BALTIMORE SAFE START INITIATIVE
Revised Evaluation Design 2004

Impact Assessment

The evaluation is designed to determine the impact of the Baltimore City Safe Start Initiative (BCSSI) Demonstration on reducing the impact of violence on children 0-6 using its strategies for systems and community change and intervention services for children exposed to violence (CEV). An evaluation caveat for consideration is that although the BCSSI enters year 4 of the demonstration grant, it will not complete a full year of implementation until spring 2004. It is commonly understood that demonstration projects spend much of the first year of implementation working out the problems that inevitably arise. Therefore, assessing the impact of BCSSI strategies is a challenging endeavor because there is insufficient time to allow for a reasonable operating period for systems to change their practices regarding CEV and for appropriate and effective interventions for CEV to be identified. Consequently, the evaluation plan design has undergone additional revisions that reflect a reprioritization of the evaluation questions and a focus on three specific project strategies, training/education, inter-agency collaboration and intervention services.

The BCSSI proposes to help CEV and their families at the systems level in the following ways:

- By expanding the capacity of service systems like childcare systems, domestic violence systems, police and Department of Social Services/child protective services to identify/screen for CEV and to make referrals of CEV.

- The BCSSI partners with Baltimore Mental Health System to increase the number of clinicians trained in early childhood development and CEV and to make mental health resources available as part of Safe Start Intervention Services (SSIS) for young children impacted by violence and their families.

- The BCSSI seeks to promote collaboration across systems through its Council and its strategy to include a service linkage component that expands the service referral base for CEV.

The BCSSI underlying theory of change may be summarized as follows:

Community support for reducing CEV, early identification of children harmed by violence exposure, availability of appropriate and accessible mental health treatment and support services will reduce the impact of exposure to violence on children 0-6.

Using this theory of change, a logic model was developed to help guide the evaluation design (see attachment 1). The BCSSI expects that the attainment of its goals will produce the following types of changes at the community, systems and child levels.

Outcome 1: Increased awareness among community residents/parents and providers of the impact of child exposure to violence and Safe Start Intervention Services.

Outcome 2: Children impacted by exposure to violence are detected early.

Outcome 3: CEV and their families are assessed, referred and have access to mental health services provided by Safe Start trained clinicians

Outcome 4: Systems collaborate on the issue of CEV and coordinate some of their services around the needs of children impacted by exposure to violence.

Outcome 5: Children impacted by exposure to violence show a reduction in behavioral and emotional symptoms associated with witnessing violence and show a reduction in risk factors and an increase in protective factors that buffer exposure to violence.

Impact: Reduction of the impact of exposure to violence on children 0-6.

The following evaluation questions are revised to reflect modifications to the program design and priorities of the evaluation.

Systems Change:

1. **Has the implementation of Safe Start community education and training components increased public awareness and knowledge of CEV?**
2. **To what extent has service systems participating in Safe Start collaborated and coordinated services to identify children exposed to violence?**

Intervention Impact:

1. **What type of intervention works best for children impacted by exposure to violence?**

2. Does mental health treatment make a difference in outcomes for children impacted by exposure to violence?

Data Collection Plan

The impact assessment on systems change will involve five data collection efforts: (1) post/follow-up survey of participants in the Safe Start community education and training activities and post training survey of mental health clinicians (2) review of program documents and analysis of program data. (4) Key informant interviews with Safe Start provider agencies' administrators. These data collection efforts on systems and community change will be ongoing at multiple points in time throughout the course of the Demonstration.

Process data will be collected on 2003 and 2004 implementation activities and on the actions of the policy analysis workgroup that is charged with identifying policy issues that would potentially impact CEV and the sustainability of Safe Start resources for CEV. These data will be submitted quarterly to the National Evaluation Team for review and analysis.

Assessment data on children enrolled in Safe Start Intervention Services (SSIS) will be collected for the intervention study and scores from the assessments completed at baseline will be compared with scores from the same assessments completed post-treatment and at 4-month follow-up. Data on the type and dosage of services received by clients enrolled in SSIS will also be collected.

