National Center of Excellence for Infant and Early Childhood Mental Health Consultation

Supporting Statement

A. JUSTIFICATION

1. Circumstances of Information Collection

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services, in partnership with the Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF), is requesting approval from the Office of Management and Budget (OMB) for data collection activities related to the efforts of its National Center of Excellence (CoE) for Infant and Early Childhood Mental Health Consultation (IECMHC).

The instruments that will be used to collect data related to IECMHC activities and participants are as follows:

1. **Service Pre-Assessment Form—**Training event registration and participant assessment form
2. **Training Feedback Form—**Client satisfaction with event
3. **Training Follow-up Form—**Client assessment of utility and impact of training after 2 months
4. **Technical Assistance Follow-up Form—**Client assessment of impact of technical assistance (TA) after 2 months
5. **IECMHC Assessment of Cumulative Toolkit-related Services—**Annual client assessment of overall quality, utility and impact of the Toolkit-related training and technical assistance (TTA) at the State/Tribe level
6. **IECMHC Annual and Quarterly Benchmark Data Collection Forms—**Annual and quarterly tracking of achievement of IECMHC and selected MIECHV (Maternal Infant and Early Childhood Home Visiting) benchmarks at the State/Tribe level

This data collection is authorized under Section 501(d)(4) of the Public Health Service Act (42 USC 290aa)—Data Collection.

The primary goals of the CoE are to promote the healthy social and emotional development of infants and young children and to prevent mental, emotional and behavioral disorders within this population. Its work builds on Project LAUNCH, SAMHSA's early childhood prevention and wellness promotion initiative, and aligns with the President's early learning agenda, which has placed an unprecedented emphasis on improving the school readiness of the next generation of young children. Not only does school readiness require well-developed cognitive and language skills, but, equally important, strong social/emotional skills, engagement in learning, and self-regulation.

Despite early education's promise, the U.S. struggles to ensure the school readiness of young children. An estimated 40% of children are not ready for kindergarten, often with delayed social-emotional skills, poor behavioral self-regulation and weak attentional skills.[1] And too many lack executive function skills—organizing information, staying focused, exercising self-control[2]—that support school success. These deficits can result in future school failure, behavioral disorders, and child and adolescent mental illness. Structural and family factors that contribute to mental and behavioral health problems throughout childhood and adolescence persist. As widely recognized, poverty, continues to be the greatest threat to young children¹s well-being, impacting mental and physical health as well as school readiness and success. The percentage of infants and toddlers living in low-income families increased from 44% in 2006 to 48% in 2012.[3] While African Americans and Latinos make up 29% of the U.S. population, they represent 41% of the population living in high poverty/high-inequality counties.[4] Findings from a recent national prekindergarten study[5] showed that African-American preschoolers were about twice as likely to be expelled as European-American (both Latino and non-Latino) preschoolers and over five times as likely as Asian-American preschoolers. The increased likelihood of boys to be expelled over girls was similar across all ethnicities, except for African-Americans, where boys accounted for 91.4% of the expulsions. Overall, the national rate of prekindergarten (pre-K) expulsion was found to be 3.20 times higher than the national rate of expulsion for K–12 students. Other studies have uncovered much higher expulsion rates in individual states; for example, a recent study revealed that pre-K children were being expelled at 34 times the state rate for K–12 students in Massachusetts.Error: Reference source not found[6]

Early childhood programs, including childcare, Head Start, preschool and home visiting, ideally focus on promoting optimal health and development, strong social/emotional skills and referral to interventions for children and families with identified challenges. Unfortunately, in many communities and early childhood programs across the nation, there is limited training for the early childhood workforce on fostering children's social-emotional development, or recognizing and identifying developmental and behavioral issues. Further, when developmental and behavioral issues do arise, many programs have scarce support to help providers and families address issues and link with appropriate services.

SAMHSA has long realized the importance of investing in mental health consultation as a means of supporting the healthy development of young children, and the parents and providers who care for them. As a follow-on to this effort, recently SAMHSA and federal partners HRSA and ACF recommended developing: a larger, well-trained early childhood development workforce; guidelines and established models for implementation; continued building of the evidence base; and technical assistance for States, Tribes and communities to help them improve the quality of early childhood development and learning programs and outcomes for young children and their families. To spearhead these initiatives, the CoE was developed to advance IECMHC across the nation through the development of tools, resources, training, technical assistance and collaborative public and private partnerships.

