of CT-AIMH.

Recommendations

Wheeler Clinic's Promising Starts initiative has made significant progress in implementation across major program targets in Years 1-5 of implementation. The three primary direct services to children and families (i.e., Child First, COS-P, and HALO) exceeded project benchmarks and implementation and data collection related to the use of Second Step has finally begun. Training in developmental screening and utilization of the ASQ-3 are complete and continue to occur, and the Council and the Health and Wellness Strategy Group provided oversight and fostered enhanced collaboration among community partners which continues under new leadership after cessation of grant funds.

Evaluation procedures and timelines captured successes with direct services and were modified as appropriate to accommodate implementation delays and challenges in other areas. Based upon this evaluation of five years of grant activities, the following recommendations are presented:

General Recommendations

1. Wheeler Clinic's implementation of Promising Starts activities met or exceeded all service benchmarks. The three primary services, COS, CF and HALO were fully implemented and all data show a high level of success. It is highly recommended that Wheeler Clinic continue efforts

underway statewide to develop policies and procedures to facilitate the implementation of these services across the state.

2. Throughout the no-cost extension period, Wheeler Clinic shall continue to seek and implement strategies to sustain and/or expand effective program components, particularly towards identifying resources and support for statewide expansion of successful components. Promoting positive outcomes of Promising Starts services and activities more widely through local, state, and national media outlets, research publications and conferences will be key in facilitating these efforts. The initiation of cohort efforts toward the development of the e-book and the provision of funds to support Dr. Lorentson's time on that e-book are a highly significant first steps in achievement of these efforts. It is highly recommended that the e-book and other summaries of program results be shared with state colleagues through all available communication channels, incorporated into the new state level LAUNCH grant, and introduced into the Office of Early Childhood's planning and implementation activities to facilitate the development of structures and processes to achieve these goals.

Ongoing Infrastructure Development and Systems Change Activities

3. Strategies to engage and retain parents and families as well as the identified key provider stakeholders for participation in the newly created Coalition and its subcommittee, the Health and Wellness Strategy Group, should be identified with clear communication about membership roles and responsibilities under the new structure. These efforts should occur in partnership with current efforts of the Office of Early Childhood (OEC). The CT OEC is emphasizing the involvement of parents and families in all early childhood activities as part of both its overall strategic plan and as part of the development of the early childhood comprehensive systems strategic plan currently being put in place. Recommendations for policy development are a major goal within each of these plans. It is highly recommended that Wheeler Clinic work closely with OEC to develop and implement strategies to engage and retain families as the local and statewide early childhood systems continue to expand and develop.

Child First Home Visiting

4. CHDI/Promising Starts evaluators and Child First supervisor/Promising Starts coordinator shall continue to meet on a regular basis together with Child First evaluators to establish and maintain agreement on a clear data reporting schedule and timeline for outcome and metric data, as data collection continues during the no-cost extension period.

5. The CT Department of Children and Families has committed to take over the responsibility for the implementation of Child First in New Britain, indicating a high level of commitment and successful project sustainability. It is recommended that the highly positive outcomes obtained by New Britain CF be shared both statewide and nationally through the publication of papers and presentations and used to encourage the development of state and local policies which support service integration.

Circle of Security Parenting (COS-P) Family Strengthening

6. Efforts to track COS-P services and impact at the community-level should be strengthened as statewide program expansion is considered by both state agencies and partnering providers outside of New Britain. As COS-P services continue to expand, additional data should be collected and reported on a consistent basis to inform quality improvement, sustainability of the service and policy development.

Mental Health in Primary Care (Behavioral Health and Developmental Assessment)

7. Promising Starts should continue to play an active role in engaging with the new Office of Early Childhood, the new Connecticut Launch grant, and the Help Me Grow developmental screening program Campaign Implementation Committee to increase utilization and tracking of ASQ screening data in the New Britain community. Process and outcome data should continue to be documented to support Promising Starts' efforts as a model for statewide implementation of universal development screening. Data should be used whenever possible to influence the development of state and local policies to support screenings. It is highly recommended that Wheeler Clinic continue to work closely with the ECCS Advisory Committee to develop statewide goals, objectives, policies and data collection measures to facilitate the use and tracking of ASQ screening tools and associated data.

HALO Health Promotion and Substance Abuse Prevention

8. As the HALO program is transitioned over to classroom teachers after cessation of grant funds, modifications to the evaluation process should continue as described in the updated evaluation plan to include fidelity and teacher outcomes measure for those facilitating the HALO curriculum.

Child Care Consultation

9. Implementation of the Second Step model across all New Britain pre-K, 1st, 2nd, and 3rd grade public school classrooms should continue as described and should be incorporated into the new SAMHSA grant currently held by New Britain Public Schools. It is highly recommended that accountability structures be developed to facilitate access to and use of the model and associated data by the school district, SAMHSA and program evaluators..

10. Ongoing barriers and challenges to implementation of CSEFEL and Second Step should continue to be monitored and documented, with any additional modifications made to the implementation activities as needed.

Workforce Development

11. Promising Starts should continue to work in collaboration with CT-AIMH to develop a training plan for New Britain providers that promotes the CT-AIMH Infant Mental Health competencies and provides endorsement opportunities and tracks eligibility of providers to pursue endorsement.

12. Barriers and challenges to increasing CT-AIMH certifications among providers should continue to be monitored and documented.

In summary, five years of data indicate a high level of program success as well as suggest a number of recommendations for policy and program management. Statewide and local level policies and structures are needed to support family engagement, increased attendance at Coalition/Council meetings, engagement of primary care providers, and use of COS, HALO and Child First at a statewide level.

The Promising Starts Coordinator is already working very closely with the Connecticut Office of Early Childhood and the ECCS Advisory Committee to develop and implementation recommendations and associated policies at a statewide level. As these recommendations and policies are developed, it is highly recommended that Wheeler Clinic incorporate these recommendations and policies in local activities.

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