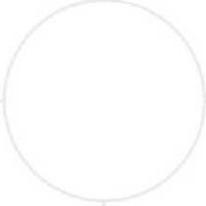


**Change in Mind Initiative:
Final Evaluation Report**

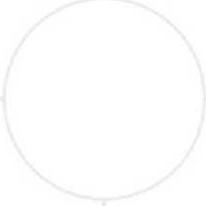
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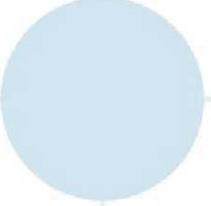
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Introduction

Through the Alliance for Strong Families and Communities' two-year Change in Mind initiative, a cohort of 15 U.S. and Canadian organizations has demonstrated the impact of intentionally infusing brain science research findings into their programs and organizations. The cohort also has identified new insights into the longer-term opportunities and challenge of facilitating and accelerating change at the systems and policy levels. The initiative, which was conducted in partnership with the Robert Wood Johnson Foundation and the Palix Foundation's Alberta Family Wellness Initiative, found that social sector organizations of all types and sizes can contribute to systems and policy change. Another breakthrough finding was that rather than treating Change in Mind projects as stand-alone activities most sites viewed Change in Mind as a "game changer" and embedded brain science principles throughout their organizations.

Change in Mind Cohort Sites

In 2015, the Change in Mind initiative created a peer learning community or cohort of 10 sites from the U.S. and five sites from Alberta, Canada (see Exhibit 1). The sites were selected by an independent selection committee based on their knowledge of adverse childhood experiences (ACEs); experience providing trauma-informed care; willingness and capacity to participate in the initiative; and proposals for how they planned to change their organizations, influence local service systems, and advocate for financial, regulatory, and legislative policy change.

Exhibit 1: Change in Mind sites reported by organizational type

Organization Type	Change in Mind Site
1. Large health systems	Children's Hospital of Wisconsin in Milwaukee, Wisconsin (CH)
	KVC Health Systems in Olathe, Kansas (KVC)
2. Multisite agencies	Big Brothers, Big Sisters of Calgary and Area in Calgary, Alberta (BBBS)
	Children and Families First in Wilmington, Delaware (CFF)
	Children's Home Society of Washington in Seattle, Washington (CHS)
3. Regional treatment facilities	CASA Child, Adolescent, and Family Mental Health in Edmonton, Alberta
	LaSalle School in Albany, New York (LSS)
	Sheldon Kennedy Child Advocacy Centre in Calgary, Alberta (SKCAC)
	The Family Partnership in Minneapolis, Minnesota (TFP)
4. Local multiservice agencies	CUPS Health, Education, Housing in Calgary, Alberta (CUPS)
	Family Service Association of San Antonio in San Antonio, Texas (FSA)
	Wellspring Family Services in Seattle, Washington (WS)
5. Neighborhood service centers	Boyle McCauley Health Centre in Edmonton, Alberta (BMHC)
	East End House in Cambridge, Massachusetts (EEH)
	Martha O'Bryan Center in Nashville, Tennessee (MOB)

The Change in Mind sites are diverse, ranging in organizational size, population reach, prevention or treatment service orientation, sphere of influence (local, state or province, or regional), and geographic location. The sites represent five different organizational groups or types:

1. Large health systems

2. Multi-site organizations with state/province-wide geographic reach
3. Regional treatment facilities with state/province-level influence
4. Local multi-service organizations with regional influence
5. Neighborhood service centers with local influence

Change in Mind Evaluation

Change in Mind's use of a developmental evaluation approach, rapid testing of program and practice innovations, and rigorous application of cohort- and site-level theories of change have become differentiating aspects of the initiative in accelerating our understanding of where policies and practices at organizational and systemic levels need to shift for true alignment with advances in neurosciences. Specifically, the evaluation was designed to understand how the Change in Mind initiative addressed the challenges of:

1. Infusing brain science research into their organizational cultures, programs, and practices
2. Leveraging scientific advances in brain development to facilitate sector and systems change
3. Accelerating systems change within a larger policy context
4. Supporting peer learning through a peer-based learning collaborative model

The evaluation was designed to monitor, track, and map the sites' development, identifying patterns of activity across organizational types and country contexts. The evaluation used a mix of qualitative data collection methods (interviews, document reviews, and site visits) and quantitative data collection methods (review of site administrative data, cross-site feedback, and two annual site reporting surveys). The evaluation's findings, as well as lessons learned by the sites, are summarized in [four lessons learned briefs](#).

This final evaluation report summarizes the findings from the final site survey the sites completed in July 2017. The report summarizes the sites' final reflections on their progress and experiences in Change in Mind. These are new findings not included in the earlier briefs. The report provides summary results, aggregating the ratings of the 14 sites that completed the survey and a cross-site analysis, reviewing differences in site experiences by organization type. The report highlights country-based differences noted by the sites, as well as sites' reports of how internal organizational factors and external environmental factors affected their progress.

The next section reports on the sites' perceptions of the progress they made in incorporating brain science research into their program practices, organizational cultures, activities to change local service systems, and efforts to advocate for larger administrative and legislative policy change. Subsequent sections provide the sites' feedback on the Change in Mind cohort model and discuss the implications of these findings for future iterations of the cohort model for the next phase of the initiative, the creation of the Change in Mind Institute.

Site Progress Findings

This section addresses three evaluation questions regarding how the sites:

- Infused brain science research into their organizational cultures, programs, and practices
- Leveraged scientific advances in brain development to facilitate sector and systems change
- Accelerated systems change within a larger policy context

The section covers the sites' development of their theories of change and their progress making changes to their program practices, organizational cultures, their external activities facilitating systems change, and their work advocating for broader policy change.

Developing Cohort- and Site-Level Theories of Change

Theories of change are “the ideas and hypotheses (theories) people and organizations have about how change happens.”¹ They explain how activities are understood to produce a series of results that contribute to the final intended impacts of an intervention.² Theories of change can be developed for interventions at any level or combination of levels including projects, programs, strategies, organizations, systems, and broader-level policies.

For the Change in Mind initiative, theories of change were developed for the cohort overall and for each of the 15 cohort members. The overall initiative theory of change was designed to facilitate change in three mutually reinforcing spheres of influence:

- The cohort's 15 social service organizations (the innermost sphere)
- The more than 400 organizations that are part of the Alliance's strategic action network of members and partners and the Palix Foundation's strategic partners (the middle sphere)
- The larger field of social service sectors (the outermost sphere).

See the Change in Mind Brief [Change in Mind Overview, Findings, and Lessons Learned](#) for more details. Each site was asked to create its own theory of change addressing four levels: Client-level programs, organization-level policies and practices; system-level activities; and broader policy-level change.

The Change in Mind theory of change development process was designed to achieve several goals:

- Provide the sites with a common language, minimum specifications, and a set of tools for developing or refining their theories of change
- Sharpen the sites' thinking about the nature of the challenges being addressed
- Guide practical decisions regarding the design and implementation of the sites' interventions
- Communicate the deeper thinking behind the sites' strategies to stakeholders

The Change in Mind theory of change narratives and diagrams were specifically designed to:

- Show the causal links between an initiative's context, activities, outputs, short-term changes, and longer-term outcomes

¹ Hivos. (2015). *Theory of change thinking in practice: A stepwise approach*. Retrieved from http://www.theoryofchange.nl/sites/default/files/resource/hivos_toc_guidelines_final_nov_2015.pdf

² Rogers, P. (2014). *Theory of change: Methodological briefs, impact evaluation no. 2*. Retrieved from UNICEF: http://devinfohive.info/impact_evaluation/img/downloads/Theory_of_Change_ENG.pdf

- Create questions and measures to test specific causal chains or pathways
- Pinpoint strategic areas for more formal evaluation
- Build the evidence base for how to design and implement effective programmatic, organizational, systemic, and policy change

The sites drafted baseline theory of change documents during the Change in Mind cohort’s November 2015 convening, reviewed and revised them as needed in the cohort’s September 2016 convening, and shared updates in the cohort’s final convening in May 2017. Throughout this process, the sites were asked to assess the completeness, coherence, plausibility, feasibility, and evaluability of their theories of change.

The theories of change created by the sites in late 2015 reflected their early understandings of how to facilitate change at different levels. In November 2015, the sites designed their initiatives as complicated projects that were comprised of separate, linear sequences of activities implemented at four different levels (program, organization, system, and policy). Of the 15 sites, 13 sites created detailed theories of change at the program level and 12 of the 13 sites also developed detailed theories of change at the organizational level. Only three sites’ theories of change were fully detailed at both the systems and policy levels. The other 12 sites drafted more emergent and less predefined theories of change at the system level and nine sites did so at the policy level. Of the 15 sites, three sites did not create policy-level theories of change in 2015.

Site Progress: Theories of Change

Through experience, the sites learned that their strategies were more iterative and intertwined than originally predicted. The sites were asked to review their theories of change in May 2017, and to make revisions if appropriate. For some sites, organizational developments that occurred between 2015 and 2017 gave them the capacity to plan and implement more fully detailed systems- and policy-change strategies. At the same time, some external policy changes that occurred between 2015 and 2017 influenced the sites’ internal programs, policies, and practices. Based on those experiences, some sites modified their theories of change in 2017 to reflect more adaptive, interdependent, and mutually reinforcing cycles of action and learning between internal (program and organization) and external (system and policy) levels.

The sites differed by organizational type in the changes they made to their theories of change. The types of changes made between 2015 and 2017 did not differ significantly between the U.S. and Canadian sites, but did vary by organizational type. For example, both large health systems in the cohort (KVC Health Systems and Children’s Hospital of Wisconsin) reported making theory of change adjustments to address internal system implementation barriers and opportunities. KVC’s primary change in its theory of change was to align its existing trauma-informed clinical model, Trauma Systems Therapy, with the new neuroscience language introduced through the initiative. “Ultimately, we found that Trauma systems Therapy could be used as part of the Change in Mind initiative.” The Children’s Hospital of Wisconsin “evolved to incorporate an increased understanding of complexity theory,” adding

communications framing, developmental evaluation, and human-centered design strategies to its organization-level theory of change.

The statewide organizations in the cohort reported retaining their original theories of change but shifted the emphasis of their implementation efforts over time. For example, the Children’s Home Society of Washington reported that its theory of change remained the same in substance, but expanded its efforts to seize on new external opportunities. Big Brothers, Big Sisters of Calgary continued worked at all four levels (program, organization, system, and policy), but redistributed its effort to work more at the organizational level to increase staff and volunteer awareness and board support. Children and Families First did not change the basic structure of its theory of change, but adjusted its systems change strategies over time as that work evolved.

