Bridgeport Safe Start Initiative

Evaluation Plan

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EVALUATION GOALS AND UNDERLYING THEORY OF CHANGE

As outlined in the Bridgeport Safe Start Initiative (BSSI) Strategic Plan, the major objectives of the Initiative are: 1) to reduce the impact of exposure to violence in the home for children 0-6 and 2) to reduce the incidence of exposure to violence in the home for children 0-6. The Management and Design Teams have developed a theoretically based strategy to attain these objectives. This strategy is represented in the BSSI Logic Model. The BSSI Logic Model includes several components:

Resources represent human, financial, organizational, and community resources that BSSI has available to direct toward completing activities and attaining the desired objectives and outcomes. As outlined in the BSSI Strategic Plan, individuals representing multiple local and state agencies were involved in the planning of the Initiative. These individuals and agencies will continue their involvement with the project and contribute resources designed to attain desired outcomes. In addition to local resources, national resources are available, including the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the National Evaluation Team (NET).

Program Activities represent the interventions-events, tools, processes, and actions-that are used to bring about the intended program outcomes (W.K. Kellogg Foundation, 2000). As a result of the BSSI assessment and planning processes, the stakeholders identified six major types of BSSI activities: 1) best practice research; 2) system/service coordination; 3) granting process; 4) policy/legislative; 5) training; and, 6) public awareness/media.

Outputs, also known as deliverables, represent the direct products of a program and its activities. Outputs produce evidence of service delivery and the work of BSSI. Activities in each of the six major BSSI activities have been linked to tangible and specific products.

Outcomes represent how target populations, including communities, are expected to change as a result of BSSI and its activities. The BSSI outcomes have been categorized as follows:

- Immediate outcomes refer to short-term outcomes, which are more immediately detectable. Typically, these types of short-term outcomes are attainable within the first few years of the initiative (W.K. Kellogg Foundation, 2000). For example, programs funded through the BSSI granting process are expected to address child abuse and neglect, violence in the home, and risk factors in the target population, as these risk factors are more readily influenced by direct service interventions.

- Intermediate outcomes typically require a longer timeframe to attain than short-term outcomes. BSSI will focus on enhancing family functioning and increasing access to medical, behavioral health and social services. The combined effort and outcomes of the BSSI activities should lead to a reduction in these salient risk factors.

- Long-term outcomes require an even longer timeframe to attain than intermediate outcomes. The long-term desired outcomes that have been agreed upon focus on a reduction in community level indicators of violence in the home (e.g., decreased number of out-of-home placements, decreased rates of substantiated cases of child abuse and neglect). Theoretically, as a result of BSSI activities, outputs, immediate outcomes, intermediate outcomes, the longer-term outcomes should be achieved.

The evaluation of BSSI will: 1) document outputs; 2) provide data for ongoing monitoring of activities; 3) help facilitate program development that is based on best practices and is outcome driven; 4) provide data to allow managers to monitor system, program, and individual level outcomes; and, 5) provide a continual feedback process to enable program and policy decisions to be informed by data (see Appendix 1 for a copy of the BSSI Logic Model).

II. EVALUATION DESIGN AND IMPLEMENTATION

Overall Design

Highlighted below are the main components of the evaluation design including: RFP funded programs; collection of community indices; assessment of interagency collaboration; focus group assessment of system level changes; policy evaluations; Management Information System; and, evaluation of trainings. A time-line highlighting evaluation activities can be found in Appendix 2.

1. RFP Funded Programs

Overview

As a result of the Request for Proposal RFP process (See Bridgeport Safe Start Initiative Local Evaluation Plan, August 2001) in which proposals were based upon best practices and with specific outcomes, the Bridgeport Safe Start Initiative funded three service delivery programs. BSSI discontinued funding of the Child Development-Community Policing of the Greater Bridgeport Child Guidance Center in 2003 due to the difficulty the program experienced in identifying and serving children ages 0-6 exposed to violence. BSSI funded a fourth program in 2002 to address a specific identified need within the judicial system and a fifth program in 2003 to provide mental health consultation to identified community-based clinicians providing services to young children exposed to violence. The evaluation plan for each of four programs that are currently funded typically includes a majority of the following components:

- Performance-based Contracting
- Logic Model Development
- Program Flow Chart
- Process Evaluation
- Outcome Evaluation
- Service System Information Tracking

Evaluation Philosophy
The evaluation plan for each of the funded programs is developed and implemented in collaboration with the Safe Start Office, program staff, and the local evaluators. It is the goal of the evaluation consultants to develop the evaluation capacity of funded programs and organizations. This capacity is best achieved through regular and consistent contact between program staff and the evaluation consultants. Throughout the funding period, we will continue to provide on-going training and technical assistance regarding proper use of outcome instruments, development of data monitoring systems, use of databases, procedures for capturing process and outcome data, and utilizing data for program development.

BSSI Funded Programs

1) Child & Family Interagency Resource, Support, and Training (Child FIRST) Program

Program Description: The Child & Family Interagency Resource, Support, and Training (Child FIRST) Program is a collaborative, multidisciplinary program whose purpose is to facilitate efficient and effective access to a continuum of comprehensive, family focused, well integrated services and community supports to address the mental health and developmental needs of high risk young children, 0-6 years, and the challenges faced by their families. Most of these children have been or are at risk of exposure to violence.

Evaluation Components: Performance-based Contracting. The initial and subsequent yearly program contracts were developed in collaboration with the Bridgeport Safe Start Office, the local evaluators, and the Child FIRST staff. The contracts outline the major expectations for the program in carrying out its work and for participating in evaluation-related activities, including regular contact with the evaluation consultants to develop and systematically implement the process and outcome evaluation components.

Logic Model Development: The logic model was developed collaboratively with Child FIRST staff to specify key program components, including resources, program activities, outputs (deliverables), and outcomes (see Appendix 3 for the Child FIRST Logic Model).

Program Flow Chart: The program flow chart specifies key aspects of the Child FIRST program implementation, including the flow of program activities and the process through which cases proceed through the program (see Appendix 4 for the Child FIRST Program Flow Chart). The flow chart development process served to further develop, refine, and standardize program operations. In addition, the process assisted in identifying activity level data that are important to collect.