The field of IECMHC includes a variety of activities, all of which are intended to strengthen the capacities of caregivers to foster healthy child behavior and development, positive interactions and relationships, social/emotional skills and children's success. For home-visiting programs, IECMHC offers training for home visitors (on topics such as attachment, maternal depression,

substance abuse, trauma and toxic stress); group reflective supervision; case consultation; referral and linkages to community-based services; and sometimes joint home visits or brief intervention. For early care and education programs, IECMHC activities include assessment/observation; modeling and coaching for parents, caregivers and teachers; and implementation of strategies to promote healthy social-emotional development and behavior at the classroom or program level. Consultation provides an opportunity to address racial and cultural biases that may be impacting child and family outcomes, and to help providers better serve diverse children and families. In addition, the link between access to IECMHC and a reduction in pre-K expulsions has already been demonstrated in researchError: Reference source not found. Infant and Early Childhood Mental Health Consultants are typically individuals with a Master's degree in mental health (often with additional Infant Mental Health training) with specialized knowledge of child development, early childhood systems, consultation and reflective and relationship-based practice. IECMHC mentors will work with States/Tribes to implement competency and credentialing standards recommended for the training of mental health consultants working with infants and young children. These standards include established core competencies, as well as additional standards that will be developed as part of the IECMHC initiative.

One major activity of the CoE will be to convene a national Expert Workgroup and to lead the workgroup in developing a state-of-the-art Toolkit of the latest research and best practices for IECMHC (e.g., training, implementation, evaluation and financing) for early childhood settings, including early care and education and home visiting programs. Based on guidance from the workgroup members, the Toolkit will also provide additional training standards for the IECMHC consultants. The CoE will also create a dissemination plan and trainings for the Toolkit, to drive adoption, implementation and infrastructure building to support IECMHC in States, Tribes and communities. The dissemination plan will include collaboration with other national early childhood technical assistance (TA) centers (e.g., the Home Visiting Technical Assistance Coordinating Center, the National Center on Health and Wellness, and those on military installations within the pilot States/Tribes) and will reach a large national audience, including universities, foundations, and other public and private organizations. Third, the CoE will provide intensive TTA to States and Tribes to help them build their capacity to implement, fund and evaluate IECMHC successfully. Each State and Tribe will be responsible for identifying an IECMHC lead (e.g., state child care administrator, children’s behavioral health director, or state home visiting coordinator) that will spearhead this effort and work to ensure the implementation, expansion and sustainability of IECMHC across the State or Tribe. These individuals will serve in the capacity of State/Tribal representatives to the IECMHC initiative.

In collaboration with SAMHSA, we will develop a process for selecting States and Tribes to participate in IECMHC and receive intensive TTA related to strategic planning for IECMHC systems development. The readiness of State/Tribal leaders to participate in the rigorous process and the availability of team members to fully engage in IECMHC planning activities are vital. Based on EDC’s experience with providing TTA to other comparable change efforts, an initial list of selection criteria has been developed that includes: (1) the support of agency administrator(s), as demonstrated by allocating time for members to participate, staying abreast of IECMHC innovations, and exercising their authority to remove barriers to full participation and innovation; (2) history of successful collaboration, such as evidence of at least one cross-

agency change that has been successfully realized through cross-agency collaboration; and (3) skilled, committed leadership that has knowledge of IECMHC, time to participate in TTA activities, and excellent verbal and written communication skills to promote new IECMHC activities within the State/Tribe infrastructure.

2. Purpose and Use of Information

Data collection is critical to documenting forward progress and indicating what systematic efforts IECMHC implementation (and systematic reporting) can achieve. CoE efforts will move the field forward by increasing capacity and documenting evidence of what benefits are achieved. To monitor the reach, implementation and impact of CoE's multiple efforts (described in Section A1), learn which practices work for which populations, and gauge overall applicability and utility of the Toolkit to infant and early childhood mental health consultation, the CoE will employ a variety of standardized process and outcome measures that have been specifically designed to reduce participant burden. The data and analytics that the IECMHC Evaluator collects will yield key information that will be used to improve how work is being conducted, and inform subsequent national, state, tribal and community policy and planning decisions. A brief description of the specific instruments, their intended respondents and purpose is summarized in Table 1, below.