The local multi-service agencies in the cohort reported embedding their theories of change deeply into their organizational goals and strategies, shifting their organizational cultures. For example, CUPS Health, Education, Housing staff reported that the first draft of its Change in Mind theory of change was completed while it was in the process of building a new organization-wide theory of change and strategic plan. “As we continued our process of revamping our organizational theory of change, we realized that our organization was so embedded in brain science that it didn’t make sense to have two theories of change any more.” The Family Services Association commented that its theory of change has evolved and gained in importance over time. “We are now at a place where we can drive the most impact from our efforts [through] our theory of change.”

The regional treatment centers in the cohort reported using their theories of change to simplify and clarify their change strategies. The Family Partnership reported, “The most significant change to our theory of change was a reduction in the complexity of the model (pruning a number of pathways of activity),” which included eliminating the agency’s vice president of public affairs position. Staff at the Sheldon Kennedy Child Advocacy Center (SKCAC) reported, “The SKCAC’s theory of change, at its core, did not change direction. But, it became increasingly solid as brain science became more clearly defined and its strategies continued to be implemented.” The LaSalle School noted that it did not make significant changes to its theory of change but gained a better understanding of the timeline needed to enact it. “We are just starting to get the foothold necessary to make real change.” CASA Child, Adolescent, and Family Mental Health refined its theory of change after the agency sought expert advice that enabled the agency to identify its strategic niche around practice innovation and policy advocacy.

The two neighborhood service centers in the cohort that completed the final site survey (Boyle McCauley Health Centre and the Martha O’Bryan Center) reported no substantive changes in their theories of change. However, the Martha O’Bryan Center did edit its theory of change document to clarify the document’s focus, underlying assumptions, and anticipated changes.

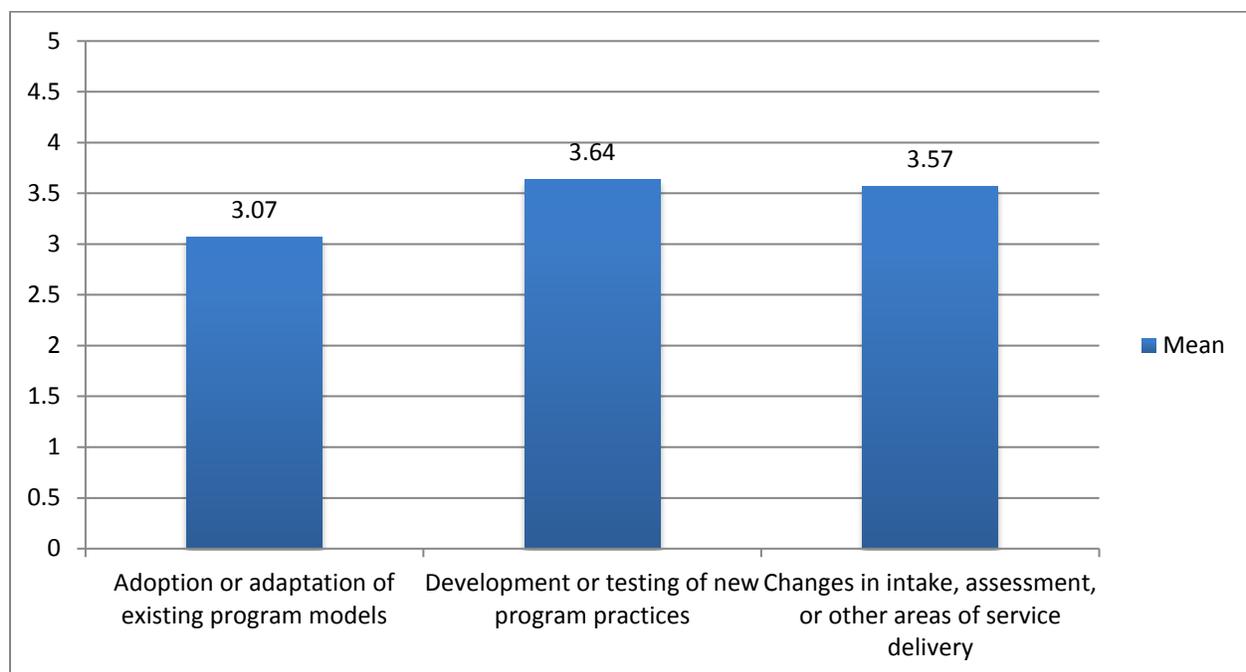
Site Progress: Program and Practice Change

Unlike other kinds of learning collaboratives that may direct participating sites to select and implement predetermined program models, policies, or practices, the Change in Mind initiative was not prescriptive in terms of how sites were to change their existing programs or adopt new practices. This enabled sites

to identify gaps between their existing programs and practices and more brain science-aligned approaches and to modify their programs and practices or develop new ones as needed that were appropriate to their local context and to the needs of their clients. The sites used several strategies to modify existing programs; develop new program practices at intake, assessment, or other areas of service delivery; and scale up their use of evidence-based programs that are aligned with the newest brain science.

On average, organizations rated their progress in areas related to adapting existing program models, testing new practices, and changes to intake assessment or other areas of service delivery between “moderate” and “substantial.” Survey respondents across the organizational groups reported between “moderate” and “substantial” progress on the development or testing of new program practices (M=3.64) and between “moderate” and “substantial” progress changing intake, assessment, or other areas of service delivery (M=3.57). Organizations across all groups rated their progress on the adoption or adaptation of existing program models as “moderate” (M=3.07) (Exhibit 2).

Exhibit 2. Reflecting on your Change in Mind activities over the last two years (since June 2015), how would you rate your progress in the following areas? (n= 14)



Note: 1= “None”; 2= “A little”; 3= “Moderate”; 4= “Substantial”; 5= “Exceptional”

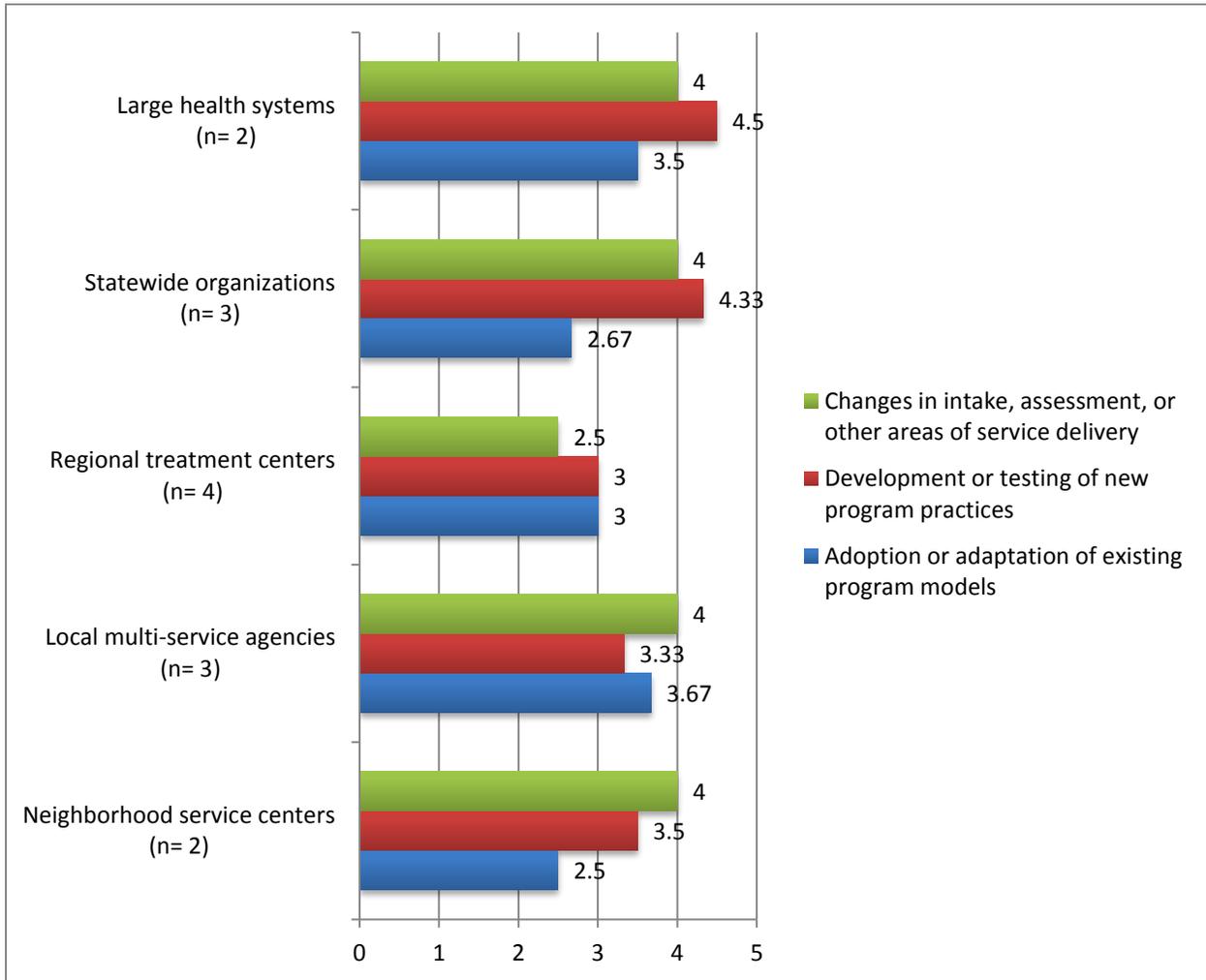
Ratings of progress varied across organizational groups. Large hospital systems and statewide organization rated their progress the highest in developing or testing new program practices (M=4.50 and 4.33, respectively). Large health systems (n=2) also reported “substantial” changes in intake, assessment, or other areas of service delivery (M=4), and between “moderate” and “substantial” adoption and adaptation of existing program models (M=3.5). One health system, KVC, reported, “We use our learning lab to test new tools on a regular basis and primarily focus on the development of

programs to teach families and children self-regulation and executive thinking skills.” Children’s Hospital staff noted, “The tools and processes from developmental evaluation and human centered design have provided tools and structure for innovation (both in policies/systems change as well as in program practice) that have become central to our practice.”

Statewide organizations (n=3) also reported “substantial” progress on changes in intake, assessment, or other areas of service delivery (M=4), but reported between “a little” and “moderate” progress in adopting or adapting existing program models (M=2.67). Two organizations were also active in developing new services or service delivery practices. One of the statewide organizations, the Children’s Home Society, reported, “CHS is leveraging its partnership with the Washington Cluster of the Frontiers of Innovation Initiative at the Center on the Developing Child at Harvard University to expand its involvement in at least seven joint [program development] projects. Most projects involve co-design between a top researcher and Children’s Home Society of an innovation to support early learning and development, followed by rapid cycle testing.” Big Brothers, Big Sisters of Calgary reported, “Through prototyping that was conducted as part of a 90-day campaign, new practices were tested including new approaches to mentor training and intake interviewing for families.”