Process Evaluation: The process evaluation captures information about program activities, including who the program is serving; client characteristics; type, number, and hours of services provided; attendance at activities; type/number of materials distributed; and amount of resources used to implement activities. Through regular and

consistent contact with the program staff, the local evaluators have developed several pencil and paper data monitoring forms to capture this process information, including:

- Referral Form captures basic demographic and presenting problem information about the child/family being referred for services (see Appendix 5);
- Service Utilization Form captures the type and duration of services provided as well as the staff providing the service at the individual client level (see Appendix 6);
- Administrative Service Utilization captures the type and duration of the Child FIRST program coordinator's non-client activities such as receipt of technical assistance from the local evaluators, quarterly evaluation meetings to review program data, and program development meetings with BSSI (see Appendix 7).
- Training and Consultation Log captures the number, type, and duration of community-based training/consultation activities, as well as participating agencies, number of participants, and staff preparation time in delivering these services to community providers (See Appendix 8);
- BSSI National Data Elements Form has been developed to standardize the process of collecting essential violence-specific data upon client intake/assessment (see Appendix 9).

In an effort to develop the program and staff capacity for evaluation, program staff is responsible for all of the data collection, entry, management, and transmission to the local evaluators. The local evaluators have developed an ACCESS database, which serves as the program's MIS system and have trained staff on the proper completion of the pencil and paper data monitoring forms and on using an ACCESS database for data entry and management. The local evaluators will continue to provide training and technical assistance on all aspects of the data collection and management process.

Outcome Evaluation: The Child First logic model specifies program outcomes and performance indicators. The outcome instruments described in Appendix 10 will continue to be administered to clients/families upon intake. This initial administration will be considered the baseline assessment. Since Child FIRST provides shorter-term care that is primarily focused on assessment, care coordination, and referral services, the program will not administer follow-up instruments. Clients/families that are referred to and receive on going mental health services from other BSSI funded programs will obtain follow-up assessments from these programs.

The outcome instruments that each BSSI funded mental health program will continue to administer this year are used to determine a child's exposure to traumatic events, the potential impact of exposure to these traumatic events, and the presence of parenting stress. The child's trauma history, including exposure to violence in the home, is assessed with the Traumatic Events Screening Inventory – Parent Report Version (TESI-PR; Ford, 2002; SAMHSA Workgroup, 2002). This instrument is the primary means of identifying children as exposed to family violence and designating children as BSSI clients. Implementation of the instrument ensures that programs are serving the appropriate BSSI target population and are institutionalizing an assessment process that specifically obtains information regarding violence exposure.

The Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2001) allows for the assessment of the impact of violence and other trauma-related experiences on children's mental health functioning, including posttraumatic stress, anxiety, and depressive symptoms and sexual concerns. The baseline assessment provides information that can be used to develop Child FIRST services and for appropriate referral services.

The level of parenting stress is assessed using Parenting Stress Index/Short Form (PSI/SF; Abidin, 1995), initially developed for a variety of settings to identify and target families most in need of follow-up services, to obtain a brief measure of stress in the parent-child system, and to evaluate prevention and intervention programs. The PSI/SF has also been widely used as a screener to identify risk for child abuse and neglect. In addition to the overall purpose of the instrument, the PSI/SF was selected as an outcome measure based upon the funded programs' outcomes specified during the logic model development phase of the BSSI evaluation and the nature of program activities. The Child FIRST Program considers attachment and the parent child-relationship to be crucial to healthy child development and conducts family-centered assessments of all clients receiving care coordination. The program staff views unrealistic parent expectations and a lack of parent knowledge regarding child development, particularly for children with special and multiple needs, as significant risk factors for negative social and emotional child development. Parent-centered program activities include in-home consultation regarding behavioral management skills, knowledge development, and concrete resources and referrals to better ensure safe and healthy home environments for children. Although important, the program previously lacked a standardized procedure for assessing and understanding the parent-child relationship. The PSI/SF provides information to assist in the development of the Child FIRST Family Plan, which specifies Child FIRST interventions and appropriate referrals for the family. It is anticipated that through the provision mental health and concrete services and referrals to address the needs of parents as they relate to their children and families, parents would experience a decrease in stress in their parenting roles.

Finally, satisfaction with services will be assessed via the six-item Global Satisfaction subscale of the Patient Satisfaction Questionnaire III (Marshall, Hays, Sherbourne and Wells, 1993). The subscale was modified to allow parents/caregivers to provide feedback specifically for Child FIRST services. Staff administers this instrument upon discharge from the program.

Service System Information Tracking: The "Bridgeport Safe Start Initiative Service Plan" is being completed for all BSSI families and captures service system level data on the barriers to service receipt, service gaps and barriers, and if there are populations that are undeserved by the system of care (see Appendix 11). The Child FIRST program reviews Initial Plans after 90 days to determine if services were received and identify barriers to service receipt.

2) Early Childhood Mental Health Program (ECMHP)-Child Guidance Center of Greater Bridgeport

Program Description: The Child Guidance Center of Greater Bridgeport has hired a 1.0 FTE Early Childhood Therapist/ Clinician (ECC) to develop the Early Childhood Mental Health Program (ECMHP) and provide mental health services to young children who have been identified as exposed to violence in the home and their families. The clinician is mobile and works within the Bridgeport community. This individual will attend existing early childhood collaboratives, (Collaborative Childrens Advisory Board and BCAC Early Childhood Task Force) to inform them of available treatment, provide periodic updates about needs and services, and seek referrals from attendees of children in need of this service. In addition, the therapist would work closely with the Child FIRST Team through 1) participation on the Child FIRST Core Team to coordinate services to prevent duplication of care and 2) share staff training opportunities.

Evaluation Components: Performance-based Contracting. The initial and subsequent yearly contracts were developed in collaboration with the Bridgeport Safe Start Office, the local evaluators, and the Executive Director of the Child Guidance Center of Greater Bridgeport. The contracts outline the major expectations for the program in carrying out its work and for participating in evaluation-related activities, including regular contact with the evaluation consultants to develop and systematically implement the process and outcome evaluation components.

Logic Model Development: The logic model was developed in collaboration with the program staff to specify key program components, including resources, program activities, outputs (deliverables), and outcomes (see Appendix 12).

Program Flow Chart: The program flow chart specifies key aspects of the program implementation, including the flow of program activities and the process through which cases proceed through the program (see Appendix 13 for ECMHP Flow Chart). The flow chart development process served to further develop, refine, and standardize program and service system operations. It should be noted that although referrals from Child FIRST have priority, any community provider may refer children 0-6 exposed to violence in the home to this service.

