SAFE START NATIONAL EVALUATION PLAN

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TABLE OF CONTENTS

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1. OVERVIEW OF THE NATIONAL EVALUATION DESIGN

The primary purpose of the Safe Start Initiative's (SSI) National Evaluation is to build the knowledge base regarding promising practices for reducing the impact of exposure to violence. Promising practices include interventions for children and families, as well as systems and community change efforts that can facilitate and strengthen appropriate interventions on behalf of children and families. The plan is designed to minimize the reporting requirements and burden for Safe Start sites, while, at the same time, producing useful data and insights in the form of practical products to move the field forward. It focuses on four major deliverables:

1. A national cross-site evaluation report that includes a) a cross-case study analysis of all Safe Start sites, and b) a compilation/synthesis of professional journal-style reports from four sites conducting enhanced evaluation activities;
2. A national cross-site process evaluation report;
3. A report on promising practices that sites have implemented and found to improve some segment(s) of their service delivery or intervention outcomes; and
4. A rapid-turnaround report on current approaches, innovations, and status of client recruitment and retention efforts.

2. NATIONAL CROSS-SITE EVALUATION

The National Evaluation Team (NET) recognizes that all sites offer valuable contributions to our understanding of how to reduce the impact that violence has on young children. As outlined in our Safe Start Initiative Phase 2 proposal, the overall design for the National Evaluation involves the participation of all 11 Safe Start sites. At several sites, however, specific programmatic, research design, or client characteristics appear to hold greater promise for enhancing the knowledge base. We are making additional funding resources available to these sites.

To operationalize this "enhanced" approach, the evaluation is comprised of two tiers of site involvement: Tier I involves all 11 sites and Tier II involves the four sites that have been selected to receive additional resources (e.g., funds, assistance in data collection, etc.). These additional resources are intended 1) to strengthen the rigor of site design, 2) to increase the power and/or precision of outcome findings, or 3) to expand and improve tools or measures available for client identification and assessment.

For Tier I, all sites will be expected to submit program-monitoring data (e.g., Core Database variables semi-annually) and to participate in the cross-site analysis. For Tier II, four of the 11 sites have been selected to develop and implement more rigorous or extensive intervention outcome evaluations. Specifically:

Tier I. This tier involves case studies of interventions and systems change efforts. All sites are expected (and will be offered technical support) to develop (with the NET) annual and final case studies of their interventions based on a reporting format/template (see Section 2 below). The reporting design is based on examination of the current data elements being collected and the Safe Start contextual and expanded intervention logic models (Exhibits 1 and 2). Local evaluators will use existing data collection methods, results, and core data elements routinely submitted to the NET to develop the case studies.

Tier II. The National Evaluation is intended to increase the knowledge base regarding 1) programs for reducing the impact that exposure to violence has on children, as well as 2) methods and approaches to evaluate such programs (according to criteria presented later in this plan). The selection of sites for Tier II took into consideration both programmatic and evaluation characteristics.

Sites interested in participating in Tier II were asked to provide a brief synopsis of their program's promising intervention, treatment, or assessment approach, as well as their present evaluation plan. They were asked to describe 1) segments of their evaluation that merit enhancement and how these segments would contribute to the field's knowledge base, 2) the timeline for implementation and expanded evaluation, and 3) the cost or other assistance needed for the enhancement. The NET worked closely with local evaluators in developing their brief proposals, and will continue to work with them to implement the enhancements and to conceptualize and plan the data analysis. Four proposals were accepted. They are:

- ***Bridgeport Safe Start***: The Bridgeport Safe Start Initiative will administer the Traumatic Event Screening Inventory (TESI), Traumatic Symptom Checklist for Young Children (TSCYC), and Parenting Stress Index (PSI) at discharge for families served by Child FIRST. Previously, these families did not participate in end-of-service assessments. The additional assessments will allow the program to compare post-intervention assessment results with pre-intervention assessment results.
- ***Chicago Safe Start***: Chicago Safe Start will collaborate with the Illinois Violence Prevention Authority's *Safe from the Start* project to compare data from as many as eight different interventions for children exposed to violence. The Tier II Enhancement Grant will be used to fund collaborative activities including developing common evaluation methods and measures, and coordinating data-sharing, analysis, and report-writing.
- ***Pinellas Safe Start***: The Pinellas Safe Start Initiative will develop a resiliency matrix to extract data from client case plans to help identify and verify risk and resiliency profiles of the individuals (parents and children) who are more successful in achieving program goals. Their Tier II efforts also will include follow-up with 1) service providers to determine if clients linked to their referred services and 2) clients to determine if they met the objectives of their case plans.
- ***Bridgeport/Rochester Collaborative Effort***: Rochester Safe Start and Bridgeport Safe Start proposed a joint study to validate the Rochester Safe Start Early Childhood Education Parent Survey. Bridgeport Safe Start will add the Parent Survey to their current measurement protocol, which includes the TESI, Parent Report Revised, Brief Version. Both instruments will be administered at the same meeting with the client.