Regional treatment centers (n=4) reported the lowest rates of progress in making changes in intake, assessment, or other areas of service delivery (M=2.5), in contrast to other organization types that reported “substantial” progress (M=4.0). Progress in adopting or adapting existing program models was rated the lowest by all types of organizations except for local multi-service agencies (M=3.67) (Exhibit 2a). One local multi-service agency, CUPS Health, Education, Housing, developed and is using the CUPS Resiliency Matrix with each client as part of a new common intake process where clients enter the agency building through a single entryway where they tell their story only once, making the process more trauma-informed.

Exhibit 2a. Program progress reported by organization type



Note: 1= “None”; 2= “A little”; 3= “Moderate”; 4= “Substantial”; 5= “Exceptional”

Contextual dynamics inside and outside the sites’ organizations created unexpected opportunities for change in some sites. In the final site survey, the Change in Mind sites were asked how internal and environmental factors influenced their projects. Children’s Hospital staff reported that when budget cuts eliminated the Change in Mind Well-Being Assessment program, the staff used core Change in Mind principles to rethink their approach and move away from creating more programs to collaborating with others on systems and policy change. Martha O’Bryan Center staff explained, “As a nonprofit organization located within an at-risk housing community in an urban area, both the programs within our agency and the needs of our community are dynamic, continually changing and adapting to the current culture in our neighborhood. Participating in Change in Mind aided us in analyzing how to link the project’s goals with our agency goals during these periods of programmatic change to develop appropriate responses.”

Site Progress: Organizational Change

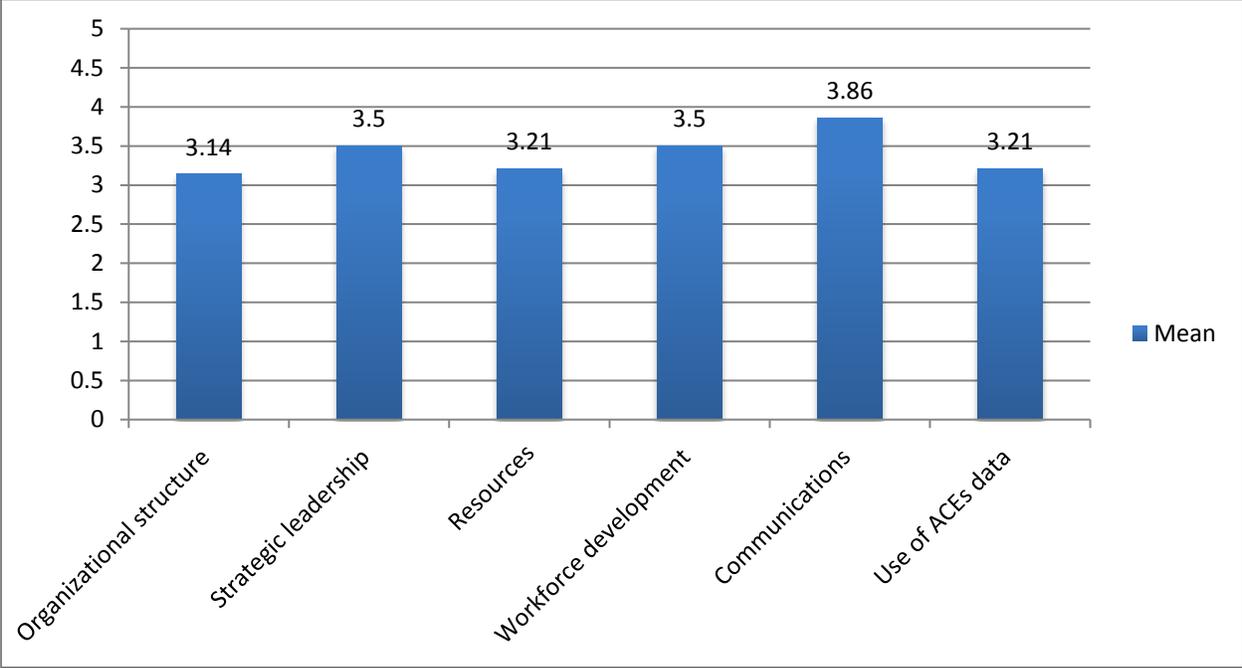
Change in Mind sites used several strategies to infuse brain science into their organizational cultures, programs, and practices. To align their organizational goals and resources with brain science research, the sites used strategic leadership methods, adapted their organizational structures, and aligned their resources. To build organizational capacity to carry out their Change in Mind goals, the sites reframed their communications strategies, enhanced their workforce development efforts, and adopted new innovation design and rapid cycle evaluation methods.

Related to changing organizational culture, the organizations, on average, rated their progress between “moderate” and “substantial.” The highest rating in this area concerned progress in communications (m=3.86), whereas the lowest was related to changing organizational structure (3.14). Other areas with highest rated progress in changing organizational culture were workforce development (M=3.5), and strategic leadership (M=3.5). In contrast, less progress was reported in the areas of shifting resources and using ACEs data (M=3.21 in both areas) (Exhibit 3). One local multi-service agency, Wellspring Family Services, explained, “All staff, including incoming staff, and all board members, have participated in or are scheduled to participate in the basic training we provide [on brain science principles]. This basic training includes the use of the Brain Architecture Game and topics that are specific to the staff’s work area ... Our fund development department and social media have been extremely successful in focusing on the communication of these principles, using the Core Story of Brain Development [created by the Palix Foundation] and the Framework Institute’s process.”

Communications received the highest rating or was tied for the highest rating for every type of organization type except neighborhood service centers. Large health systems had the highest rating of progress concerning communications (M=4.5), but all other organizational types fell between M=3.75 and M=4.0 except for neighborhood service centers, which scored the lowest (M=3.0). Similarly, all organization types reported between “moderate” and “substantial” progress concerning workforce development except for regional treatment centers, which reported less progress (M=2.75). Local multi-service agencies reported making the most progress in the collection and use of ACEs data and in changing their organizational structure (M=3.67 for both areas), while regional treatment centers reported the least progress in both areas (the collection and use of ACEs data (M=2.5) and organizational structure (M=2.75)) (see Exhibit 3a).

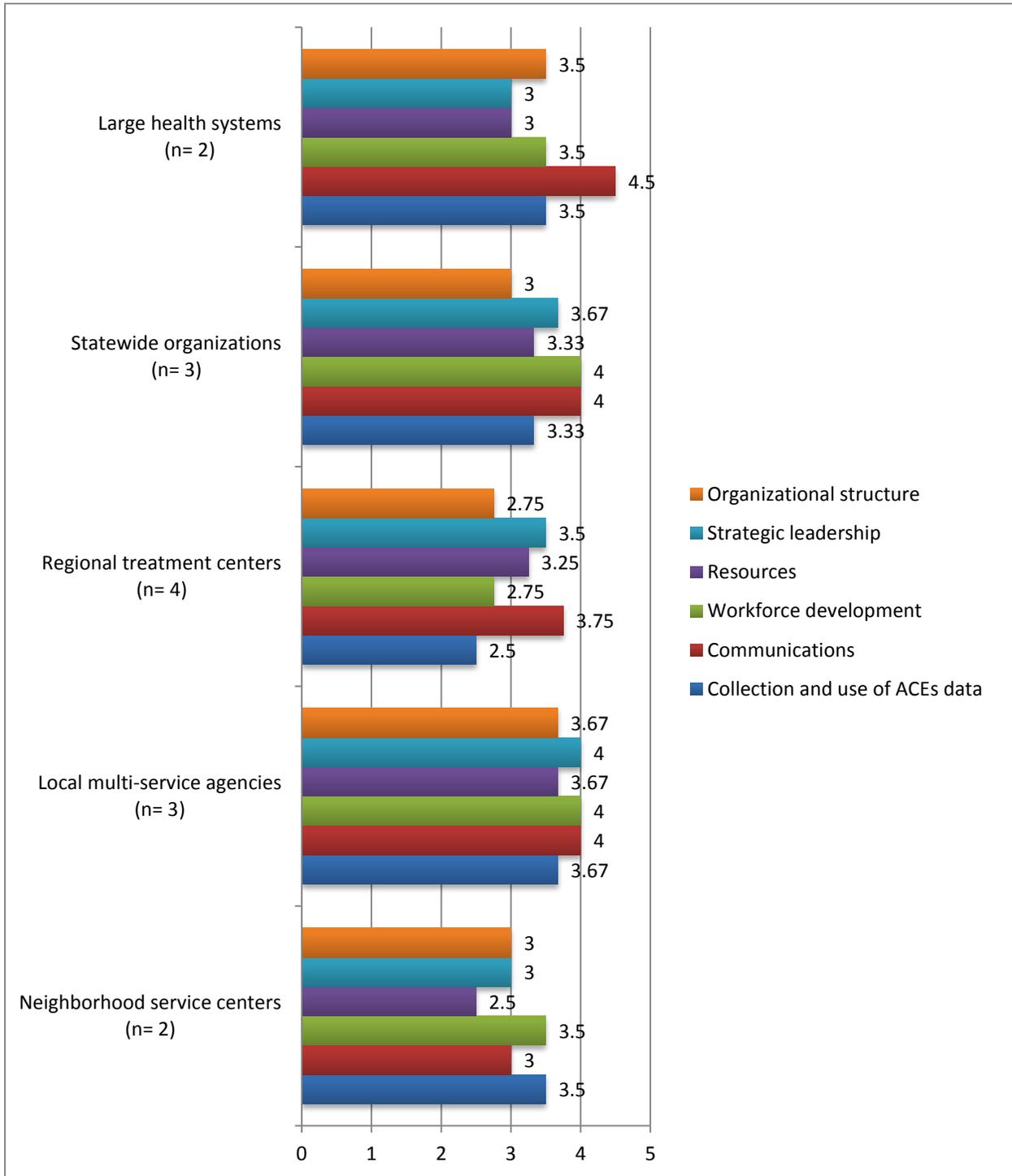
Several Change in Mind sites described the ways in which specific elements of the initiative affected their organizations. For example, the Children’s Home Society reported that the FrameWorks Institute training and materials were so compelling that their communications and marketing director adopted them. This resulted in reshaping the organization’s 2016-2021 strategic plan and revamping the agency’s service delivery model based on “the latest findings in brain science and outcomes-based, trauma-informed, multi-generational and culturally relevant approaches.”