The target communities for Safe Start implementation were Southern Park Heights (SPH) located in Northwest Baltimore and the Southwest Consortium (SW) made up of three discrete neighborhoods (Washington, Pigtown and Poppleton). These communities are a subset of the seven communities originally identified by an ongoing Initiative, Baltimore's Success by 6® Partnership. The two communities targeted by the BCSSI have a high number of risk indices for CEV among young children and greater services needs comparative to other Baltimore communities. However, the BCSSI in years III and IV is engaging in a citywide effort to train and educate and collaborate with providers and the general public on addressing the needs of CEV.

Community Awareness and Training

The CEV training curriculum developed by the BCSSI Training Coordinator is a 4-hour training protocol. Each training activity is customized to fit the audience and time allotted for the training. The CEV training is not a training series and although the content of the training is consistent across training activities the dosage may vary based on the amount of time allotted by the agency or group requesting the training.

To assess training and education activities, participants in BCSSI community education and training on CEV will be surveyed using a semi-structured evaluation form. Respondents include childcare providers, service providers within child and family serving agencies, parents/caregivers, police, and clinicians. Training participants complete the semi-structured evaluation form at the end of each activity. The evaluation questionnaire is designed to assess participants' opinions about the training activity and knowledge gained from the training. The expected outcome is that community providers and residents will express increased knowledge and awareness about CEV and SSIS and thus be able to identify children who have been exposed and refer them for services. Table 1 shows the data collection plan for measuring community and systems change.

Table 1

Data Collection for Measuring Community Awareness and Training

Outcome	Indicators	Data Sources	Methods/Timelines
Increased awareness/knowledge among community residents/parents and providers of the impact of CEV and Safe Start Intervention Services	• Participation in Safe Start community training activities • Reports of increased knowledge of CEV • Use of Safe Start resources in their community	• Attendance Rosters • Schedules of education activities • Safe Start Training Evaluation survey • Follow-up survey	• Count number of attendees • Compute mean rating scores from evaluation surveys • Calculate post-then pre ratings Frequency: At the end of each training session. **September 2002 - September 2005** • Compute scores from follow-up survey Frequency: **one month after training per training group**

The evaluation forms are designed using a likert scale format. Initially, a pre/post test designed as a true/false test was administered in the training at the beginning and end of the session to measure knowledge change but due to test bias this practice was dropped. Alternatively, two statements were added to the survey based on a 'post-then-pre' design (Rockwell & Kohn, 1989) that allows participants to retrospectively rate change in their knowledge of CEV before the training and after the training. A post-then-pre design describes a process of asking training participants at the end of the training whether they "know more now then they did before the training" on the subject matter. This approach has limitations because it is based on subjective self-reports versus an objective measure of knowledge change using a pre-post test. Nonetheless, by allowing participants to rate their knowledge change we are able collect some evidence on whether the impact of the training has resulted in increased knowledge among participants at the community level.

To assess the impact of training activities on the behavior of providers, specifically, a follow-up survey that offers a self-report measure of whether the CEV training has helped those providers change the way they respond to CEV with respect to identification and referral, is administered in six-month intervals. Given that the follow-up survey relies on self-reports, the evaluator will triangulate sources using the SMART system database to cross check CEV referrals made and received by providers that participated Safe Start training with their responses on the survey.

The follow-up survey will be distributed after initially contacting the agencies from the training attendance rosters that had staff who participated in the training to inform them about the follow-up survey. A letter of explanation about the follow-up survey, the survey and return envelope will be delivered to those agencies that have had staff participate in the Safe Start CEV training. Members of the evaluation team will pick-up all completed surveys. To review a copy of the follow-up surveys see (Attachment 2).