TABLE 1

Instruments, Purpose of Data Collection, and Respondents

Instrument	Purpose	Respondents
Service Pre-Assessment Form	To gather brief race/ethnicity demographic information, professional role and background with mental health consultation	Participants registering for national webinars and TA virtual learning events
Training Feedback Form	To learn participant satisfaction with the training, applicability of the content to their settings, perceptions of knowledge acquired, and level of cultural competency demonstrated by the training	Participants of national webinars and TA virtual learning events
Training Follow-up Form	To learn participant perceptions of usefulness/applicability of material presented at the training event and extent to which it has improved their capacity to perform mental health consultation	Participants of national webinars and TA virtual learning events
Technical Assistance Feedback Form	To learn participant perceptions of usefulness/applicability of technical assistance they've received and extent to which it has improved their capacity to perform mental health consultation	Recipients of technical assistance
IECMHC Cumulative Services Assessment Form	To assess (on an annual basis) services accessed and customer satisfaction and cumulative impact of Toolkit-related services, including trainings and technical assistance	State/Tribal representatives
IECMHC Annual and Quarterly Benchmark Data Collection Forms	To collect State- and Tribe-level benchmark information, including establishment of training standards, development of sustainable financing, and progress toward reducing expulsion rates in public and private childcare and pre-school programs. Programs receiving MIECHV funding will also be asked to report on selected MIECHV measures/constructs regarding maternal and newborn health, school readiness and achievement, and coordination and referrals for other community resources and supports.	State/Tribal representatives

SAMHSA

The data that IECMHC program staff collect will be reported to SAMHSA in IECMHC service performance reports and used in other contractually mandated reporting. SAMHSA has been, and will continue to be, able to use the results from the evaluation to monitor the CoE's progress towards achieving stated goals, fulfill SAMHSA requirements for accountability and performance monitoring including reporting for Government Performance and Results Act (GPRA), and develop policies and provide guidance regarding the ongoing development of IECMHC. In the future, this data collection may also allow SAMHSA to plan and implement other efforts designed to enhance early childhood prevention and wellness promotion initiatives.

The design for the IECMHC evaluation provides for data collection, summarization, analysis and reporting that can be used to address SAMHSA priorities including:

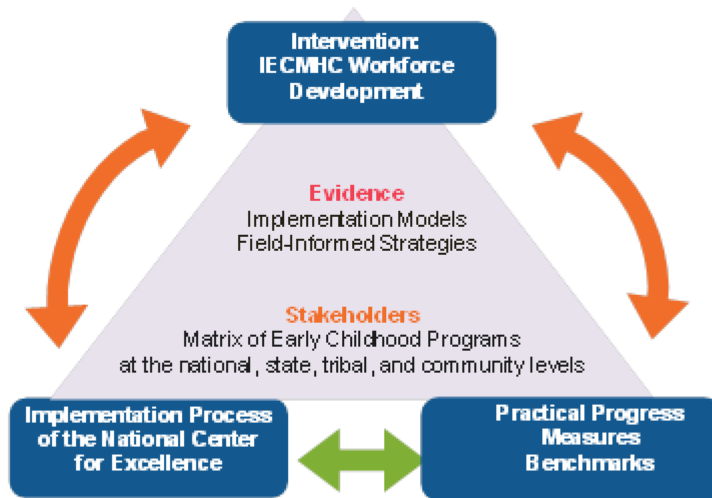
Accountability. These data-collection activities were designed in part to support SAMHSA performance measurement and management efforts. Findings from the evaluation will be used to provide objective measures of IECMHC program progress toward meeting targets of key performance indicators put forward in its annual performance plans as required by law under GPRA. Accountability to stakeholders is achieved through standardized SAMHSA and Federal Government reporting requirements outlined in GPRA.

Ongoing development. Program leadership will use evaluation data reported by mentors, pilot state representatives and mental health consultants to determine whether funded activities are progressing as expected and to keep abreast of any issues that these stakeholders are having related to carrying out their proposed activities. Program justification requires indicators not only of the effectiveness of activities and products in the abstract or in the published literature, but also of wide distribution and actual uptake of the activities and products, and evidence that they are effective, cost-effective and sustainable in communities throughout the country. With its increased emphasis on assessing the sustainability of grant activities after funding has ended and assessing the national impact of IECMHC and the impact of IECMHC on child-serving systems, this data-collection effort provides the information needed to assess program justification.