Exhibit 3. Reflecting on your Change in Mind activities over the last two years (since June 2015), how would you rate your progress in changing your organizational culture? (n= 14)



Note: 1= "None"; 2= "A little"; 3= "Moderate"; 4= "Substantial"; 5= "Exceptional"

Exhibit 3a. Organization change progress reported by organization type



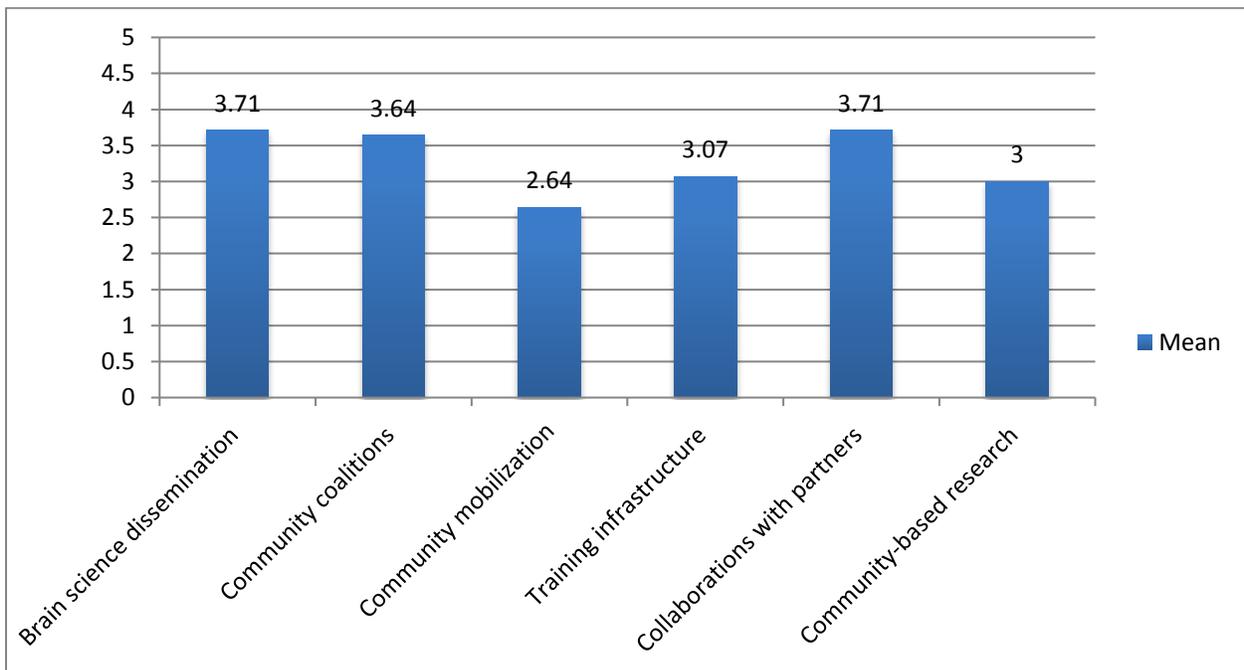
Note: 1= "None"; 2= "A little"; 3= "Moderate"; 4= "Substantial"; 5= "Exceptional"

Site Progress: Systemic Change

The Change in Mind sites also used neuroscience research to facilitate changes in community service systems. These changes were designed to support local systems' focus on supporting healthy child development, increasing resilience, and ensuring community well-being. The sites used two general approaches to achieve these goals. They began by building their communities' knowledge, networks, and skills to work effectively on neuroscience-aligned systems and policy change. They then used this enhanced capacity to work with key partners and collaborators to advocate for systemic change within and across local service sectors, including child protection, child care, K-12 education, housing services, and family and juvenile justice.

Except in the areas of community mobilization and engagement, ratings of progress related to changes in community systems fell between “moderate” and “substantial” across all organization types. With a mean rating of 2.64, community mobilization and engagement fell between “a little” and “moderate,” on average. The highest ratings of progress were reported in the areas of brain science dissemination and collaborations with partners (M= 3.71 for both areas), followed closely by progress working with community coalitions (M=3.64) (Exhibit 4).

Exhibit 4. Reflecting on your Change in Mind activities over the last two years (since June 2015), how would you rate your progress concerning changing community systems? This includes actions involving building collective community capacity through: (n= 14)



Note: 1= “None”; 2= “A little”; 3= “Moderate”; 4= “Substantial”; 5= “Exceptional”

Across all organization types, community mobilization and engagement was consistently one of the areas with the lowest progress rating. While regional treatment centers and neighborhood service centers reported “moderate” progress in this area (M=3.25 and M=3 respectively), all other organization

types reported less (“a little” to “moderate”) progress. One regional treatment center, The Family Partnership reported, “Our Two Generation Executive Functioning model with parents and children in child care will be a major project that will engage two communities we serve: Families on the North Side of Minneapolis (a predominantly African-American community) and American Indians who are using our Four Directions Family Center on the South Side of Minneapolis.”

At the neighborhood level, the Boyle McCauley Health Centre also reported on its engagement with Edmonton’s Aboriginal community, “We have had the chance to start talking with the Homeward Trust (Edmonton’s Housing First Program) about the use of ACEs surveys in more Housing First programs in the city. We were also able to talk with them about a way to incorporate First Nations questions into the ACEs survey to look at the effects of residential schooling on our homeless Aboriginal people. First Nations staff see this as an opportunity for healing and reconciliation for both Aboriginal and non-Aboriginal people.”

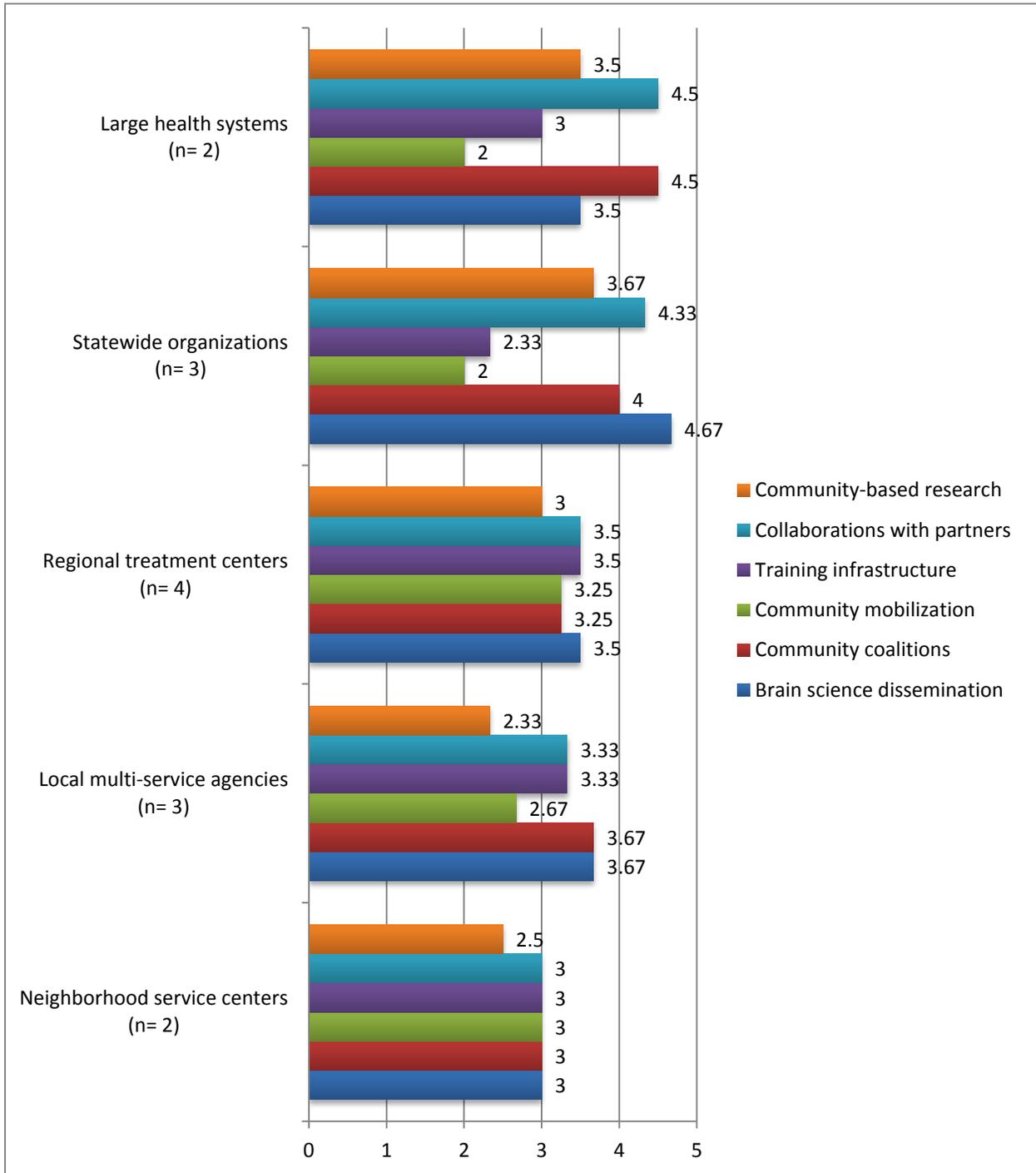
Statewide organizations reported “substantial” progress in brain science dissemination (M=4.67), with other organization types reporting between “moderate” and “substantial” progress. The statewide organizations may have had more success in this area because they may have access to more channels of dissemination. One statewide organization, Children and Families First, commented, “We have come so far in this [dissemination] area of work. We have become sought-after for training around topics related to ACEs and toxic stress, particularly in the education community. We are leveraging that work to develop a more comprehensive brain science institute.”

Across organization types, large health systems gave the highest systems change ratings in the areas of collaborating with partners (M=4.5) and working with community coalitions (M=4.5), reporting between “substantial” and “exceptional” progress. KVC staff commented, “We have shared [brain science] information with three community groups: the Missouri Trauma Roundtable, Resilient KC (Kansas City), and Trauma Matters KC.”

Several sites noted both positive and negative influences of politics on Change in Mind projects.

Among the cohort’s two large health systems, KVC noted that Kansas’ state government has limited access to state funding for new projects. The Children’s Hospital reported a different experience, that the 2016 release of *Evicted*, Matthew Desmond’s acclaimed book on Milwaukee’s housing crisis, made it “noticeably easier to engage others, including health care providers, on the issue of housing, opening up a dialog and opportunity for one of its core Change in Mind projects.”