Identification, Assessment, Mental Health Treatment Utilization and Referral

Program documents will be reviewed and analyzed to assess whether there is service system participation in the identification of CEV in the birth to six-age range. A screening questionnaire and events questionnaire used by the mental health provider

providing SSIS will be used to generate identification statistics on the rate of exposure to violence among this age group and the time between exposure and detection. Life Domain Assessment (LDA) data and information on the number of CEV that require and receive mental health treatment will be tracked and used for the intervention research component of this evaluation. The LDA contains multiple standardized assessment tools to measure child and family status across multiple domains. The LDA will be completed within 21 days by clinicians at Urban Behavioral Associates (UBA) the mental health provider, and assessment results will be shared with the local evaluator for those clients whose caregiver consents to participate in the evaluation**.**

Referral source data are entered into the Safe Start Service Management and Resource Tracking (SMART) system by the BCSSI data specialist and are compiled by the evaluation team to assess the extent to which agencies are appearing responsive to CEV.

Table 1 cont'd.
Data Collection for Measuring Identification, Assessment, Mental Health Services and Referrals

Outcome	Indicators	Data Source	Methods/Timeline
Children impacted by exposure to violence are detected early CEV and their families are assessed, referred and have access to mental health services provided by Safe Start trained clinicians	▪ Number of children screened ▪ Number of children assessed ▪ Number of children identified as impacted by violence exposure ▪ Number children 0-6 identified by CD/CP trauma response team ▪ Number of clinicians that participate in mental health training series ▪ Number of children exposed to violence who receive mental health treatment ▪ Number of CEV diagnosed with trauma symptoms/PTSD ▪ Dosage of mental health treatment for CEV	• SMART/MIS • CD/CP child contact form for children 0-6 • Training rosters/attendance sheets • Quarterly reports from BMHS/UBA • Life Domain Assessment logs • PTSD treatment protocol clinical monitoring checklists	• MIS • CD/CP reports **(At the end of months 7, 8, 9, 10, 11, 12 for year 2003.Then continued monthly from January 2004 thru November 2005**) • Calculate number of attendees after each training series. • Follow-up training series survey distributed every 6 months • Case record Reviews (**Quarterly- October 2005**)

The BCSSI determined that that the availability of appropriate mental health services for CEV was an important system change objective. In order to meet this

objective the BCSSI sought to work with BMHS to increase the number of mental health providers trained to work with young children by offering an Early Childhood Development Mental Health Training Series to mental health clinicians throughout Baltimore City. Data are collected on the training in the form of attendance sheets and evaluation forms that measure participants' reaction to the training. These data will be used to calculate a percentage for the number of mental health agencies represented and clinicians that participated in the training. A follow-up training survey has been designed for these participants to assess whether the training has impacted their work and responsiveness to CEV and will be distributed at the end of January 2004.

Interagency Collaboration and Coordination

Collaboration is considered key to systems change in Baltimore City and is measured using an Interagency Collaboration Scale. Using a survey method, a sample of public and private child serving agencies and staff within these agencies were selected to complete the scale. Using this tool, collaboration among provider agencies participating in Safe Start can be measured in four core areas, 1) policy direction on CEV, 2) staff training, 3) program operations and 4) information dissemination.

Table 1 cont'd
Data Collection Plan for Measuring Service Coordination and Collaboration

Outcome	Indicators	Data Sources	Methods/Timeline
Enhanced referral system with Improved service coordination and increased collaboration	▪ Number of CEV referrals made to SSIS ▪ Clients satisfaction with services provided ▪ Increased collaborative activities among providers serving children exposed to violence	• Smart MIS referral forms • Satisfaction survey • Interagency Collaboration Scale (ICS)	Frequency: MIS tracking **(Daily thru October 2005**) Analyze satisfaction survey responses at the end of service provision ICS distribution done in **9 month intervals:** **(May, June, July 2003)** **(Feb., Mar., Apr. 2004)** **(Nov., Dec., 2004)** **(Jan., Aug., Sept 2005)**

The Interagency Collaboration Scale (ICS) was developed by a team of researchers at the University of South Florida, Louis de la Parte Mental Health Institute

in Tampa. The developers conducted an initial validation study to assess test-retest reliability and construct validity in June 2002. This validation study was completed in December 2002 and results are still pending. The ICS is a 52-item scale that is used to measure beliefs about collaboration and the extent of collaborative activities between agencies.