IECMHC Program Management

IECMHC leadership will be able to use evaluation data reported by participants and stakeholders to determine whether funded activities are progressing as expected and to keep abreast of any issues that grantees are having related to carrying out their proposed activities. Efforts will be conceptually grounded in the Evidence Integration Triangle (Figure 1) that illustrates a dynamic process where progress measures and benchmarks, collected over time, continue to inform implementation strategies and practices to improve the ultimate aim of the program, to develop an effective IECMHC workforce.

Figure 1. Evidence Integration Triangle



Data will be collected on an ongoing basis to determine how the IECMHC Toolkit is used by providers and how related TTA is used to support States and Tribes in implementing IECMHC, as well as how the models and strategies presented address their needs as they move through a strategic-planning process. IECMHC staff will monitor the TTA provided and TTA requests from the field.

Assessments will be made regarding whether and how States and Tribes are being supported in meeting goals outlined in their IECMHC Strategic Plans as well as TTA service needs that Expert Mentors will document in annual and updated quarterly service plans. Specifically, mentors will work closely with assigned States and Tribes to monitor progress toward meeting goals outlined in State/Tribe IECMHC Strategic Plans and SAMHSA's benchmarks. During their regularly scheduled quarterly meetings, state officials and mentors will document and update information on State/Tribe progress toward meeting these and other benchmarks using a web-based reporting tool (Attachment F).

Information and feedback on these services will be stored in the IECMHC Services Database, which is accessible via the web to authorized CoE staff. This system enables staff to generate reports based on key performance indicators—including products disseminated, participants served, content and type of TTA delivered, and staff/consultant hours that were spent on developing content and providing mentoring—as well as generate online surveys to capture and store information from participant feedback and key benchmark reporting.

Information collected from these various sources will be used to improve IECMHC-related services, make midcourse corrections, and better match mentors and consultants with the intensity and types of TTA. These efforts may result in improving States' and Tribal communities' capacity to implement IECMHC. Findings will be summarized for presentation to SAMHSA in an annual assessment report that includes information on: the purpose of the assessment and methods used; quantitative findings; extent to which services have been timely,

responsive and accurate; and thematic analysis of qualitative data collected on the impact of services.

Stakeholders (States, Tribal Communities)

Findings from the evaluation have been, and will continue to be, used by stakeholders to improve the services, processes and functions of their IECMHC programs. States and Tribal communities can use the information gathered to better identify their target populations and improve their services. The information can assist stakeholders in better understanding disparities in access to services for different subgroups of children and youth served by mental health consultants so that these disparities might be addressed. Grantees can also use data on lessons learned and strategies to accomplish evidence-based practice implementation and enhancement of early childhood prevention services. Finally, they can use data on the factors facilitating and hindering efforts to promote the sustainability of IECMHC program activities after Federal funding has ended.

Research Community

The research community, particularly the field of children's mental health services research, will profit in a number of ways from the information gathered. First, outcome measures will contribute to the understanding of the association between high-quality infant and early childhood mental health consultation and the achievement of Maternal Infant and Early Childhood Home Visiting (MIECHV) benchmarks and reduction of pre-K expulsions. Second, assessment of the process by which infant and early childhood mental health consultation practices are developed, disseminated and adopted will contribute to understanding the barriers and facilitators that affect this process. Finally, the analysis of evaluation data aids researchers in formulating new questions about IECMHC and will help both service providers and researchers improve the delivery of early childhood prevention services. IECMHC leadership will also discuss with SAMHSA ways in which data collection efforts may inform development of other materials, such as topical briefs and peer-reviewed journal articles.

Summary

The IECMHC data and related reports produced will be essential to SAMHSA (and, by extension, HRSA and ACF), IECMHC program management, stakeholders and the research community for monitoring the implementation of program activities, assessing their quality and utility for target audiences, and determining best practices that can be spread beyond the pilot sites to other settings in need of early childhood mental health consultation services. As evidence of the crucial role these assessment activities play in program success, SAMHSA has approved a total budget of approximately $299,300 to perform them.

At all levels of government—Federal, State and local—and in the private sector, decisions are being made that are dramatically impacting the social and emotional development of children and families. To make these decisions in a responsible way, policymakers, centers and other stakeholders need information such as the findings to be produced by IECMHC data and reporting.