Process Evaluation: The process evaluation captures information about program activities, including who the program is serving; client characteristics; type, number, and hours of services provided; attendance at activities; and amount of resources used to implement activities. Since the Child Guidance Center of Greater Bridgeport is a well-established mental health-serving agency, the local evaluators will coordinate with its existing MIS system to collect client and system level data such as client demographic and service utilization needed for the evaluation. The local evaluators have developed a pencil and paper data monitoring form to capture data currently not collected by Child Guidance.

- BSSI National Data Elements Form has been developed to standardize the process of collecting essential violence-specific data upon client intake/assessment (see Appendix XX).

Outcome Evaluation: The logic model specifies program outcomes and performance indicators. Outcome measures will be administered to clients/families upon intake/assessment and then at each 3-months of service or discharge, whichever comes first. These instruments will assist with case planning, service provision, and referral services. The level of the child's trauma history including exposure to violence in the home will continue to be assessed by the Traumatic Events Screening Inventory: Parent Report Version (TESI-PR; Ford, 2002). In addition to baseline administration, the TESI will be administered at each follow-up assessment. To best understand potential treatment effects, it is important to determine if children have experienced additional traumatic life events during service receipt that might affect treatment outcomes.

Children's trauma symptomatology will be assessed via the Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2001). Through the provision of mental health services to the child and the family that specifically address violence in the home, it is anticipated that there will be a decrease in children's trauma-related symptomatology over time.

The level of parenting stress will be assessed using the Parenting Stress Index/ Short Form (PSI/SF; Abidin, 1995). Overall, there is a growing emphasis in the Bridgeport community on providing family-centered services. Although the child age six and under is the primary focus of intervention, BSSI funded programs are encouraged to assess the needs of the entire family affected by violence. The programs work with parents in the context of family therapy to help them understand the effects of violence on their child's development and how to manage behavior. Similar to Child FIRST, the Child Guidance programs emphasize the importance of the parent-child relationship in the young child's development and well being. To this end, services provided to children and their families include assessment, crisis intervention, individual and family therapy, and case management. It is anticipated that the provision of these services will decrease parental distress.

Finally, satisfaction with services will be assessed via the six-item Global Satisfaction subscale of the Patient Satisfaction Questionnaire III (Marshall, Hays, Sherbourne and Wells, 1993).

Service System Information Tracking: The "BSSI Service Plan" (see Appendix 11) will be completed for all ECMHP clients and will capture both individual client and service system level data on the barriers to service receipt, service gaps and barriers, and if there are populations that are underserved by the system of care. The initial Plan will be reviewed after 90 days to determine if services were received and identify barriers to service.

The staff is responsible for entering the BSSI National Evaluation data, outcome data, and BSSI Service Plan data into an ACCESS database created for the program by the local evaluators. Once data are entered, staff electronically transmit these data to the local evaluators for data analysis, report preparation, and transmission to the NET.

3) Mental Health Consultation Program (MHCP)

Program Description: The Mental Health Consultation Program (MHCP) is designed to increase the capacity in Bridgeport to provide quality mental health treatment to young children and their families who are affected by family violence. The MHCP is a yearlong program that provides specialized training and on going clinical consultation to five mental health clinicians around strategies that address the mental health needs of young children and their families. The MHCP consultant provides individual and group consultation to five masters level mental health clinicians who currently work with Bridgeport children. Clinicians may draw upon their current agency caseload or accept referrals from community agencies (see Appendix 14 for program flow chart).

Evaluation Components: Performance-based Contracting. The contract was developed in collaboration with the Bridgeport Safe Start Office and the mental health consultant. The contract outlines the major expectations for the consultant in carrying out the consultation work and for participating in evaluation-related activities, including regular contact with the evaluation consultants to develop and systematically implement the process and outcome evaluation components.

Logic Model Development: The MHCP logic model (see Appendix 15) outlines the evaluation and specifies how the MHCP is expected to achieve the program's primary objectives and outcomes, which are ultimately related to positively impacting children ages 0-6 affected by violence in the home and their families. Theoretically, through the provision of quality, multi-faceted mental health consultation services to qualified mental health service providers the following intermediate outcomes will be achieved: 1) enhanced skill and confidence of service providers to provide mental health services to children and their families, 2) the development of a good working alliance between mental health consultant and consultee, 3) attainment of clinicians' personal goals for participating in the program, and 4) clinician satisfaction with the consultation experience. As a result of attaining these proximal or more immediate outcomes, children and their families affected by violence in the home will be positively impacted, including decreased parenting stress and decreased trauma-related symptoms (distal outcomes).

Process Evaluation: The process evaluation captures information about program activities, including who the clinicians are serving; client characteristics; type, number, and hours of services provided; attendance at activities; and amount of resources used to implement activities. The clinicians will utilize the pencil and paper forms described below and forward them to the local evaluators for data entry and analysis. Data required for the Safe Start Evaluation will be transmitted to the NET:

Client Level

- BSSI National Data Elements Form has been developed to standardize the process of collecting essential violence-specific data upon client intake/assessment (see Appendix 9).
- Client Service Utilization form has been developed to capture the type and duration of services provided to children and their families.

Clinician Level

- Mental Health Clinician/Service Provider Information form was developed and implemented to obtain clinician demographic data and educational, training, and supervisory experiences (see Appendix 16).
- Administrative Service Utilization form has been developed to capture the type and duration of non-client related activities (e.g., BSSI meetings, group supervision, process note development) (see Appendix 7)
- Monthly Census Form has been developed to track and monitor case openings and closings each month (see Appendix 17).

Consultant Level

- Administrative Service Utilization has been developed to capture the type and duration of the consultant's activities and services provided to the mental health clinicians.

Outcome Evaluation: The logic model specifies program outcomes and performance indicators. Outcome instruments will be administered to clients/families upon intake/assessment, and every three months or termination, whichever occurs first.

Client Level

The Traumatic Events Screening Inventory– Parent Report Version (TESI; Ford, 2002; SAMHSA, 2002) will assess the level of the child's trauma history, including exposure to violence in the home and trauma symptomatology will be assessed via the Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2001). The level of parenting stress will be assessed using the Parenting Stress Index/ Short Form (PSI/SF; Abidin, 1995). Satisfaction with services will be assessed via the Global Satisfaction subscale of the Patient Satisfaction Questionnaire III (Marshall, Hays, Sherbourne and Wells, 1993). These instruments will assist with case planning, service provision, and referral services. Instruments will be administered upon identification as a BSSI client.