A sample size of (N=75) individuals within 15+ public and private agencies and across multiple systems were surveyed. The unit of analysis is individuals representing three levels of staff within agencies (administrative, management, frontline). The proposed sample for the distribution of the Interagency Collaboration Scale (ICS) was determined through a process of purposive variation sampling that involves selecting cases that are most pertinent to what we are studying and that illustrate variation in the phenomenon being studied (Gall, Borg & Gall, 1996). In this case, the variation in respondents is across levels of providers and agencies. The sample of agencies includes childcare providers, family support centers, and Head Start sites. Citywide agencies will also be surveyed and they include Department of Social Services Child Protective Services unit and the Police Department domestic violence unit, House of Ruth domestic violence provider, and Child Development Community Policing.

The same persons should complete the ICS at each administration but considering the budget cuts and downsizing by agencies in Maryland and Baltimore specifically in 2003, the evaluation team proposes to reduce the time interval form completion of the ICS from 12 months to 9 months. It is expected that by reducing the time gap, the risk of attrition is decreased.

The extent to which there is improved service coordination will be measured using consumers' report of satisfaction with service delivery. A Consumer Satisfaction Survey (short version) developed by Baltimore Mental Health Systems will be administered to consumers at 4-month follow-up by the Service Linkage Coordinators of SSIS.

Summary of Community/Systems Variables

The variables of interest that are the focus of the systems change impact assessment are listed with corresponding hypotheses and proposed analyses in Table 2. These variables reflect the program strategies and are based upon a set of assumptions about the relationship between the strategies and the expected outcomes. Each variable also represents the unit of analysis that is being measured and findings on these measures are presented as part of the evaluation results.

Table 2
Community and Systems Variables

Variable	Hypothesis	Analysis
Community Change: Community education and training on reducing the impact of CEV	Involvement in Safe Start CEV education/training will increase the knowledge about the impact of exposure of violence on children among community participants.	Descriptive statistics and paired samples t-tests will be used to determine if knowledge changes are statistically significant.
Systems Change: Identification, Assessment, Mental Health Services and Referral	Safe Start training for identification, assessment and treatment of children impacted by exposure to violence will result in expanded and enhanced programming for CEV.	Descriptive statistics will be used to calculate frequencies on the number of children identified, assessed, treated and referred for services.
Systems Change: Interagency Engagement and Collaboration Service Coordination	Participation in Safe Start by child serving systems will increase interagency collaboration on the issue of CEV. Providers participating in Safe Start will show improved service delivery and coordination	Scores from the Interagency Collaboration Scale will be analyzed on four core areas at three different time points. Descriptive narrative of key informant interviews. Calculate agency score on service delivery and coordination from Satisfaction Survey

Safe Start Intervention Study-Revised 2004

The evaluation design for assessing Safe Start Intervention Services has been revised to reflect changes in the assessment protocols. Specifically, preliminary reports indicated that the assessment process was too cumbersome consequently; some assessment instruments originally prescribed were dropped. For the purpose of assessing child outcomes the *Trauma Symptom Checklist for Young Children* by John Briere that was proposed for use to assess child outcomes was dropped due to its length and time required to complete it and substituted with the *Post Traumatic Stress Disorder Semi-Structured Interview and Observational Record for Infants and Young Children* (for ages 0-48 months) developed by Michael Scheeringa.

Design

There is a dearth of literature and research on what intervention works best for children impacted by exposure to violence. It is also unclear as to whether mental health treatment makes a difference in terms of outcomes for children exposed to violence (CEV). This study will hopefully increase the knowledge base on interventions for CEV. The following revised research questions are proposed:

What type of intervention(s) works best for children impacted by exposure to violence?