3. Use of Information Technology

To minimize respondent burden, web-based surveys and forms will be used to collect and process information from all instruments. These web-based surveys and forms are:

1. **Service Pre-Assessment Form**
2. **Training Feedback Form**
3. **Training Follow-up Form**
4. **Technical Assistance Follow-up Form**
5. **IECMHC Assessment of Cumulative Toolkit-related Services**
6. **IECMHC Annual and Quarterly Benchmark Data Collection Forms**

The use of web-based surveys and forms decreases respondent burden, as compared to that required for alternative methods, such as a paper format, by allowing for direct transmission of the survey or form. Further, the data entry and quality control mechanisms built into the web-based format reduce errors that might otherwise require follow-up, thus reducing burden, as compared to that required for a hard-copy administration. As well, respondents can complete the survey at a time and location that is convenient for them.

To ease data collection and reporting, IECMHC program management will host and maintain the IECMHC Services Database (mentioned above), a sophisticated data repository and online reporting system for collecting, managing and analyzing data on the reach, implementation and impacts of IECMHC services.

All web-based applications will comply with the requirements of Section 508 of the Rehabilitation Act to permit accessibility to people with disabilities. This includes ensuring that all posted documents are compliant or have a compliant alternative. IECMHC program management utilizes Adobe products that are capable of producing compliant PDF files per the SAMHSA-recommended process that can be accessed using a variety of assistive technologies, including screen readers, screen magnifiers and voice recognition software.

4. Efforts to Identify Duplication

These forms are designed to specifically for the IECMHC program and, thus, such data are not available elsewhere.

5. Involvement of Small Entities

Most IECMHC data will be collected from mental health consultants and mentors in the course of performing their paid duties for the IECMHC initiative and State/Tribal administrators who work for public entities. Accordingly, participation in the evaluation is considered to fall within their job responsibilities. However, some organizations and individuals providing services to the target population (such as community-based organizations, not-for-profit agencies or private childcare providers) that may qualify as small entities may complete survey instruments. However, data-collection activities are not expected to have a significant impact on these organizations or individuals.

6. Consequences if Information Is Collected Less Frequently

Surveys will be conducted only at intervals appropriate to inform delivery of or measure the impact of services and monitor the continued level of performance and respondent satisfaction. Collection on a less frequent basis would preclude IECMHC program management from meeting contract requirements, reduce the practical utility of the information, and inhibit both the program's and SAMHSA's ability to utilize rapid cycle assessment processes that can quickly identify areas that might require improvement and make appropriate mid-course corrections if warranted.

7. Consistency With Guidelines of 5 CFR 1320.5

The data collection fully complies with the requirements of 5 CFR 1320.5(d)(2).

8. Consultation Outside the Agency

Federal Register Notice

The notice required in 5 CFR 1320.8(d) was published in the *Federal Register* on July 28, 2016 (81 FR 49684) soliciting public comment on this study. SAMHSA received no comments on the planned data collection.

Consultation Outside of the Agency
Consultation on the design, instrumentation and data availability of the data-collection activities occurred throughout the development process. Consultations were sought from the following:

Jordana Ash, LCSW, IMH-E (IV)
Early Childhood Mental Health Director
Denver, CO.

Allison B. Boothe, PhD
Assistant Professor of Psychiatry
Director, Quality Start Early Childhood Mental Health Consultation Program
Tulane University School of Medicine

Nicola A. Conners-Burrow, PhD
Associate Professor
Department of Family and Preventive Medicine
University of Arkansas for Medical Sciences College of Medicine

Sherryl Scott Heller, PhD
Director, Fussy Baby Network New Orleans and Gulf Coast
Tulane University

Alison Steier, Ph.D.
Director, Harris Infant and Early Childhood Mental Health Training Institute
Director, Smart Support: Arizona's System of Early Childhood Mental Health Consultation

Elizabeth Bicio, LCSW
Program Manager
Early Childhood Consultation Partnership®Advanced Behavioral Health, Inc.

These consultations serve several purposes: (1) to assess perspectives across stakeholder groups regarding evaluation priorities; (2) to ensure the feasibility of implementation; and (3) to verify the general relevance of the data to be collected and their specific relevance to families and members of minority groups.

9. Payment to Respondents

Respondents will not receive any payments.