Bridgeport Safe Start will share with Rochester Safe Start the TESI and Parent Survey data on all families enrolled. This effort will measure *concurrent* validity, and standard techniques in concurrent validation will be employed (e.g., examination of the item- and scale-level inter-correlations). The two sites will co-author publications resulting from the collaboration.

2.1 Tier I Site-Based Analysis: A Case-Study Approach

All sites will contribute to an in-depth case study analysis of their programs though the amount and depth of data will vary among sites depending on the local evaluation plan and activities. The design of Tier I will be based on the Safe Start logic model, which was developed collaboratively with the assistance of national and local program and evaluation staffs.

There are several reasons for a case study approach. First, a case study allows the NET to analyze the context within which services are provided across sites, looking for common or distinctive features, including:

- Community makeup;
- Ethnicities and cultures of the populations served;
- Organizational characteristics and capacities;
- Types of violence addressed; and
- Resources available.

Second, using a case study design allows for a multi-method approach to understanding the Safe Start Demonstration Project. The National Evaluation will utilize quantitative core data (which is already being collected), as well as implementing qualitative data collection methods, including:

- Interviews with key program staff;
- Interviews with service providers;
- Interviews with key informants from community agencies (e.g., police departments, child protective service agencies, domestic violence agencies, etc.); and
- Examination of organizational documents (e.g., training manuals, public service announcements, meeting minutes, etc.).

Each site's case study, as well as data gathered from their final core database, will be integrated into the cross-case study and evaluation report. Onsite process and other data collection (e.g., follow-up interviews, collection of archival information) by the NET will be conducted in Year 4 and included in the case studies. All the information then will be used in a cross-case analysis of the Safe Start Initiative. The analysis will be based on the previously developed Safe Start logic models (see Exhibits 1 and 2) and the data elements that each site selected to reflect those logic models (i.e., Exhibit 3, the *Overall Safe Start Logic Model Reporting Framework*, and Exhibit 4, the *Enhanced Intervention Logic Model Reporting*

Framework). These templates will be used for guiding the outcome analyses, and for organizing the reporting of local evaluation findings and the development of case studies. The case studies will be written in a collaborative interactive manner:

- The NET will provide a framework for the case study similar to Exhibit 3;
- The NET will provide a comprehensive content outline for reporting evaluation findings (see Exhibit 5, Case Study Outline for Tier I Sites);
- The local evaluators will complete the case study according to the reporting framework (similar to Exhibit 3), by providing descriptive findings on the major logic model constructs/variables (e.g., Contextual Conditions or Institutionalization of Change), based on the indicators that they used to capture those constructs in their site-specific Reporting Framework Summaries [see Appendix A, the *Spokane Reporting Framework* (February, 2004), for examples of *"model"* descriptive findings];
- The local evaluators will include a brief section describing the individual-level intervention research design, methods, and results (i.e., main CEV outcomes);
- The NET will add to the report from process evaluation findings to blend process and outcome findings into a coherent case study of each site; and
- The NET will work with the local evaluator, through review and revision(s), to develop a mutually acceptable case study that accurately reflects the implementation process, multi-level outcomes, and potential impact of the SSI at each site.

The cross-case evaluation design will highlight common strategies for improving services and child/family outcomes, as well as significant challenges encountered in providing services to children exposed to violence. The comparative focus will be on the implementation and immediate outcomes of intervention, treatment, and prevention strategies, as well as systems change. Attention will be given to lessons learned and other knowledge that can enhance future practice, evaluation approaches, and sustainability issues.

2.2 Tier II Outcome Evaluation: Enhanced Evaluation of Promising Interventions or Components

The goal of Tier II local evaluations is to enhance, where possible, current evaluations of Safe Start direct interventions with children and families (not systems change efforts) that show good promise for producing additional knowledge, measurement tools, or analytic methods pertaining to interventions that can reduce the impact of exposure to violence. This requires certain evaluation conditions (such as the availability of reliable data and the potential to create comparison groups) to allow for the implementation of more rigorous or precise outcome evaluations.

Safe Start evaluations that will receive increased funding were determined in consultation with the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and are included in the Program Selection Matrix described in Exhibit 6.

The Tier II Selection Process. Brief evaluation-enhancement proposals were solicited from all interested sites**.** In addition to the criteria for the intervention, evaluation proposals had to address questions such as:

- Using either previous research or other knowledge sources, how does the intervention or treatment program "test" or enhance what is known?
- How can funds be used to enhance the evaluation according to the criteria?
- Why is this enhancement proposal feasible?