Exhibit 4a. Community systems progress reported by organization type



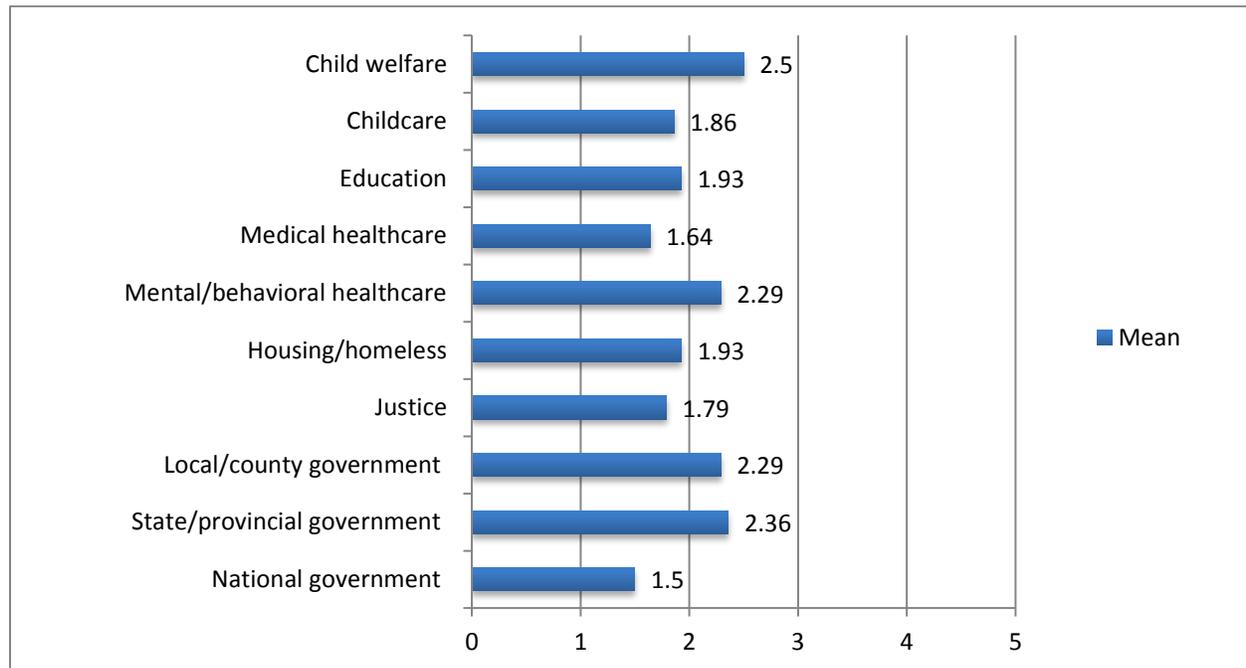
Note: 1= "None"; 2= "A little"; 3= "Moderate"; 4= "Substantial"; 5= "Exceptional"

Site Progress: Policy Change

Using their communities' enhanced collective capacity, the sites also worked with key partners and collaborators to advocate for policy change within specific service sectors, including child welfare, childcare, K-12 education, housing services, and family and juvenile justice.

Ratings of progress related to policy change were lower on average than the other areas reported. In six of the reported policy areas, respondents indicated between “no” and “a little” progress. In the remaining four areas, respondents reported between “a little” and “moderate” progress. On average, the lowest level of progress was reported in the areas of working to change national government policy and health care policy (M=1.5 and M=1.64 respectively). Progress in working to change child welfare policy was rated the highest and fell between “a little” and “moderate” progress (M=2.5) (see Exhibit 5).

Exhibit 5. Reflecting on your Change in Mind activities over the last two years (since June 2015), how would you rate your progress concerning policy change? This includes actions involving advocating for or impacting policy change: (n= 14)



Note: 1= “None”; 2= “A little”; 3= “Moderate”; 4= “Substantial”; 5= “Exceptional”

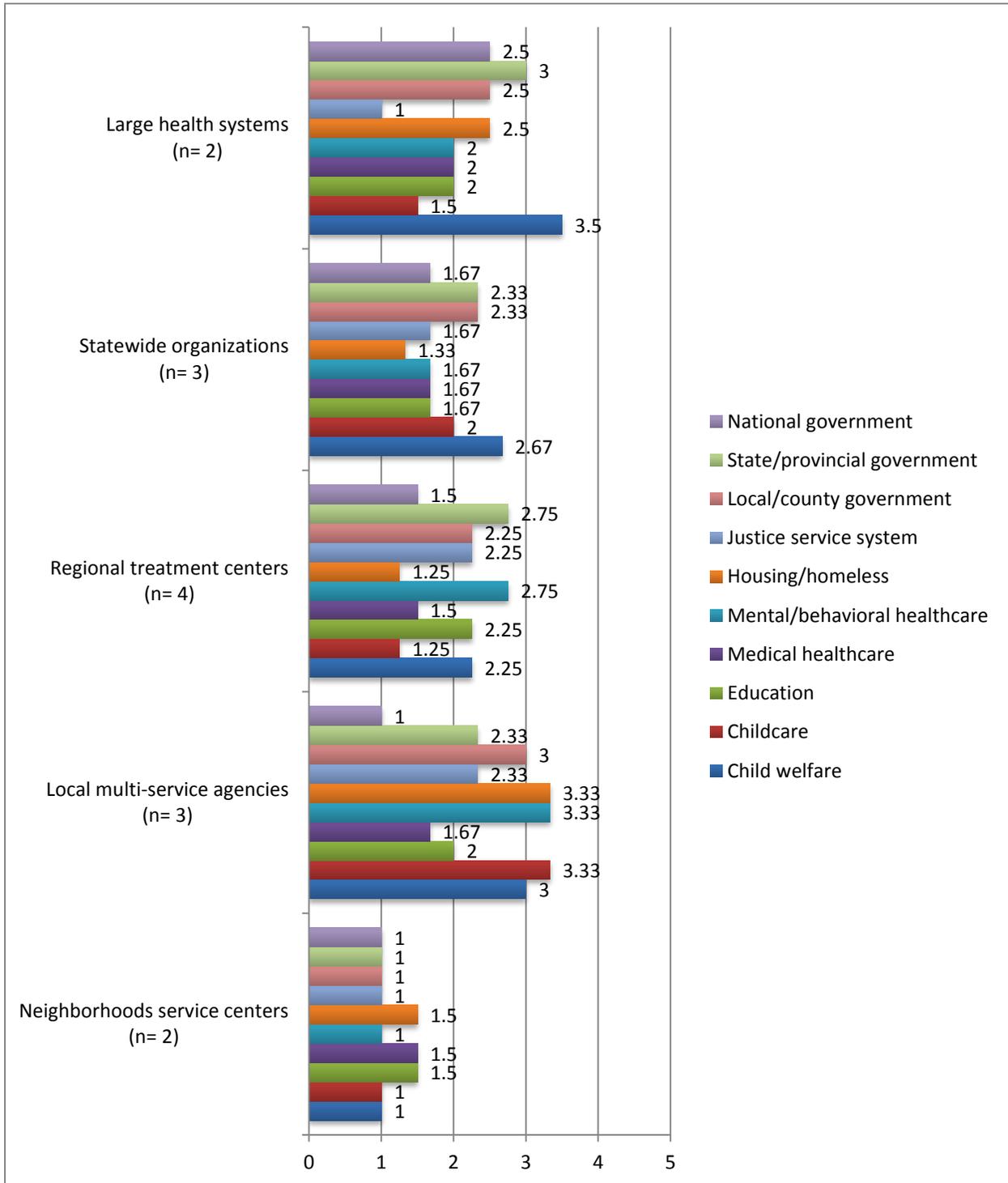
Overall, rating of progress related to policy change was lower than other areas across all organization types. Different types of organizations also focused on changing in policy in different service sectors. Neighborhood service centers reported the lowest progress ratings in most areas of policy change. Conversely, the two large health systems in the cohort reported making the most progress in working to change child welfare policy (M=3.5) and state/provincial government policy (M=3). The local multi-service agencies in the cohort reported making the greatest progress working to change in the areas of housing/homeless policy (M=3.33), mental/behavioral health care policy (M=3.33), and child care policy (M=3.33) (Exhibit 5a).

One local multi-site agency, Wellspring Family Services, explained its progress ratings in housing/homeless services. “We made two forays into changing elements of the homeless family system: First, we were awarded a contract to team a housing specialist with a child mental health specialist to provide housing and parent/child services to homeless families in one elementary school near us. The contract is with the local housing authority, which is providing housing vouchers to the families. Second, a local nonprofit housing developer who had not previously provided supportive services to formerly homeless families has entered into a memorandum of understanding with us to provide housing with parent/child support services to 40 formerly homeless families in a new residential building that will be completed in the spring of 2018.”

One large health system, the Children’s Hospital of Wisconsin, has also made progress in changing local housing services for families who are at risk of entering the county’s child welfare system. They reported, “Through our Housing Opportunities Made to Enhance Stability (HOMES) housing initiative and by doing expert interviews based on [principles of] human-centered design, we have developed new partnerships with local housing agencies that are leading to exciting new projects (Medical-Legal Partnerships, Supportive Housing in Child Welfare, Parent-Child Interaction Therapy (PCIT)/parenting services integrated with housing services) and to the development of a new response to physical neglect/housing in child welfare.”

New state/province-level policies and institutional structures created more favorable conditions for brain science-aligned reforms. One local multi-service organization, Family Services Association of San Antonio (FSA), commented that the creation of the State Trauma-informed Learning Community by the Texas Department of State Health Services provided an opportunity for FSA to advocate successfully for the local collection and use of ACEs data to adapt local services to client and community needs. The LaSalle School, a regional treatment center, also discussed the brain science-related benefits of New York State’s policy change that raised the age of criminal responsibility to age 18. In addition, new state and provincial agencies were created in Washington State and Alberta, combining the full spectrum of children’s services from childcare and early learning to child welfare, foster care, and adoption services within a single organization.

Exhibit 5a. Community policy progress reported by organization type



Note: 1= "None"; 2= "A little"; 3= "Moderate"; 4= "Substantial"; 5= "Exceptional"

Change in Mind Cohort Evaluation Findings

This section addresses a fourth evaluation question regarding how the Change in Mind initiative supported peer learning through a peer learning-based cohort model. The section covers the sites' feedback on the cohort's meetings, webinars, technical assistance, and other resources, including the Alliance website and resource library.

Cohort Convenings

Through the initiative, the Change in Mind sites received grants of \$50,000, which some sites used to participate in a series of six in-person meetings between September 2015 and May 2017.

- The first convening (Aug. 24-26, 2015) provided an orientation to the project, and extensive grounding in foundational brain science including advances in neuroscience-informed programs, practices, and tools.
- The second convening (Nov. 3-5, 2015) focused on the use of developmental evaluation methods, the creation of cohort- and site-level theories of change informed by complexity, systems, and implementation science theories, and the use of iterative cycles of rapid testing and evaluation for learning and improvement.
- The next two meetings (Jan. 13-14, and April 13-14, 2016) were dedicated to framing science and communications training provided by the FrameWorks Institute.
- The fifth convening (September 20-22, 2016) returned to systems and policy change topics.
- The sixth convening (May 24-26, 2017) provided an opportunity for the sites to reflect on what they had learned through their participation in the initiative, their accomplishments, and how their theories of change had deepened or developed through the experience.

Neuroscience researchers have developed and disseminated many frameworks, models, tools, and techniques using neuroscience advances. A number of these experts trained the sites directly on these materials at the cohort convenings, through online webinars and hundreds of resources posted on the Change in Mind website. The sites were also encouraged to follow up with these experts, as needed, for further site-specific consultation or advice.

In the final site survey, the sites were asked which elements of the Change in Mind initiative worked best for them and to provide evidence supporting their answers. **Of the 14 sites that completed the survey, 10 mentioned the cohort convenings as the best element of the cohort model.** All types of sites, from the smallest neighborhood centers to the largest health systems, responded positively to the meetings. KVC staff commented, "The meetings were probably the best part of the initiative. While travel can be difficult, it was great to meet with so many other organizations that were doing work parallel to ours. Taking the lessons learned [from the meetings] and applying them to our work was extremely helpful." The Boyle McCauley Health Centre team added, "The earlier convenings were amazing. We came away with a lot of really useful information—sometimes too much. But it was really inspiring and motivational."