Clinician (Consultee) Level

- *Working Alliance Inventory - Trainee* (WAI-T; Bahrick, 1990) is adapted from the Working Alliance Inventory (Horvath & Greenberg, 1986). The WAI-T assesses trainees' perceptions of the three factors of the supervisory working alliance: agreement on goals of supervision, agreement on the tasks of supervision, and an emotional bond (see Appendix 18).
- *Working Alliance Inventory - Supervisor* (WAI-S; Bahrick, 1990) is adapted from the Working Alliance Inventory (Horvath & Greenberg, 1986). The WAI-S assesses supervisors' perceptions of the three factors of the supervisory working

alliance: agreement on goals of supervision, agreement on the tasks of supervision, and an emotional bond (see Appendix 19).

- *Self-Efficacy Scale* is a modified version of the Self-Efficacy Inventory (Friedlander & Snyder, 1983b) that was developed to assess trainees self-efficacy as applied to a counselor supervision context and was designed to assess trainees' perceptions of their confidence in their ability to perform counseling related activities. The Self-Efficacy Scale has been modified to assess the MHCP clinicians' confidence in their ability to perform a host of counseling related activities as they relate to young children and their families affected by violence in the home (see Appendix 20).

- *MHCP Service Provider Satisfaction Scale* was adapted from Ladany, Ellis, and Friedlander (1999). The MHCP Service Provider Satisfaction Scale is a self-report instrument that assesses the providers' perceived satisfaction with consultation (see Appendix 21).

Service System Information Tracking: The "BSSI Service Plan" (see Appendix 11) will be completed for all clients and will capture both individual and service system level data on the barriers to service receipt, service gaps and barriers, and if there are populations that are underserved by the system of care. The Initial Plan will be reviewed 90 days following service delivery to determine if services were received and identify barriers to service.

All data are collected via pencil and paper forms and forwarded to the BSSI Office and finally to the local evaluators for data entry; analysis; report preparation; feedback to the MHCP consultant, participants, and BSSI; and transmission to the NET.

4) Court Assessment Project, The Center for Women and Families of Eastern Fairfield County, Inc.

Program Description: The goal of this program is to increase the coordination within the judicial system through an ongoing process assessment, whereby gaps and barriers in the system will be identified and addressed, such that the effectiveness of the Court System response to families with children ages 0-6 who have been impacted by violence is improved.

Logic Model Development: The logic model was developed collaboratively with the program staff to specify key program components, including resources, program activities, outputs (deliverables), and outcomes (see Appendix 22).

Process Evaluation: The process evaluation captures information about program activities, including who the program is serving; client characteristics; type, number, and hours of services provided; attendance at activities; type/number of materials distributed; and amount of resources used to implement activities. Through regular and consistent contact with the program staff, the local evaluators have developed several

pencil and paper data monitoring forms to capture this process information. The following forms are under development:

- Intake Form captures demographic and presenting problem information as well as the BSSI National Data Elements for the child/family presenting at the civil and criminal court for advocacy services (see Appendix 23 for Civil Court Intake and Appendix 24 for Criminal Court Intake);
- Training Log captures the number, type, and duration of community-based training/consultation activities, participating agencies, number of participants, and staff preparation time in delivering these services to community providers (see Appendix 25).

In an effort to develop the program and staff capacity for evaluation, program staff is responsible for the majority of data entry and management. The local evaluators have created an ACCESS database and will train staff on the proper completion of the pencil and paper data monitoring forms and on using an ACCESS database for data entry and management.

Service System Information Tracking: The "BSSI Service Plan" (see Appendix 11) will continue to be completed for all clients with children 0-6 years of age coming through the court advocate office and will capture both individual client and service system level data on the barriers to service receipt, service gaps and barriers, and if there are populations that are underserved by the system of care. Court advocates will follow-up with families after 90 days to determine if services were received and identify barriers to service receipt.

The CAP staff enters all data into agency MIS and ACCESS databases created by the local evaluators and transmit data to the BSSI Office and finally the local evaluators for data analysis, report writing, feedback to programs and BSSI and transmission to the NET.

5) Classroom Consultation for Early Childhood Educators

Program Description: The BSSI will work with existing agencies and collaboratives to provide on-site consultation to classroom teachers to help them implement classroom and individual child strategies to improve outcomes for identified children.

Evaluation Components: Performance-based Contracting. The contract will be developed in collaboration with the Bridgeport Safe Start Office, the local evaluators, and the consultant. The contract will outline the major expectations for the consultant and program in carrying out the work and for participating in evaluation-related activities, including regular contact with the evaluation consultants to develop and systematically implement the process and outcome evaluation components.

Logic Model Development: A program logic model will be developed in collaboration with the program staff to specify key program components, including resources, program activities, outputs (deliverables), and outcomes.

Process Evaluation: The process evaluation will capture information about program activities, including who the program is serving; client characteristics; type, number, and hours of services provided; attendance at activities; type/number of materials distributed; and amount of resources used to implement activities. Through regular and consistent contact with the program staff, the local evaluators will develop appropriate pencil and paper data monitoring forms to capture process information.

Outcome evaluation activities and responsibilities will include the collection of child/family, classroom, and consultee level outcomes:

Child and Family

- The Classroom Consultant will provide training to the settings and staff with whom he/she is consulting in the administration of early childhood developmental, emotional, and/or traumatic events screeners (e.g., Ages and Stages). The screeners will be used to assess and monitor child level change over time.

- Parent/caregiver satisfaction with services being provided to agency/setting/ children will be obtained.

Classroom

- The consultant will be responsible for conducting and/or training staff in classroom observations (e.g., Eckers) as another means of determining how the consultation services and interventions are impacting the classroom environment.

Consultee

- The satisfaction of the educators with the consultation services will be obtained.

- The Classroom Consultant will work closely with the local evaluators to develop the necessary system for collecting and reporting data outlined above and will be responsible for reporting evaluation data monthly to the BSSI.

All additional program components added to BSSI will have the same level of technical assistance and involvement in the evaluation process. Along with understanding how each program is helping children and families, our goal is to have common data elements across programs to enable an examination of the progress of the initiative at the systems level.

2. Community Indices

As documented in the Community Assessment, there are a number of community indices of violence that are direct risk factors for young children in the Bridgeport community. It will be important to look at these community indices on a yearly basis to determine if there are changes from year to year and to ascertain what impact BSSI may have had on these. In addition, it will be important to continue to compare the data

from Bridgeport with neighboring communities (e.g., New Haven and Hartford, CT). These comparisons between cities will allow for an understanding of any state-level impact. For example, the rate of children placed out-of-home by DCF almost doubled in Bridgeport from 1998 to 2000. It will be important to see if that increase was also evident in New Haven and Hartford and if any policy changes at DCF could have accounted for these changes. Table 1 presents the indices to be examined.