10. Assurance of Confidentiality

The protection of respondents' identity and information will be assured to the maximum extent allowed by law. Completion of the participant feedback and follow-up forms will be fully voluntary and, to the extent possible, responses will be stored separately from personally identifiable information (PII), which will be limited to the following:

- Username
- Name
- Email
- Phone numbers
- Mailing address

While completing the pre-assessment (which will collect the demographic information above) is also voluntary, it is required to register for the national webinars and virtual TA events. Collection of this information will fully comply with all aspects of the Privacy Act (System of Records 09-30-0036, Alcohol, Drug Abuse and Mental Health Epidemiologic and Biometric Research Data). PII will generally be maintained by Education Development Center, Inc. (the data collection contractor) inside the above-mentioned IECMHC Services Database, and will not be given to SAMHSA. Respondents will be assured that neither their participation/non-participation nor any responses to items will have any effect on their future eligibility for services, or continuation of employment.

IECMHC management has developed and submitted a Privacy Impact Assessment (PIA) to SAMHSA's Chief Information Officer using the Department of Health and Human Service's PIA/PTA Template. The PIA describes the types of data that will be collected as part of this initiative and how they will be handled within the initiative's electronic systems.

11. Questions of a Sensitive Nature

There are no questions of a sensitive nature.

12. Estimates of Annualized Hour Burden

Table 2 shows the burden associated with IECMHC data collection activities for Option Years 1–3 of this program, the period for which this OMB clearance is being sought. The annualized hourly costs to respondents are estimated to be $13,514.09, based on the assumptions that mental health consultants (i.e., participants in the training and technical assistance activities) will be master's-level counselors and social workers. State and local government employees who will be tasked with the various reporting requirements will have positions equivalent to GS12. The estimates below were calculated based on the Bureau of Labor Statistics Median Weekly Earnings table for counselors and social workers (with 33% added for fringe benefits) and the Federal government's 2015 General Schedule of hourly wages for the state employees. Average burden estimates are based on reported experiences implementing similar feedback instruments and State/Tribal reporting requirements that have been developed for SAMHSA-funded programs.

TABLE 2

Estimate of Respondent Burden

Note: Total burden is annualized over the 3-year clearance period.

Instrument	Number of Respondents	Average Number of Responses per Respondent per year	Total number of responses	Hours per Response	Total Annual Burden Hours	Hourly Wage Rate ($)	Total Cost per Year ($)
Service Pre-Assessment Form	150	6	900	.167	150.30	$28.15	$4,230.95
Training Feedback Form	112	6	672	.167	112.22	$28.15	$3,159.11
Training Follow-up Form	112	4	448	.167	74.82	$28.15	$2,106.18
Technical Assistance Follow-up Form	30	6	180	.167	30.06	$28.15	$846.19
IECMHC Cumulative Services Assessment Form	17	1	17	.333	5.66	$29.46	$166.74
IECMHC Annual and Quarterly Benchmark Data Collection Forms	17	4	68	1.5	102.00	$29.46	$3004.92
TOTALS	**438**	**27**	**2,285**	**—**	**475.06**	**—**	**$13,514.09**

13. Estimates of Annualized Cost Burden to Respondents

There are no startup, capital and maintenance costs associated with this data collection.

14. Estimates of Annualized Costs to the Government

SAMHSA has planned and allocated resources for the efficient and effective management, processing, and use of the collected information in a manner that enhances its utility to agencies

and the public. Including contract costs for collecting, analyzing and reporting performance and outcomes data to inform SAMHSA about the reach, implementation and impact of IECMHC on the populations of interest and Government staff to oversee the evaluation, the annualized cost to the Government is estimated at $79,145. These costs are described below.

A Federal contract was awarded to Education Development Center, Inc., to coordinate the development and implementation of IECMHC data-collection activities. The portion of the contract that covers these activities provides for 1 base year of $83,200, with an option to renew for 3 more years. The estimated average annual cost of the evaluation portion of the contract is $74,825. Included in these costs are the expenses related to supporting the development of, implementing and monitoring the evaluation, including, but not limited to, the following activities: developing an evaluation design based on feedback and program requirements (including GPRA requirements), establishing the web portals that will enable the electronic administration of surveys, providing intensive TTA to State/Tribal mentors to enable them to initiate and lead evaluation efforts with State/Tribal administrators, and performing data analysis and dissemination activities.

It is estimated that SAMHSA will allocate 5% of an FTE each year for Government oversight of the evaluation. Assuming an hourly rate of $41.40 (for a GS14-level position), these Government costs will be $4,320 per year.

15. Changes in Burden

This is a new data collection.

16. Time Schedule, Publication and Analysis Plans

Time Schedule

The time schedule for the evaluation is summarized in Table 3. A 3-year clearance is requested for this project.