Does mental health treatment make a difference in outcomes for children impacted by exposure to violence?

The effects of exposure to violence on children are widely discussed in the literature and have been labeled a public health concern (Margolin & Gordis, 2000; Cooley-Quille, Turner, & Beidel, 1995). The continuum of negative effects for children exposed to family and community violence range from developmental regression and behavior problems to the more severe problem of traumatic stress disorder or PTSD. Since impact from exposure to violence may vary depending on the presence or absence of child/caregiver resilience or protective factors, the extent and duration of exposure and the child's relationship with the perpetrator of the violence, the BCSSI proposes a two-level intervention strategy.

Level One Intervention-Parent Group Support and Services

SSIS will provide support to parents and caregivers of CEV using a structured group process to provide education and clinical services to build resilience among caregivers and children. According to the literature, when caring adults (parents/caregivers, relatives and teachers) intervene in the lives of children exposed to violence this buffers the impact of violence on children (Groves, 1999; Groves, Lieberman, Osofsky, & Fenichel, 2000). Based on this premise, SSIS seeks to bolster protective factors with the child/family as an intervention to reduce the impact of exposure to violence on CEV.

Level Two Intervention-Individual Mental Health Treatment and Services

Children who have been exposed to violence who are assessed as showing symptoms of trauma from exposure and who are eligible for treatment will receive a structured mental health intervention. The intervention protocols may vary depending on the results of the Life Domain Assessment and the age of the child. Specifically, in the case of preschoolers traumatized by violence who meet criteria for treatment, the "Preschool PTSD Treatment" version 1.0 designed by Michael Scheeringa and colleagues will be used. The protocol is a 12-week program for 90 minutes per session with the child and parent/caregiver based on cognitive behavioral treatment and parent-child relationship dynamics (Scheeringa, Amaya-Jackson, Cohen, 2001).

There are certain components of treatment for traumatized children that are important, including providing the child with an opportunity to evaluate and reconsider the cognitive assumption made with regard to the trauma, and including parents and others in the treatment process. In addition, educating parents about PTSD and helping them learn how to manage symptoms has also been shown to be effective (Cohen, 1998; Deblinger, Mcleer, Atkins, Ralphe, 1989; Parso, 1997 and Rigamer, 1986). It is expected that this therapeutic intervention should result in a reduction in PTSD symptoms and an improvement in coping resources (Amaya-Jackson & March, in press).

Sampling

The aim is to conduct this intervention study using a quasi-experimental design in which treatment and comparison groups are formed. The study is designed to determine what intervention(s) work best with children impacted by exposure to violence and whether there is a difference in outcomes for children who receive mental health treatment versus children who do not.

Participants in the SSIS study will have provided informed consent to participate in the BCSSI intervention research. Non-random sampling will be used to establish a treatment and comparison group. The samples for the study will be recruited from Safe Start providers that are responsible for completing the Life Domain Assessment. The treatment group will be selected from participants who have been screened for violence exposure, assessed for impact from exposure and referred for mental health treatment. Comparison group participants will be screened for exposure to violence assessed for impact from exposure but will not receive mental health treatment; these families will get service linkage and support for parents who participate in support group activities.

Comparison and treatment group participants will be matched as closely as possible on variables like family socio-economic status, child's age, type and level of violence exposure, duration of exposure, symptoms, family structure, parent/caregiver stressors, risk and protective factors. Sample size for each group is projected for up to 25/30 participants. Research supports sample sizes for quasi-experimental designs between 15-30 participants per group being compared (Gall, Borg and Gall 1996**).**

Sampling Issues

Since implementation of SSIS in April 2003 referrals have been minimal, over a period of five months approximately 6-8 referrals have been made and only one case enrolled. The Project Coordinator has initiated efforts to increase the referral rate but it remains an ongoing process as part of training. If the rate of referrals continues to remain low this will pose a problem for achieving the proposed sample size and forming the comparison group. The current plan for the intervention study is subject to further change and is contingent upon change in the status of child enrollment in SSIS.