The sites also listed specific elements of the convenings as the best parts of the initiative.

1. Five sites mentioned the access and exposure to top experts at the convenings. CFF staff commented, “The cohort convenings were incredibly valuable. Not only did we hear up-to-the-minute content from leaders from the field, we had the opportunity to learn so much from each other and to develop a network of professionals to this work.”
2. Three Alberta sites mentioned the opportunity for the Alberta sites to network with each other at the convenings. SKCAC staff reported, “The connection to other sites, particularly those in Alberta, was very helpful and facilitated a community of practice. The convenings were great opportunities to network and better understand the work of others and get ideas about how to apply the brain science.”
3. Three sites wrote about the opportunity for sharing and peer learning at the meetings. FSA staff commented, “The meetings were the best; it was great to hear other agencies’ ideas and thoughts. It was an important part of the work because we were not alone in learning the material, and we have people we can contact around the world to talk about best practice models as necessary.”
4. Three sites also commented on the value of the FrameWorks Institute’s communications training provided in two cohort meetings. However, one site suggested that the material could have been combined into one session for more continuity.

When asked about what seemed to make the Change in Mind cohort special, the sites mentioned the high caliber of the sites selected. Children’s Hospital noted, “The agencies selected weren’t starting from the basics; all seem to be high-performing agencies that have put thought and time into these concepts before Change in Mind.” The sites also commented on the quality of the convenings and their ability to bring the sites together to learn from each other. The Family Partnership explained:

“People came together across vast geographic areas (from two nations) to learn and experiment together on projects of common interest. We were far enough from home, most of the time, so that we could be vulnerable about what was not working in our projects and organizations. That helps. There were also powerful and compelling moments of truth, such as the gathering with Sheldon Kennedy [a founder of the SKCAC]. Finally, we were exposed to all sorts of great ideas, and it was easy to be carried forward and inspired by those ideas, as well as by each other.”

The sites also offered suggestions for how to improve the Change in Mind cohort experience. The most frequently cited suggestions were the following:

- More funding to include more site team members at the convenings (n= 6)
- More time for networking during the meetings (n= 4)
- More time to discuss human centered design approaches, scaling up reforms, and sustaining site reform efforts (n= 3)
- More training and technical assistance on developmental evaluation and rapid testing (n = 3)
- More consistent timing between convenings (n = 2)

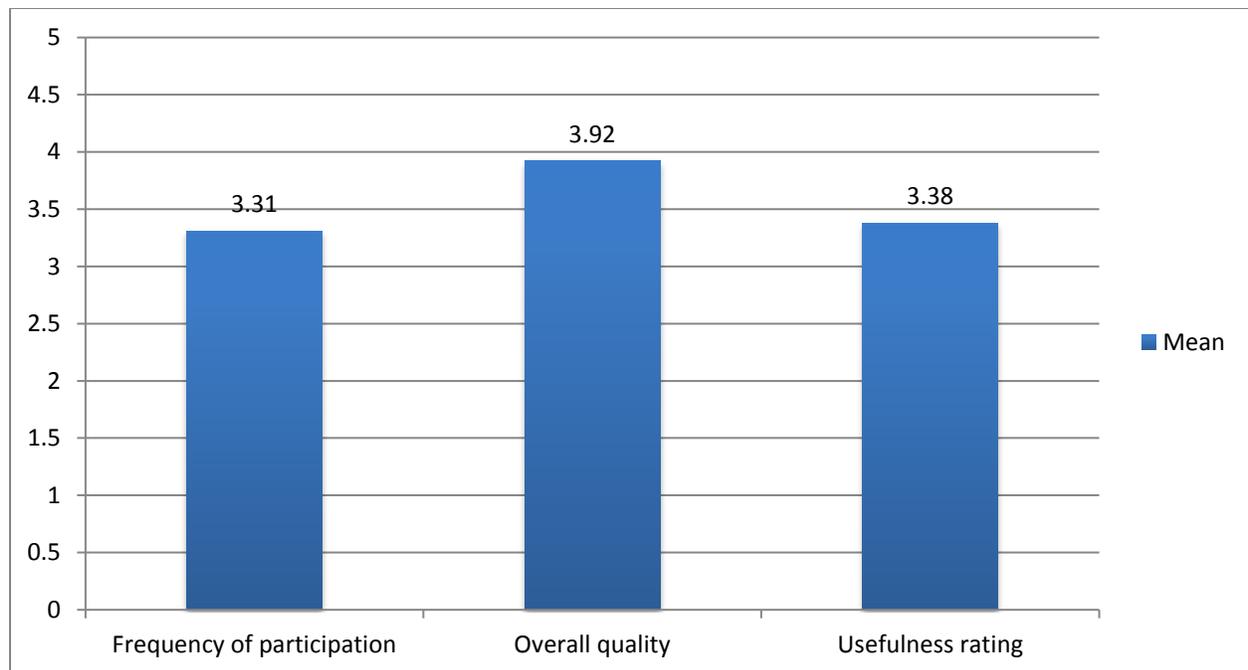
- More access to the neuroscience experts after the convenings (n = 2)

Cohort Webinars

Between convenings, the sites received additional training, including 18 webinars on topics that were recommended for the cohort by the Change in Mind Project and Evaluation Team or were requested by cohort members. Attendance averaged 42 per session. The webinars covered a range of topics including neuroscience (e.g., “Neuroscience Supporting New Parents and Children,” “Applying the Science of Child Development,” and “Building Core Capabilities for Life”); ACEs data (e.g., “Using the ACE Survey in Your Organization,” “The Philadelphia ACE Study,” and “Balancing ACEs with HOPE”); and systems and policy change (e.g., “Aligning Policy Efforts with Brain Science,” “How to Use Brain Science Research to Create Systems Change,” and “Using Evaluation to Fully Support Innovation”). These webinars were also available to the broader Alliance network.

On average, webinars were generally well attended and well received across all organizational types. Respondents across all organizational types reported attending webinars between “sometimes” and “often” (M= 3.31). On average, webinars were rated between “alright” and “good,” (M= 3.92). Finally, considering usefulness, webinars were rated between “somewhat useful” and “quite useful” on average (M= 3.38).

Exhibit 6. Webinar Ratings (n = 14)



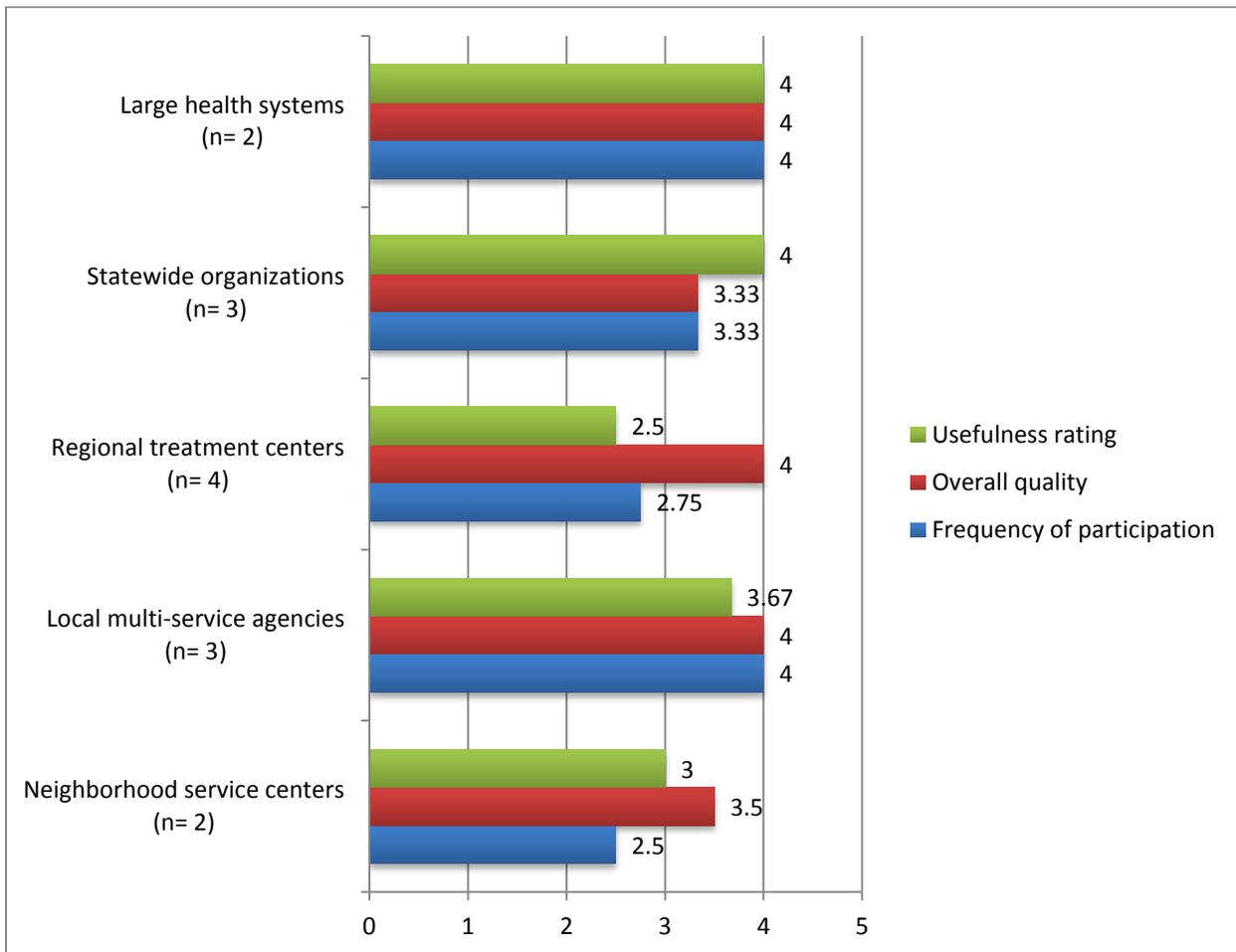
Note: For Frequency, 1= “Never”; 2= “Rarely (>25%)”; 3= “Sometimes (26-50%)”; 4= “Often (51-75%)”; 5= “Always (76-100%)”

Note: For Quality, 1= “Very Poor”; 2= “Not Good”; 3= “Alright”; 4= “Good”; 5= “Excellent”

Note: For Usefulness, 1= “Not useful at all”; 2= “Not very useful”; 3= “Somewhat useful”; 4= “Quite useful”; 5= “Extremely useful”

Quality ratings fell between “alright” and “good” for all the organization types, and more variability was seen in webinar usefulness and participation ratings. Regional treatment centers rated the webinars as least useful (M= 2.5), whereas neighborhood service centers reported attending with the least frequency (2.5). Considering usefulness, the cohort’s large health systems and statewide organizations found the webinars most useful (M= 4.0). The cohort’s large health systems and local multiservice agencies attended the webinars most often (M= 4.0).