This evaluation activity will examine the impact that BSSI is having on the long-term outcomes highlighted in the strategic plan and logic model.

Table 1. Community Indices

Indices to be Examined	Years of Data Needed	
	Bridgeport	New Haven & Hartford
Family Violence		
# of family violence arrests	2001-2005	2001-2005
# of children either directly involved or present at time of family violence arrest	2001-2005	2001-2005
# of calls to police for domestic disputes	2001-2005	2001-2005
Child Abuse/Neglect		
# of children under the age of 6 with substantiated abuse/neglect by type of abuse	2001-2005	2001-2005
# of children under age 6 who were placed out of home by DCF	2001-2005	2001-2005
# of violent crimes	2001-2005	2001-2005

3. Interagency Collaboration

As with any emerging system of care, it is important to evaluate the level and quality of collaboration between service providers. The children's mental health field has been involved in developing systems of care for the past 15 years. The University of South Florida has been instrumental in this effort with regard to increasing the understanding of various ways that systems develop over time. A hole in the literature has been the ability to systematically evaluate the quality and quantity of collaboration within systems of care. Paul Greenbaum, Ph.D. of the University of South Florida has developed a measure to assess collaboration within systems of care. Although this instrument is still in development, the initial factor analysis has shown that there are three distinct factors: Beliefs and Attitudes (regarding collaboration); Behavior; and Knowledge of Most Collaborative Organization (which are significantly, but moderately correlated at .23, .28, and .23). It is unclear what the final factor analysis will reveal in terms of the utility of a single sum score or the examination of the individual constructs (personal communication, April 30, 2002).

As part of the evaluation of BSSI, Paul Greenbaum's Collaboration Survey was administered to 40 service providers in the Bridgeport community via telephone interview between February and April of 2002. Half of these providers were administrators and half front-line staff. Although the analysis of this data is not yet complete (since the psychometrics of the measure are still in development) we are in the process of mapping the network to enable the Safe Start staff to understand which agencies are currently on the fringes of the system of care so that they can be further integrated. This initial assessment of Interagency Collaboration was completed to get a baseline assessment. The measure will be re-administered in the Fall of 2003 and again in the Spring of 2005 to allow for assessment of changes in the quality and quantity of collaboration over the course of the Initiative. Please see Appendix 26 for a copy of the Collaboration Survey and Appendix 27 for a Copy of the Consent Form signed by all participants in the Collaboration Survey.

4. Focus Group Assessment

One aspect of the evaluation plan is a qualitative assessment of the system of care including its strengths, service gaps, barriers to obtaining services, and training needs. This assessment was completed through a series of seven focus groups conducted with consumers, providers and policymakers. This series of focus groups provides an assessment of the *current* system of care. The focus group evaluation will be replicated in the Fall of 2003 and the Spring of 2005 to enable assessment of changes within the system of care over time. The seven focus groups included: day care providers; consumers of domestic violence services; foster parents; a mono-lingual Spanish group of parents; policy makers; court and police personnel; and caseworkers.

The focus group protocols were developed in collaboration with the BSSI Management Group and were designed to illicit the participants' impressions of the current system of care in the city of Bridgeport, including: service system strengths; service gaps; barriers to receipt of services; and, recommendations from key stakeholders regarding enhancement of the current system of care (see Appendix 28 for a copy of the focus

group protocols). Each of the focus groups were audio taped and a verbatim transcript of the group was produced. Data was analyzed using standard procedures for analyzing qualitative focus group data (Krueger, 1994); data was aggregated and synthesized through careful reviews of focus group transcripts and notes as well as reviews of individual interviews. Focus groups were completed between February and April of 2002 with follow-up telephone interviews conducted through May of 2002.

The results of the baseline focus groups were summarized in five sections, including: community awareness of the effects of exposure to child abuse and domestic violence; service needs; barriers to service receipt; training needs; and, the need for increased collaboration among Bridgeport service providers. The participants in the monolingual Spanish-speaking group presented a myriad of concerns that went beyond the BSSI focus group protocol; however, this information is vitally important for the leadership of BSSI and members of the Bridgeport service provider community to have. In light of that, a transcript of the monolingual Spanish speaking focus group, with all identifying information removed, was provided in the Appendix of the full report. Please see Appendix 29 for a copy of the Consent Form that each Focus Group participant signed.

Replication of the focus groups in the Fall of 2003 and Spring of 2005 will allow for an assessment of the growth of the system of care over time with regard to system access; barriers to services; service system gaps; and system strengths. This information combined with information gathered regarding system strengths and barriers from the BSSI Service Plans of families involved in the system of care will clearly show where the Initiative is being successful and where modifications may need to be made.

5. Policy Assessment

The BSSI Leadership Team has the goal of examining the system level policy issues that impact the provision of services to children 0-6 and their families affected by violence in the home. As interventions are put into place to affect policies, it is imperative that these interventions be evaluated to indicate whether or not they were effective. The evaluation team will continue to work with the Management Group and Leadership Team to develop ways to assess the efficacy of interventions to affect policy.

6. Evaluation of Trainings

The Bridgeport Safe Start Initiative has developed a comprehensive training plan to increase the knowledge and skills of providers within the Greater Bridgeport community. An evaluation will be conducted of all training activities and will include attendance monitoring, satisfaction with the training and an assessment of knowledge and skills. This information will be used to assess whether the trainings are reaching the target audience, how the trainings are received by the participants and whether participants increase their knowledge subsequent to participation in a training. The assessments of the trainings will be fed back to the Safe Start office within one week of the training and will be used to guide the implementation of future trainings.

In addition, a database will be maintained to determine the number of trainings each provider received and the quality of these trainings. This information will be combined with the process and outcome data from the funded programs to determine if the quantity and quality of training received by program staff had any direct and measurable impact on the outcomes of children and families.

7. Evaluation of Public Awareness Campaign

BSSI will be embarking on a Public Awareness Campaign this year. Once the firm that will be doing the work is under contract and have developed their plan, the evaluation team will develop the methodology of evaluation for this aspect of the BSSI plan.