TABLE 3

Time Schedule

ACTIVITY	SCHEDULE
Receive OMB approval for data-collection activities	6 months from the OMB submission date
Service Pre-Assessment Form	2 weeks prior to each national webinar and TA event — approximately 9 for Option Years 2 and 3
Training Feedback Form	Immediately following each national webinar and TA event — approximately 9 for Option Years 2 and 3
Training Follow-up Form	2 months following each national webinar and TA event — approximately 9 for Option Years 2 and 3
Technical Assistance Follow-up Form	2 months following the delivery of TA — approximately 10 for Option Years 1, 2 and 3
IECMHC Cumulative Services Assessment Form	At end of Option Years 1, 2 and 3
IECMHC Annual and Quarterly Benchmark Data Collection Forms	Quarterly for Option Years 1, 2 and 3, with Annual reporting at the end of each Option Year

Publication Plan

Annual and final reports will be submitted to SAMHSA with anticipated subsequent dissemination to other interested parties, such as researchers, policymakers and program administrators at the Federal, State and local levels. As part of the contract, in Option Year 3, IECMHC management will disseminate products that will share lessons learned, models developed, challenges, new findings, and/or other information that may emerge from the CoE's work. Examples of the types of products are topical briefs, peer-reviewed journal articles, manuals and conference presentations.

Data Analysis Plan

Data collected on the Assessment, Feedback and Follow-up forms will be analyzed using descriptive statistics (e.g., frequencies, percentages), allowing for comparisons and generalization. Correlations will be examined between individual- and State/Tribe-level reporting for relationships between training topics, audiences and specific interventions or assessments that were the focus of trainings. Results of the annual State/Tribe assessments will be compared against benchmarks established by SAMHSA. All data will be aggregated at the State/Tribe level.

Data collection from TTA recipients will be guided by pragmatic questions:

- What was the reach and nature of products and services provided? What was their perceived quality? How useful were they? What are the characteristics of participants reached? What populations do they serve?
- What was the perceived impact of products and services? Did participation result in changes in individual knowledge, attitudes, and practices—that is, did they advance the core competencies of the IECMHC workforce?
- Did improvements in workforce and infrastructure capacity to implement IECMHC result in improved processes, practices, systems and/or policies?

Other measures the IECMHC Evaluator will collect include numbers, distribution and nature of products/training and TA services delivered; number, distribution and characteristics of participants; quality, utility and impact of services provided; and cumulative service assessments.

Data to be collected from States/Tribes include:

- The number of States/Tribes that identify a dedicated lead for IECMHC at the State level
- The number of States/Tribes developing and/or distributing marketing materials for IECMHC to programs to increase utilization of IECMHC services
- The number of States/Tribes that establish or adopt standards for the training of IECMHC consultants in their State (e.g., core competencies, credentials)
- The number of States/Tribes that implement IECMHC and include formal evaluation of the impact of IECMHC on provider practices and child and/or parent outcomes
- The number of States/Tribes that have developed sustainable financing, business and/or payment models for the continuation of IECMHC in their States, Tribes and/or communities
- Benchmark performance measures for States/Tribes with MIECHV-funded home visiting programs (4 total)

- Rates of pre-K expulsions in each State/Tribe

17. Display of Expiration Date

All data collection instruments will display the expiration date of OMB approval.

18. Exceptions to Certification Statement

This collection of information involves no exceptions to the Certification for Paperwork Reduction Act Submissions. The certifications are included in this submission.

[1]Hair, E., Halle, T., Terry-Humen, E., Lavelle, B., & Calkins, J. (2006). Children¹s school readiness in the ECLS-K: Predictions to academic, health, and social outcomes in first grade. *Early Childhood Research Quarterly*, *21*, 431454.

[2] Center on the Developing Child at Harvard University. (2011). Building the brain's "air traffic control" system: How early experiences shape the development of Executive Function: Working Paper No.11.

[3]http://www.nccp.org/publications/pub_1087.html

[4]Mather, M., & Jarosz, B. (2014). Where poverty and inequality intersect in the U.S. Chapter in PRB Population Bulletin, The Demography of Inequality in the United States. http://www.prb.org/Publications/Reports/2014/us-inequality-poverty.aspx (accessed on 5/15/2015)

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

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[6]Gilliam, W. & Shahar, G. (2006). Pre-kindergarten expulsion and suspension: Rates and predictors in one state. *Infants & Young Children*, 19 (3), 228-245.