Data Collection

Upon entry into SSIS all children/caregivers are screened and assessed using the Life Domain Questionnaire (LDQ) +scales. The evaluator collects data on families that applied and enrolled in SSIS. The LDQ +scales provide baseline data on type, level and duration of violence exposure, protective factors, and measures on trauma symptoms and parent stressors. The LDQ and two assessment measures used at baseline will be used at treatment follow-up to assess child and parent outcomes.

The measures proposed for use by the evaluation are the *Post Traumatic Stress Disorder Semi-Structured Interview and Observational Record for Infants and Young Children* (for ages 0-48 months) developed by Michael Scheeringa and *Parenting Stress Index/Short form* (PSI) designed by (Abidin, 1995). These measures are selected because they will allow for an assessment of change in risk and protective factors impacting the parent child relationship, family functioning and the child's trauma symptoms post treatment. Specifically the PSI assesses risk for child abuse as a function of parental stressors or protective factors such as parental skill level in managing stress. The PTSD Semi-Structured Interview assesses child trauma and symptoms related to the trauma and is a clinician administered instrument incorporating standardized interview and play sequences.

The clinical staff will administer the tools at treatment baseline and post treatment. The research assistants to the evaluation will receive training in administration of the PSI in order to administer this tool to participants in the study at 4-month follow-up. A summary of the data collection plan is shown in **Table 3**.

Table 3

Safe Start Intervention Services (PTSD Treatment)

Outcome	Indicators	Data Sources	Methods/Timeline
Decreased trauma symptoms as a result of exposure to violence for children 0-6 in SSIS **Improvement in risk and**	Decreased trauma Symptoms for CEV ▪ Anxiety ▪ Depression ▪ Acting out ▪ Dissociation ▪ Aggression Decreased risk factors ▪ Parental stress	• PTSD Semi-structured interview • Life Domain Treatment Summary Report • Parenting Stress Index (PSI) • Life Domain Assessment questionnaire	PTSD scale administered **pre/post/follow-up** to parent/caregivers of children 0-6 enrolled in SSIS and participating in the evaluation PSI administered **pre/post/follow-up** to parent/caregivers

Outcome	Indicators	Data Sources	Methods/Timeline
protective factors among CEV.	**Protective factors** • **Improved parental bonding** • **Increase in positive parent/child interaction** • **Increased parental participation**		enrolled in SSIS and participating in the evaluation Total sample size for two groups: (N=50) Treatment group (n=25) Comparison group (n=25)

Participation in the evaluation study is voluntary and parents/caregivers will be told that they may drop out of the study at any time. Families will receive a stipend of $25.00 for participating in this phase of the evaluation. All participants who consent to participate in the study will receive a pre/post and follow-up assessment. Results from the assessments will be analyzed to measure change overtime and to compare scores of the treatment and comparison groups.

Data Analysis

A t-test to determine whether there is statistical significance in the difference between pre/post functional assessment scores at baseline and follow-up will be conducted. Multivariate analysis of variance will be used to analyze the impact of SSIS and to control for differences between the comparison and treatment groups. A variety of factors, including severity of exposure can be taken into account, or number of protective and risk factors. This analysis will permit a better understanding of how the intervention impacted children on a variety of emotional, social and behavioral indicators.

Study Limitations

Studies using quasi-experimental designs with a non-equivalent matched comparison group are challenging because of the difficulty constructing comparison groups and collecting comparable information on comparison group participants (Harrell et al., 1996). Consequently, threats to the validity of the study are posed. In this instance, because the target population being studied is children 0-6 who are at varying

developmental stages, there is the threat of 'maturation' in which age related processes may contribute to outcomes, independent of the intervention (Harrell et al., 1996). Moreover, several initiatives have been launched in Baltimore City before and since the inception of Safe Start; for instance, the two communities targeted for implementation of Safe Start are also recipients of resources from the Success by 6 ® Partnership. Through the Success by 6® Partnership, work has been ongoing in these communities to support children 0-6 and their families through a comprehensive family support strategy to reduce rates of low birth weight infants, infant mortality, child abuse and neglect and childhood injury. The presence of other Initiatives poses the threat of 'history' in which other events unrelated to Safe Start may affect child outcomes.