8. Evaluation of the Initiative to Improve Domestic Violence Investigations Assessment Protocol

One community-based initiative that is a direct result of Safe Start is the Domestic Violence Assessment Project initiated by the Bridgeport Regional Office of the Department of Children and Families (DCF). This project brought together DCF staff, domestic violence providers and BSSI staff, including members of the evaluation team, to develop a more effective and efficient process to assess families referred to DCF for the presence of domestic violence. The work group developed a plan where all members of the Bridgeport DCF office would participate in a comprehensive 3-day training on DV including: understanding, recognizing, and working with victims; the effects of domestic violence on children; the effects of sexual abuse on children; domestic violence and the court system; and, perpetrators. In addition, 2 of 5 units will have a fourth day of training on the new DV Assessment Protocol. Participants in the training will complete pre-post test surveys to assess knowledge acquisition and will report their satisfaction with the trainings. After completion of the training, the 2 teams trained on the assessment protocol will begin to use it.

The BSSI evaluation team worked with the group to develop a logic model (see Appendix 30) and evaluation plan. We will compare the effects of utilizing the protocol with regard to articulation of the impact of DV on the child; documentation of the victim's strengths, appropriate referrals for the victim, children and batterer, batterer accountability, number of DV allegations added after assessment, number of substantiations overturned when DV is the predominant risk to the child, number of removals from families based strictly on DV and reduction in incidents of repeat maltreatment where DV was a factor. The 3 units not utilizing the DV Assessment Tool will be the comparison group for this evaluation. Data will be collected through chart reviews by DCF supervisory staff and pulls from the DCF MIS system. After one year of data collection we will examine the impact of utilizing the protocol on the outcomes listed above. If the outcome is positive the plan is to have the 3 remaining units begin to use the protocol, and to consider having this tool and training process instituted in the other regions of the state.

9. Management Information System

The data collected by contracted programs including: demographic and descriptive data, outcomes, service planning, satisfaction and, service utilization data will be collapsed into a centralized MIS system. Data regarding program staff participation in the trainings offered by BSSI will also be pulled into the system.

The MIS system will be used to generate quarterly, semiannual and annual reports summarizing the activities of the programs involved in the Initiative and the progress and development of the integrated service system. In addition, the integrated MIS system will enable the Evaluation Team to look at system level indicators such as the types of barriers to service acquisition, gaps within the system of care and the percentage of services recommended that are received. It is expected that over the course of the Initiative the number of barriers and gaps in the system of care will decrease and the percentage of services recommended that are received will increase. These indicators have all been found to be an accurate measure of service system maturity (Tebes, Kaufman, Connell, Ross 2002). In addition, this integrated database will enable an examination of the types of service plans that are most effective for families affected by violence. The system will be used to look at the types of families being served by the system of care to insure that the target population is being served. In addition, this system will enable the comparison of the amount and content of program staff's involvement in trainings and the determination if these trainings had any impact on the outcomes of families and children served or agency performance measures (e.g., % of families involved in the development of treatment plans). Finally, the system will allow easy access to the data needed for the Performance Indicators set out by OJJDP and any identified by BSSI as outcomes of the system of care.

Local Impact Assessment

Each component of the Bridgeport Safe Start Evaluation plan examines the impact of the intervention at the local level. The evaluations of the RFP Funded Programs provide information on the impact of each of the 5 funded programs (and any other programs that will be added over the course of the Initiative). The collection of the Community Indices data allows for assessment of the long term outcomes at the system level over time and in comparison to similar communities. The Collaboration Survey will assess any changes in the quality and quantity of collaboration within the system of care over time, along with changes in the service provider network. The Focus Group Assessment looks at service system strengths, gaps, barriers to service acquisition and satisfaction with the system. Replication of the Focus Group evaluation every 18 months allows for these outcomes to be assessed over time. The Policy Assessments enable BSSI Staff, Management and Leadership Teams to examine the impacts of policy changes at the local level. The Evaluation of Trainings will allow the Safe Start staff to understand who is attending the training sessions (are the trainings reaching the intended audience) and how effective the trainings are in enhancing knowledge. Evaluation of the Public Awareness Campaign will enable the Safe Start management to know who is receiving the messages and the impact of these messages on referrals. The Evaluation of the Domestic Violence Assessment Protocol will demonstrate to DCF the efficacy of this tool in increasing the identification of DV and workers skills in referring families to

services for DV and for childhood exposure to violence. The Management Information System will be utilized to determine if the trainings had an impact on program efficacy, if the programs are serving the target population, and how system level barriers to service acquisition, service gaps and proportion of services received change over time. All of the data collected as part of BSSI will be fed back to the BSSI Office, Management Group and Leadership Team on a timely basis and the evaluators will continue to work with these groups to understand the data and to utilize the data for program and policy decision-making.

Intervention Research

The evaluations of the funded programs set out in the Overall Design section of this Evaluation Plan form the basis for the Intervention Research component of the Bridgeport Safe Start Initiative. Each of the 5 funded programs (and any other programs that will be added to the BSSI in subsequent years) has integrated into their program design a comprehensive evaluation that enables the collection of demographic and descriptive information, process and outcome data. All program participants will have a comprehensive intake assessment and the same measures will be administered every 6-months or at program discharge, whichever comes first. Because the design of the programs does not easily allow for comparison groups, an examination of the differences between program participants based on dosage of the intervention (or interventions since participants may be involved in more than one aspect of the system of care) will be conducted. This information will reveal whether level of participation in any one program impacts on successful outcomes or whether multiple interventions were more effective for particular families. This design allows for statistical analysis to be conducted at multiple time periods and specifically allows for the evaluation team to perform the data analysis after 2 years to allow for an increased number of families involved in the intervention to insure that the statistical power is adequate to reveal any real differences. A significant benefit of this design is that it can be continued after the end of the Federal grant as the majority of the burden rests on the funded programs to collect and enter the data. An external evaluator is only needed to provide technical support to the agencies and to analyze the data once collected.

Outcome Indicators

The BSSI Logic Model specifies six activities 1) best practice research; 2) system/service coordination; 3) granting process; 4) policy/legislative; 5) training; and, 6) public awareness/media that will theoretically lead to important individual and system level outcomes. Below we provide an overview of the outcome indicators for each activity and Table 2 summarizes this information including the outcome measures to be used.

As a result of best practice activities, it is anticipated that there will be increased provider and community knowledge and awareness of best practices to address violence in the home. This increased knowledge and awareness will be assessed following all training activities.