Sites were selected based on the above criteria and the merits of their programs and proposed enhancement plans. OJJDP made the final selections with the advice and assistance of the NET. (Appendix B contains a brief summary/scope of work and proposed timeline for each site's enhancement.)

Final evaluation plans, specifically describing the enhancement and methods by which the sites intend to evaluate their intervention, will be developed collaboratively among the local evaluators, project directors, and the NET, for approval by OJJDP before being implemented. For each Tier II site, the final evaluation plan will contain the following sections:

1. Brief summary of the current individual- and/or family- level intervention evaluation approach and design;
2. Brief summary of the evaluation enhancement (which will be an elaboration and update on the material presented in the Program Selection Matrix, Exhibit 6);
3. Brief description of the enhancement target population and expected sample size available for final analysis;
4. Brief summary of the analysis plan, including intended statistical methods (e.g., factor or cluster analysis to obtain client profiles, analysis of covariance to examine changes in outcomes over time);
5. Brief discussion of potential problems and possible solutions (e.g., clients do not take up referrals to treatment as often or as quickly as anticipated, so additional staff time must be allocated to follow up on referral status or client location); and
6. Timeline of major milestones.

Final Report Requirements for Tier II Sites. Local evaluators for sites participating in Tier II are required to write a final report on their intervention research, following the format and standards of a refereed social science journal, in addition to the general reporting required of Tier I participants. The Methods and Results sections of each site's report should be a natural extension of the major sections of their final evaluation plan approved by the NET. Those sections are likely to include the following subsections:

1. Brief summary of the "final" individual- and/or family- level intervention evaluation approach and design (which incorporates the "enhanced" approach/features);

2. Brief summary of the evaluation enhancement, if it is not a central part of the overall individual-level outcome evaluation (e.g., the implementation of an instrument validation study);
3. Brief description of the enhancement target population and "final" sample size available for outcome analysis;
4. Explanation of any limitations or factors influencing the general ability or validity of the study;
5. Brief summary of the analysis plan, including statistical methods used (e.g., factor or cluster analysis to obtain client profiles, analysis of covariance to examine changes in outcomes over time);
6. Results of the enhanced intervention research in terms of outcomes effectiveness; and
7. Discussion and conclusion (including implications, if any, for this specific site, other SSI sites, and future SSI replications).

3. NATIONAL CROSS-SITE PROCESS EVALUATION APPROACH AND REPORT

A process evaluation will be conducted to help identify what is and is not working and why, as well as depicting how the Safe Start Initiative operated across sites in 2004. The overarching goal is to understand the implementation process and how, under various circumstances, sites were able to contribute to systems and individual changes around children's exposure to violence.

The NET will be using the Safe Start logic model to guide the evaluation and help formulate the evaluation questions, methods, and analysis. The model will be used to organize, analyze, and report the information, and will serve as a "general and flexible" template for comparisons across sites.

3.1 Protocol Development

Site visit and data collection protocols will be developed to guide data collection activities. Protocols will be based on two previous and ongoing data-collection efforts: 1) previous years' process-evaluation data collection and 2) site-specific data collection in previous and current efforts. For example, specific protocols will be developed based on each site's characteristics, which will be determined using information from previous collection efforts and current site documents.

The NET has developed a series of core and secondary questions that will guide protocol development. The following comprise the core questions to be addressed:

1. How did the composition and process of the collaborative in each site influence the types of strategies implemented, and, as a result, the systems change outcomes?
2. How has SSI changed the service delivery system for children, and the families of children, exposed to violence?

3. What organizational, community, point of service (POS), and collaborative capacities (knowledge, skills, resources, and relationships) are required for successful implementation and sustainability of the systems changes at each site?
4. What strategies were developed to respond to external changes (e.g., fluctuations in the economy, political changes, etc.) affecting the successful implementation and goal achievement of the Safe Start Initiative at each site?
5. How did each site handle anticipated or unanticipated critical changes at the program level?
6. What were the milestones reached, goals attained, and indirect impacts of the Safe Start Initiative in the past year?
7. What strategies are being used to achieve sustainability in policies, procedures, and practices?
8. What lessons have been learned about the implementation and replication of a national initiative such as Safe Start?

A list of core questions and secondary tier questions can be found in Appendix C, along with a graphic representation of the Safe Start logic model with each question inserted in the appropriate position on the model. Protocols will be tailor-designed for each site.

3.2 Site Visits

Visits to the 11 sites will be conducted from September through November 2004. Two staff members from the Association for the Study and Development of Community (ASDC) will conduct each site visit over a two-day period. During the site visits, the evaluation team will:

- Provide onsite technical assistance regarding monitoring and evaluation of Safe Start Initiative activities;
- Build relationships;
- Collect project documents; and
- Conduct onsite interviews with key informants in the Safe Start Initiative.