Exhibit 6a. Webinar ratings reported by organization type



Note: For Usefulness, 1= “Not useful at all”; 2= “Not very useful”; 3= “Somewhat useful”; 4= “Quite useful”; 5= “Extremely useful”

Note: For Quality, 1= “Very Poor”; 2= “Not Good”; 3= “Alright”; 4= “Good”; 5= “Excellent”

Note: For Frequency, 1= “Never”; 2= “Rarely (>25%)”; 3= “Sometimes (26-50%)”; 4= “Often (51-75%)”; 5= “Always (76-100%)”

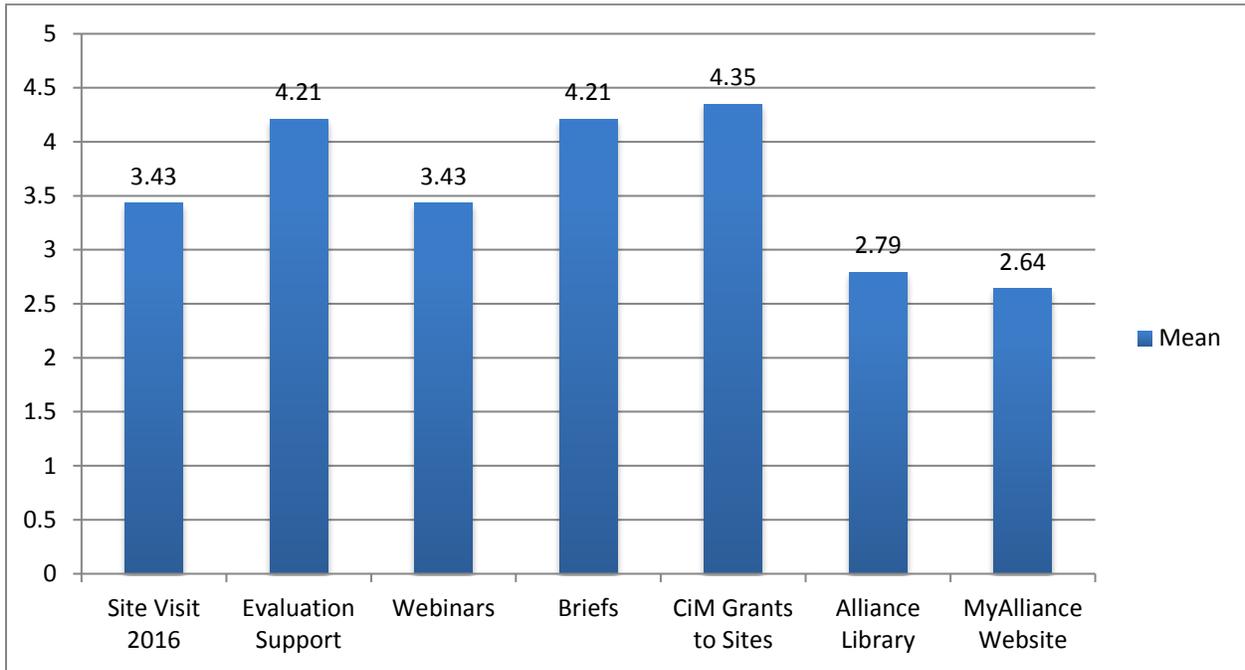
Cohort Technical Assistance and Resources

The sites also received extensive communications and evaluation technical assistance. The FrameWorks Institute provided site consultations reviewed the sites' communications materials. The evaluation team members (Meg Hargreaves, Mark Cabaj, and Aimee White) were assigned as liaisons to specific sites, providing technical assistance on site evaluation tasks between meetings. The sites received phone or in-person consultations from their liaison two-three times per year. The sessions were designed to help sites complete evaluation assignments between cohort convenings or to provide additional assistance on specific evaluation topics.

In the spring of 2016, site visits combined evaluation data collection interviews, evaluation technical assistance sessions, and meetings between site leaders and stakeholders and the initiative's director to discuss system and policy change challenges and opportunities. In addition, the sites participated in smaller "community of practice" workgroups focused on policy, measurement, and messaging. The policy and messaging communities of practice helped create the initiative's policy statement, "Using a Brain Science-Infused Lens in Policy Development: Achieving Healthier Outcomes for Children." The measurement community of practice created an inventory of the sites' ACEs, trauma, resilience, and child development measurement tools. Additional resources were made available to the sites through the Alliance website and online library.

While value ratings for technical assistance and resources provided varied, these resources were rated highly across all organizational types. Evaluation support (M= 4.21), lessons learned briefs (M= 4.21), and Change in Mind grants to sites (M= 4.35) were rated as the most valuable features of the initiative across all organization types. All three elements were rated between "valuable" and "very valuable," on average. While the 2016 site visit (M= 3.43) and webinars (M= 3.43), were not rated as highly, respondents still reported them as having between "some value" and being "valuable" (Exhibit 7). The MyAlliance online collaboration portal (M= 2.64) was the lowest rated form of technical support.

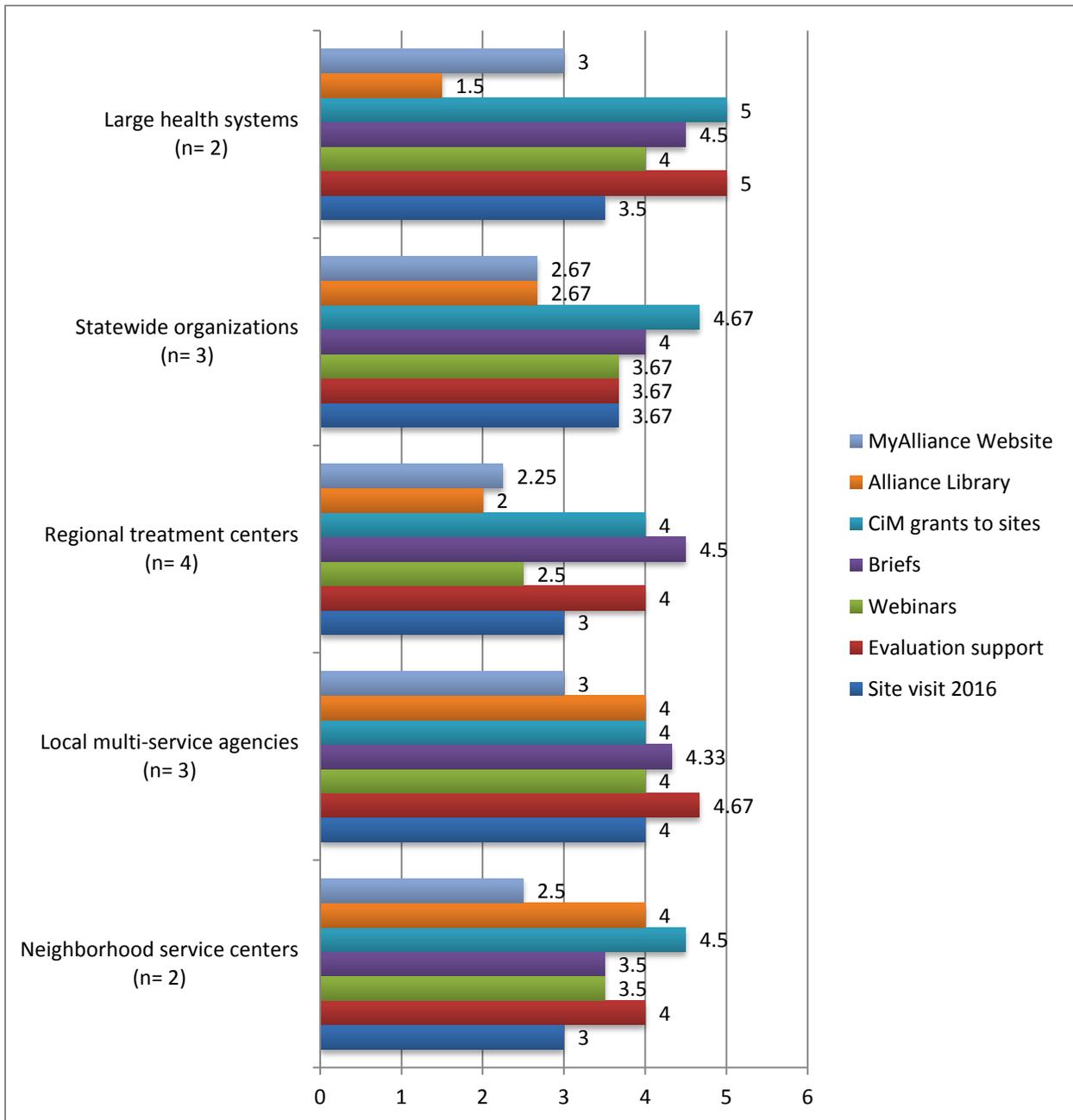
Exhibit 7. How would you rate the value of different parts of the Change in Mind initiative? (n= 14)



Note: 1= "No Value"; 2= "Limited Value"; 3= "Some Value"; 4= "Valuable"; 5= "Very Valuable"

When broken down by organizational levels, more variance can be seen in value ratings of the different types of technical assistance and resources provided. The MyAlliance online collaboration portal tended to be reported as one of the less valuable resources. The Alliance Library received relatively low ratings from the large health systems, statewide organizations, and regional treatment centers, but received higher rating from the local multi-service agencies and neighborhood service centers. Evaluation support, Change in Mind grants to sites, and briefs were consistently rated as valuable across the different organization types (Exhibit 7a).

Exhibit 7a. Change in Mind initiative ratings reported by organization type



Note: 1= “No Value”; 2= “Limited Value”; 3= “Some Value”; 4= “Valuable”; 5= “Very Valuable”

Conclusions and Implications for Change in Mind

This report assessed the effectiveness of the initiative at both site and cohort levels. These findings have implications that lead to recommendations for the future of Change in Mind.

On average, the sites that responded to the final site survey (n=14) rated the overall contribution of the Change in Mind initiative to their efforts to infuse brain science into their work between “moderate” and “substantial” (M=4.38).

- Survey respondents across the organizational groups reported between “moderate” and “substantial” progress on the development or testing of new program practices (M=3.64) and between “moderate” and “substantial” progress related to changes in intake, assessment, or other areas of service delivery (M=3.57).
- Related to changing organizational culture, the sites rated their progress between “moderate” and “substantial,” on average. The highest rating in this area was in the area of communications (m=3.86). Other areas with the highest organizational change were workforce development (M=3.5) and strategic leadership (M=3.5).

The sites reported more progress at program, organization, and systems levels than at the policy level.