With respect to increasing the number of youth identified as violence exposed, The National Evaluation Team has assisted BSSI in locating a trauma-screening instrument (Traumatic Events Screening Inventory-Parent Report Version; Ford, 2002). It is anticipated that providers will be trained on the proper use of the screening instrument as well as accessing referral sources. The number of youth identified as exposed to violence in the home will be monitored via the number of referrals to the RFP funded programs. In addition, some of the RFP funded programs will provide training and community education to providers regarding the identification of violence exposure. Monitoring of these RFP funded activities has been built into the RFP process evaluation.

It is anticipated that BSSI activities will result in a continuum of services to serve children and their families exposed or at risk for exposure to violence in the home. The number of programs/services developed and funded will serve to assess this outcome. In addition, an assessment of system barriers to the receipt of services via the MIS system tracking and focus groups will assess this outcome.

An increase in the quality and quantity of interagency collaboration is an important system-level outcome. Collaboration will be assessed via the Collaboration Survey and based upon the findings, a map of the existing agency networks will be developed.

It is anticipated that BSSI activities will result in policy changes to support BSSI goals of reducing the impact or exposure to violence in the home and reducing the incidence of exposure to violence in the home for children 0-6. On-going policy assessments will determine the number of policies developed and implemented as well as the effectiveness of the policies.

An assessment of changes in child abuse and neglect, risk and protective factors will take place via the RFP funded programs. The outcome evaluation for three of the programs (Child FIRST, Early Childhood Mental Health Program (ECMHP), and Mental Health Consultation Program (MHCP)) specifies the collection of parenting stress, social support, and child trauma symptom data.

As a result of the BSSI's training plan and specified activities, it is anticipated that there will be an increase in provider knowledge, skill, and capacity to identify, refer and/or deliver a range of child abuse and neglect services. An on-going evaluation of BSSI sponsored trainings will assess the number of providers trained and provider satisfaction with the training. In addition providers will assess their pre and post training evaluation knowledge, skill, and capacity to deliver services.

The BSSI public awareness activities are focused on increasing the awareness of the impact of violence exposure and of the available services. These outcomes will be assessed via an evaluation of training activities and focus groups in which providers discuss their level of knowledge of available resources and services. In addition, the Initiative will track the extent of the public awareness campaign including the number of PSA's and the number of bulletins distributed to demonstrate the magnitude of the campaign.

Table 2. Outcome Indicators

Outcomes Indicators	Indicators	Source of Data	Reporting Frequency
Increased knowledge, awareness of best practices to address violence in the home	• Number of providers/agencies trained on best practices • Assessment of participant knowledge and awareness of best practices	Evaluation of Trainings Evaluation of DV Assessment Protocol	On-going
Increased identification of youth exposed to violence	• Number of providers/agencies trained on screening instrument • Number of agencies utilizing the screening instrument • Number of youth identified and referred to funded services	RFP Funded programs	Annually
Continuum of community-based, school-based, and home-based services	• Number of funded programs • Increase in the number services • Decrease in barriers to service receipt	MIS system Focus Group Assessments	Annually Every 18 months
Increased interagency collaboration (information, resource sharing)	• Increased quality and quantity of collaboration • Agencies reporting an increased number of collaborations	Collaboration Survey Network Mapping	Every 18 months
Decreased parenting stress	• Parent Stress Index (Abidin, 1995)	RFP Funded Programs	Annually
Decreased trauma symptoms in children	• Trauma Symptom Checklist for Young Children (TSCYC, Briere, 2001)	RFP funded Programs	Annually
Policy changes to support BSSI goals	• Number of policies developed and implemented • Policy impact	Policy Assessments	On-going
Increased provider/agency knowledge, skill, capacity to deliver range of child abuse and neglect services	• Number of providers trained • Participant satisfaction • Pre-post assessment of participant knowledge, skill, capacity change	Evaluation of Trainings Evaluation of DV Assessment Protocol	On-going
Increased awareness of the impact of violence exposure	• Number of awareness activities • Assessment of knowledge and awareness of the impact of violence exposure	Evaluation of Trainings Evaluation of DV Assessment Protocol	Annually
Increased awareness of available services	• Number of service requests to Infoline from Bridgeport • Number of calls to Help Me Grow from Bridgeport • Assessment of knowledge of available resources	Focus groups Infoline/ Help Me Grow	Every 18 months

IV. PLANS FOR REPORTING AND UTILIZATION

The evaluation team from The Consultation Center will work with the Safe Start office, Management Group and Leadership Team, community-based organizations, program participants and policy makers to develop data feedback mechanisms that meet the needs of stakeholders from across the service delivery system. We envision that data feedback will come in the form of newsletters, presentations at meetings and community forums, reports developed for specific purposes (e.g., data report cards for individual agencies); and formal reports. As with all aspects of the evaluation process, these data feedback tools will be continually assessed regarding their utility and revised to meet the needs of the stakeholders in the system of care. The data feedback mechanisms highlighted below are intended to allow for a continual feedback process to the Safe Start office and Management and Leadership Teams. The Local Evaluators will work on an ongoing basis with the program mangers to understand the data and to assist them in utilizing the data for continued program development. It should be noted that the mechanisms presented can and will be modified as the needs of the service system and Safe Start Office, Management and Leadership Teams evolve. In addition, the Local Evaluators have every intent to provide data back to the consumers served by the project and the community at large. The nature and format of this data feedback will be determined in collaboration with the BSSI Leadership Team.

RFP Funded Programs

Data will be fed back to the Safe Start Office and Management Team on a monthly, quarterly, semi-annual and annual basis. The Safe Start office and Management Team will receive quarterly reports summarizing information from the funded programs, including: demographic and descriptive information of clients seen by contracted and partner agencies; an unduplicated count of clients; service units received; and barriers to receipt of service units. On a quarterly basis, report cards will be generated for all contracted agencies documenting the outcomes of their clients; client satisfaction with services; and performance indicators. Finally, on a yearly basis, a report will be generated that summarizes the work of the agencies, including: clients served; service utilization; system access; and system barriers (see Table 3 for a summary of the data feedback plan).

Community Indices

Reports will also be generated on a yearly basis summarizing the community indices and comparing the statistics from Bridgeport to those from New Haven and Hartford. In addition, this report will look at changes in these indices over time.

Collaboration Survey

At the completion of the telephone surveys that will assess the level and quality of collaboration a report will be generated to summarize the information and to provide a map of the service delivery network. Each time this survey is re-administered the report will compare the current findings to those previously found.

Focus Groups

At the completion of each round of focus groups, a report will be generated summarizing the information collected from the focus group participants. The data will be coded to identify emerging themes and themes that are evident across groups or are held by a consensus of one group will be summarized into a report to be presented to the BSSI Office and Management Group and Leadership Team.