Every effort will be made by the evaluator to reduce the threats to validity of this study. But in view of the limitations described findings from this study should be interpreted cautiously and alternative hypotheses given serious consideration.

Consent, Confidentiality and Protection of Human Subjects

To ensure the protection of individuals, who agree to participate in the evaluation, the BCSSI evaluation has sought approval from the Institutional Review Board of the Baltimore City Health Department's. A Privacy Certificate to safeguard privacy and confidentiality of client records and data obtained for the purpose of the evaluation will be kept on file at the Office of Juvenile Justice and Delinquency Prevention and the Family League of Baltimore City.

Consent to participate in the evaluation will be obtained from the parent/caregiver of children served in SSIS after enrollment in Safe Start and eligibility for mental health treatment has been established. Safe Start clinicians trained in the consent process will initiate families into the evaluation. The consent form will be attached to the Parent Handbook provided to all clients by the mental health provider. The handbook along with the consent form will be read to the caregiver to ensure that they are fully aware of what participation in the evaluation will entail. Potential participants will have opportunity to ask any questions and if the person is agreeable will sign the consent form at that time. The Patient Handbook is currently under revision to include information specific to Safe Start and the Safe Start Evaluation consent form.

Reporting and utilization plan

The impact assessment and intervention study findings will be shared in report form with the collaborative partners including the lead agencies, the Department of Juvenile Justice and the Family League of Baltimore City and the funding agent the Office of juvenile Justice and Delinquency Prevention. It is anticipated that the results from this evaluation will inform practice on working with children impacted by exposure to violence and will be used for decision-making on further replication of SSIS and continued funding for SSIS in Baltimore City.

Evaluation Management

As of September 1, 2003 the local evaluator for the Safe Start project is on contract with the Family League of Baltimore City and is conducting the evaluation as an independent contractor. Support staff to the evaluation includes a fulltime data entry specialist and two part time research assistants. Training and technical assistance needs are met through the Association for the Development of Community. **Table 4** is a summary of who assists with the evaluation and the responsibilities of the team.

Table 4

Evaluation Staffing Structure

Staff Name and Title	Percent of time on Evaluation	Responsibilities
Deloris Vaughn, Ph.D. D. Vaughn Training and Evaluation Services	50% contractual	• Revise evaluation plan as needed • Develops or identifies all measures that will be used in the evaluation • Works with FLBC MIS unit to ensure that design of Safe Start management information system includes data elements required by the local and national evaluation • Submits IRB proposal • Coordinates all data collection efforts • Conducts data analyses and interprets results • Participates in negotiations with collaborative partner agencies to gain access to data for the evaluation • Conducts intervention study • Trains clinicians in data collection for evaluation • Trains Research Assistants • Submits evaluation reports to local site and national team
Andrea Reddick, Data Specialist	100%	• Enters data on performance measures for SSIS • Generates reports on SSIS utilization • Collects all data from SSIS sites • Monitors Safe Start MIS
2 Research Assistants Laia Block, BS Claudette Williamson-Taylor, BA	50% x 2=100%	• Will assist with distribution of Interagency Collaboration Survey • Will collect completed surveys from partner agencies. • Will enter survey data in SPSS for analysis • Will enter data collected from training and education activities into SPSS program • Will conduct analyses of Pre/post exercises completed by participants in Safe Start training • Will conduct follow-up assessments with families participating in the intervention study • Will assist with report writing
Technical Assistants	Per diem	• Provides technical assistance on evaluation design

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