- Except for the area of community mobilization and engagement, sites’ progress ratings related to systems change also fell between “moderate” and “substantial” across all organization types. With an average rating of 2.64, community mobilization and engagement fell between “a little” and “moderate,” on average. Brain science dissemination and collaborations with partners were the highest rated areas of community systems progress (M= 3.71 for both areas), followed closely by progress with community coalitions (M=3.64).
- Ratings of progress related to policy change were lower on average than in other areas. In six of the 10 policy areas surveyed, respondents indicated between “no” and “a little” progress. In the remaining policy areas, the sites reported making between “a little” and “moderate” progress. The highest progress was in the area of child welfare policy, which fell between “a little” and “moderate” progress (M=2.5).

These ratings varied by site. No ratings patterns were found by type of organizational type, level, or geographic location.

- No one organizational type rated its progress consistently higher, on average, than other organizational types. Progress ratings also varied by site and by site-specific (program, organization, system, and policy) levels, for a wide range of idiosyncratic, contextually-specific reasons. There were also not consistent differences in the progress reported by the Alberta sites compared to the progress reported by the U.S. sites.

The report also assessed the initiative’s effectiveness at the cohort level.

The sites identified the cohort convenings as the best feature of the initiative, but rated other elements highly as well, including webinars, evaluation technical assistance, and learning briefs.

- Of the 14 sites that completed the survey, 10 mentioned the cohort convenings as the best element of the cohort model. All types of sites, from the smallest neighborhood centers to the largest health systems, responded very positively to the meetings.

- Five sites specifically mentioned the access and exposure to top experts at the convenings as cohort successes. Other sites praised the opportunity for the Alberta sites to network at the convenings (n = 3), the opportunity for sharing and peer learning at the meetings (n = 3), and the value of the FrameWorks Institute’s framing science training (n = 3).
- On average, the webinars were generally well attended and well received across all organizational types. Respondents across all organizational types reported attending webinars between “sometimes” and “often” (M= 3.31). The webinars were rated between “alright” and “good” (M= 3.92), on average. Finally, considering usefulness, webinars were rated between “somewhat useful” and “quite useful” on average (M= 3.38).
- While value ratings for technical assistance and resources provided varied, these resources were rated highly across all organizational types. Across all organization types, evaluation support (M= 4.21), lessons learned briefs (M= 4.21), and grants to sites (M= 4.35) were rated as the most valuable elements of the initiative. All three resources were rated between “valuable” and “very valuable,” on average.

These findings have implications for the design and implementation of Change in Mind.

- At the site level, three elements were identified as critical factors in the sites’ transformation: (1) the knowledge and use of neuroscience findings, including the Core Story of Brain Development; (2) the use of mutually reinforcing transformational change strategies within and across program, organization, system, and policy levels; and (3) the capacity to develop, test, and improve innovative programs, policies, and practices using human-centered design and developmental evaluation techniques. These three elements could constitute the core components of the Change in Mind transformational change model.
- At the cohort level, key elements identified as critical factors to the success of the initiative were: (1) careful selection of cohort sites; (2) two or more in-person cohort convenings per year; (3) funding to support team travel to the meetings; and (4) access to neuroscience content, communications, design, and evaluation experts during and after the convenings to provide ongoing site-specific training and technical assistance. These four elements could constitute the core components of the Change in Mind cohort model.
- At the geographic level, the five Alberta sites gained additional benefits from their proximity. They could meet as a subgroup between the cohort convenings. They had access to the same local evaluator for group trainings and consultations. They were also able to cultivate local or regional partnerships to work on systems and policy change. These findings suggest that geographic clustering of cohort sites should be considered in future cohort designs.
- There is much more to learn about the reasons why the cohort sites made less progress in supporting policy change than work at other levels. Constraining factors may have included the relatively short timeframe of the initiative, dynamic changes in the political environments in which the sites were operating, and the complexity of the policies that were targeted for change. These and other important questions will be explored through the next phase of the initiative, the Change in Mind Institute.

In January 2018, Change in Mind started a one-year planning process during which the Alliance for Strong Families and Communities is partnering with the Palix Foundation to launch the Change in Mind Institute. Housed at the Alliance, the Institute serves as the hub for future Change in Mind activities. The Institute is working with Phase 1 Change in Mind sites that serve as innovators, consultants, mentors, and advisors. The Phase 1 evaluation team is also working with the Institute to develop its theory of change and evaluation design. The Institute's planning focuses on five strategic areas: (1) supporting Change in Mind knowledge dissemination, education, and communications; (2) expanding Change in Mind training and technical assistance; (3) replicating collaborative, cross-sector learning cohorts; (4) advancing transformational change research and evaluation; and (5) building a long-term business model for the Institute.

Change in Mind Initiative: Final Site Survey

1. Reflecting on your "theory of change" presentation at the Nashville convening in May, in what ways, if any, has your theory of change evolved since the beginning of the Change in Mind project? What were those changes and why were they made?

2. Did any contextual changes within your organization impact your Change in Mind work? If so, in what ways did these internal changes help or hinder your ability to achieve your project's goals?

3. Did any contextual changes in your community or state-level policy impact your Change in Mind work? If so, in what ways did these external changes help or hinder your ability to achieve your project's goals?

4. Reflecting on your Change in Mind activities over the last two years (since June 2015), how would you rate your progress in the following areas?

	None	A little	Moderate	Substantial	Exceptional
i. Adoption or adaptation of existing program models					
ii. Development or testing of new program practices					
iii. Changes in intake, assessment, or other areas of service delivery					
iv. Other (please specify below)					

5. Please use the space below to briefly explain your ratings.

6. Reflecting on your Change in Mind activities over the last two years (since June 2015), how would you rate your progress in changing your organizational culture?

	None	A little	Moderate	Substantial	Exceptional
i. Organizational structure (e.g., work units, committees, task forces)					
ii. Strategic leadership (e.g., organization-wide)					

goals, strategic plans, staffing assignments)					
iii. Resources (e.g., budget priorities, funding allocations, new grants)					
iv. Workforce development (e.g., training staff, hiring new staff, developing staff competencies)					
v. Communications (e.g., new CiM concepts and messages for multiple audiences)					
vi. Collection and use of ACEs data (e.g., trauma, brain science, resiliency)					
vii. Other organizational changes (please specify)					

7. Please use the space below to provide a brief explanation of your organizational culture ratings.

8. Reflecting on your Change in Mind activities over the last two years (since June 2015), how would you rate your progress concerning community systems change? This includes actions involving building community systems capacity through:

	None	A little	Moderate	Substantial	Exceptional
i. Brain science dissemination (e.g., hosting, partnering, or giving presentations at summits, conferences)					
ii. Community coalitions (e.g., working with task forces, work groups, consortia on brain science issues)					
iii. Community mobilization and engagement (e.g., with clients, families, residents, or general public using brain science messages)					
iv. Training infrastructure (e.g., expanding brain science training to other organizations, service sectors or states; creating new online or in-person training curricula for universities, service systems, or governments)					
v. Collaborations with community partners (e.g., developing brain science-					

related partnerships with community-based agencies, foundations, government agencies, media, advocates, or colleagues)					
vi. Community-based research (e.g., starting or participating in brain science-related research projects with local populations, clients, or other community groups)					
vii. Other community systems change efforts (please specify)					

9. Please use the space below to briefly explain your community systems change ratings.

10. Reflecting on your Change in Mind activities over the last two years (since June 2015), how would you rate your progress concerning community policy change? This includes actions involving advocating for community policy change:

	None	A Little	Moderate	Substantial	Exceptional
i. Child welfare service system					
ii. Childcare service system					
iii. Education service system					
iv. Medical healthcare service system					
v. Mental/behavioral healthcare service system					
vi. Housing/homeless service system					
vii. Justice service system					
viii. Local/county government (e.g., policies, priorities, programs, regulations, service eligibility, funding)					
ix. State/provincial government (e.g., policies, priorities, programs, regulations, service eligibility, funding)					
x. National government (e.g., policies, priorities, programs, regulations, service eligibility, funding)					
xi. Other policy change efforts (please specify below)					

11. Please use the space below to provide a brief explanation of your community policy change ratings.

12. Please consider each of these areas of potential impact for your CiM work during the past 2 years. Offer 1-3 stories that you feel exemplify your CiM work and share why these stories exemplify that work.

13. Please describe any other funding you have received from other foundations, corporations, or government bodies for the CiM project.

Funder Name	Funding Amount

14. Is there a key component of CiM that you think should be highlighted to potential funders? If so, please explain. (max. 125 words)

15. Is there a change in funding model that you would like to see in future grant applications/funding requirements based on your experience with CiM that Palix /the Alliance/RWJF could advocate? If so, please explain. (max. 250 words)

16. Now that the initial phase of our CiM work has completed, how will you continue to infuse brain science into your work moving forward? Please reflect for us your planned strategies for each of the focus areas of CiM (organizational, community, and systems/policy). (max. 250 words)

17. How would you rate the value of different parts of the CiM initiative?

	No Value	Limited Value	Some Value	Valuable	Very Valuable
The Site Visit in 2016					
Evaluation Support (Meg, Aimee, and Mark)					
Webinars					

Lessons Learned Briefs					
Framing Briefs					
CiM Grant to Sites					
Alliance Library					
MyAlliance Website					
Other (please explain below)					

18. Why did you rate the Site Visit this way?

19. Why did you rate Evaluation Support this way?

20. Why did you rate Webinars this way?

21. Why did you rate Lessons Learned Briefs this way?

22. Why did you rate Framing Briefs this way?

23. Why did you rate the CiM Grant to Sites this way?

24. Why did you rate the Alliance Severson Center Library this way?

25. Why did you rate the MyAlliance Website this way?

26. What is "other", and why did you rate "other" this way?

The CiM initiative organized webinars concerning different topics related to the infusion of brain science. Please rate the following aspects of the webinars:

27. How frequently did you participate in CiM webinars?

- 1) Never
- 2) Rarely (>25%)
- 3) Sometimes (26-50%)
- 4) Often (51-75%)
- 5) Always (76-100%)

28. Why did you rate your participation this way?

29. What was the overall quality of the webinars that you attended?

- 1) Very Poor
- 2) Not Good
- 3) Alright
- 4) Good
- 5) Excellent

30. Why did you rate the webinar quality this way?

31. How useful were the webinars to your work?

- 1) Not useful at all
- 2) Not very useful
- 3) Somewhat useful
- 4) Quite useful
- 5) Extremely useful

32. Why did you rate webinar usefulness this way?

33. What parts of the CiM initiative worked best for you? Why?

34. What are three things you think should be done differently? Why?

35. Several times over the course of the CiM project many of you have expressed that this group is "unique" in some way. You've mentioned feeling close with one another and working together more effectively than on other group projects. Could you please take a few moments to articulate what it is about the CiM project that you feel created this unique ability to bond with your colleagues, if in fact you feel that way?

36. What is the overall contribution of the CiM initiative to your effort to infuse brain science?

- 1) Not at all
- 2) Slight

- 3) Moderate
- 4) High
- 5) Very High

37. Why did you rate the CiM initiative contribution this way?

38. What else would you like us to know about your experience in the CIM initiative?