Policy Assessments

A report will be generated each time a policy intervention is evaluated. These reports will summarize the policy decision, the intervention and will provide an indication of the impact of the policy decision. Assessments will be completed at baseline and follow-up for each policy decision.

Evaluation of Trainings

Evaluations will be completed at each Safe Start funded training (see Appendix 32). These evaluations will gather demographic information and identifying information from participants and will assess satisfaction with the training. In addition, a pre-post knowledge survey (based on training curriculum) will be administered. A summary of each training will be produced within one week.

Public Awareness Campaign

A report summarizing the focus and impact of the public information campaign will be produced semi-annually. These reports will summarize the activities of the campaign and the impact with regard to the numbers of individuals the campaign reached and the rates of referrals to BSSI funded activities.

Evaluation of the Domestic Violence Assessment Protocol

A report summarizing satisfaction with and knowledge acquisition will be completed at the end of each training cycle. This data will be useful to further develop the training protocol. At the end of the first year of training, a report will be generated summarizing satisfaction and impact.

An annual report will be produced that summarizes the differential outcomes of the units utilizing the assessment protocol and those that are not. This report will include data from the DCF MIS system and chart review data and will be used to assess the impact of the new assessment tool and process.

MIS System

The Management Information System will be used to develop cross-system reports on a quarterly basis (looking across time) at the service gaps, barriers and percentage of services recommended that were received. In addition, analyses will be done to examine the impact of services across the agencies.

Table 3. Reporting and Utilization of Data

Data Source	Report	Reporting Frequency
RFP Funded Programs	Census Report Demographic and descriptive information of families assessed; Service information (e.g, barriers)	Monthly
	Quarterly Progress Report Demographic and descriptive information of clients served by contracted and partner programs; Unduplicated count of clients served; Service units received (by service type); Barriers to service receipt	Quarterly
	Semi-Annual Report Cards Outcomes of clients served; Client satisfaction with services; Performance indicators (e.g., % of clients with completed assessment of strengths); Agency staff participation in BSSI trainings Data analysis will take into account program dosage and participant risk and protective factors.	Semi-Annual
Community Indices	Yearly Indices Report Summarizing community indices for Bridgeport compared to other communities; Examination of trends over time	Annually
Collaboration Survey	Collaboration Assessment Examination of the level and quality of collaboration over time	Every 18 Months
Focus Groups	Qualitative Assessment of BSSI System of Care Thematic analysis of focus group data comparing trends over time	Every 18 Months
Policy Assessments	Assessment of policy interventions. A systematic look at the impact of policy decisions of the Greater Bridgeport provider community.	As Indicated
Evaluation of Trainings	Training Evaluation Report A summary of the participants; Participant satisfaction with training; Assessment of knowledge acquisition (pre/post testing).	Within 1 week post training
Public Awareness Campaign	Assessment of community response to Public Awareness Campaign	Annually
Evaluation of Domestic Violence Protocol	Training Evaluation Report A summary of participants Participant satisfaction with training Assessment of knowledge acquisition (pre/ post testing)	Within 2 months following completion of training schedule
	Assessment of protocol, case conference, and training effectiveness on DCF staff, domestic violence practice and service planning	Annually
Management Information System	System Level Analyses Cross-system look at service system strengths, barriers and gaps; Impact on level and quality of training on client outcomes.	Quarterly

V. NATIONAL AND LOCAL CAPACITY BUILDING EFFORTS

The National Evaluation Team has been instrumental in assisting us with identifying outcome measures that are appropriate for children 0-6 exposed to violence in the home. We know that as future programs get funded at the local level, we will again ask for assistance from the NET in identifying measures. In addition, as we continue to collect the data required as part of the national evaluation effort including process data, descriptive/outcome data and performance indicators, we will ask for assistance from the National Evaluation Team as needed.

Our approach to evaluation is one focused on enhancing the capacity of provider organizations to collect and utilize evaluation data for program and policy development. At the program level, we work closely with providers to develop their logic models, modify and create data collection forms, and choose outcomes and measures. In addition, as the data begins to come in we will work with provider organizations to understand the data, help them to identify the questions that they want answered from the data, and provide them with the skills to get this information. In our experience thus far with BSSI and other systems that we have evaluated, providers use the technical assistance we provide to not only evaluate the program funded by the Initiative, but also to modify the evaluation of their entire agency. This enhanced evaluation capacity will enable them to sustain the programs long after the Federal monies have ended.

At the system level, we work closely with the BSSI Project Director and Management Group to feed data back to the system to enable them to make informed decisions regarding policy and resource decisions. Table 2 specifies the reporting frequency of the data. In addition, Dr.'s Kaufman and Crusto attend the BSSI Management and Leadership meetings on a regular basis with the goal of insuring that data is considered in decisions regarding program development and policy issues. We are clear that the data feedback structure has to be a consistent part of the Initiative to insure it's development in ways that best meet the needs of the Greater Bridgeport community.

VI. INSTITUTIONAL REVIEW BOARD

The Evaluation Plan for the Bridgeport Safe Start Initiative has been approved by the Human Investigation Committee at Yale University School of Medicine and has been assigned HIC #XXXXX.

VII. REFERENCES

Abidin, R. (1990). "Parenting Stress Index, 3rd Edition: Test Manual." Charlottesville, VA: Pediatric Psychology Press.

Bahrick, A. S. (1990). "Role induction for counselor trainees: Effects on the supervisory working alliance." *Dissertation Abstracts International*, 51, 1484B (University Microfilms No. 90-14, 392).

Briere, J. (2001). "Trauma symptom checklist for young children (TSCYC)." Unpublished manuscript, University of Southern California, Keck School of Medicine: Los Angeles, CA.

Ford, J. (2002). "Traumatic Events Screening Inventory – Parent Report Revised (TESI)." Unpublished Manuscript. University of Connecticut.

Friedlander, M.L. & Snyder, J. (1983b). "Trainees' expectations for the supervisory process: Testing a developmental model." *Counselor Education and Supervision*, 22, 342-348.

Horvath, A.O., & Greenberg, L.S. (1986). "The Development of the Working Alliance Inventory." In L.S. Greenberg & W. M. Pinsof (Eds.), *The Psychotherapeutic Process: A research handbook* (pp. 529-556). New York: Guilford.

Ladany, N., Ellis, M.V., and Friedlander, M.L. (1999). "The supervisory working alliance, trainee self-efficacy, and satisfaction." *Journal of Counseling Development*, 77, 447-455.