3.3 Data Collection Methods

Document Review. Site progress reports, as well as each site's current strategic and implementation plans, will be reviewed prior to each site visit. Other documents, such as meeting minutes and training and technical assistance records generated by each site's Safe Start Initiative team, also may be reviewed to determine each site's milestones and evolution. This document review will enable interviewers to familiarize themselves with site activities and strategies prior to initiating onsite discussions.

Interviews with Key Informants. Key informants will be interviewed during site visits in the fall of 2004. Depending on the specific information to be gathered, based on each site's

protocol, interviews may be conducted with some or all of the following participants in the Safe Start Initiative:

- Key members of each collaborative;
- Project directors;
- Key staff members;
- Point-of-service deliverers; and
- Key community members.

Additionally, to gather information about the relationships and processes among sites and their national partners, interviews may be conducted with training and technical assistance providers, representatives of OJJDP, members of the NET, and other national support team members.

The number of interviews at each site will vary depending on the extent to which information can be gathered from less intrusive sources. Furthermore, if we determine that information would be better or more efficiently gathered using a group format, focus groups will be considered. For example, for collection of Initiative-specific information (versus site-specific information), we may consider gathering project directors at a cross-site meeting for a group discussion about the issues. The goal is to minimize the burden on sites, while still collecting valid, high-quality, complete data.

After the site visits have concluded, follow-up telephone calls will be made to each site's project director to update and complete the information gathered during the visits. If necessary to complete the 2004 information, follow-up calls also will be made to other key informants.

3.4 Data Analysis

All interviews will be transcribed for analysis purposes. Transcripts, along with any data available electronically (e.g., progress reports, etc.), will be entered into the database of a qualitative software package. Codes will be developed that reflect the components of the logic model, and each data piece will be analyzed using these codes. The information will be examined for common themes and patterns. Any divergence across sites also will be noted.

3.5 Process-Evaluation Report

A report on the processes used by local sites to implement the Safe Start Initiative in 2004 will be delivered for review by OJJDP by January 31, 2005. The report will focus on a description of Safe Start activities and changes in immediate, short-term, and intermediate outcomes across sites, and will be comprised of information about the Safe Start Initiative, as a whole, with site-specific data used as examples and illustration. All of the 11 Safe Start Demonstration Sites will be included in the process evaluation. The two tribal sites will be analyzed separately because they are in an earlier stage of development.

The report will be approximately 25 pages in length and will present information collected through document reviews, telephone interviews, and site visits. The outline for prior process

evaluation reports will be used to design this report. The report is expected to include, at minimum:

- Results of our investigation of the eight core questions;
- A summary of major activities for each site, with information on collaboration, community capacity building, project management, resource development, program improvement, intervention or treatment program implementation, and sustainability;
- Barriers and challenges; and
- Lessons learned and other recommendations for addressing barriers and improving the Initiative.

The NET is very concerned about the presentation of this information and will work very closely with all stakeholders (e.g. OJJDP program and evaluation managers) to ensure that the format and content of the report is useful. One of the strengths of ASDC is our practical experience, not only with the Safe Start Initiative, but also in the use of this type of information in planning and program improvement.

4. PROMISING PRACTICES IDENTIFICATION AND REVIEW APPROACH AND REPORT

The NET will develop a report outlining each site's self-identified promising practices, which will enhance communication among the sites and allow them to share information about practices that are working or have the potential for success. This report will be developed using 1) Safe Start site progress reports, 2) other reports currently being submitted by the local Safe Start sites, and 3) discussions with site staff. This process will occur in four steps.

4.1 Step 1: Review of Site Implementation Plans

All 2004 implementation plans will be reviewed by the NET for initial identification of components that each site views as promising. These program components will be noted and recorded by NET members. Each promising practice recorded on a site-specific matrix will have the following sections:

- Area of program into which the practice falls (e.g., assessment, community awareness, referral, etc.);
- Type of practice;
- Reason practice is promising; and
- Any other essential details.

4.2 Step 2: Review of Current Progress Reports

Once implementation plans have been reviewed and promising practices recorded, current progress reports will be reviewed by the NET for confirmation. Promising practices on matrices will be matched with activities and results recorded in progress reports. Additional information will be recorded on matrices, including:

- Types of activities conducted to meet the goals of the promising practices;
- Whether the goal of the practice was met; and
- If so, additional details and comments of explanation; if not, reasons for not accomplishing the goals.

4.3 Step 3: Confirmation of Data with Site Staff

Matrices completed based on written materials will be discussed with site staff to confirm the details and accuracy of the information. This step will, itself, be a multi-step process:

1. Make telephone contact with the sites to confirm, verbally, the information gathered;
2. Update the information based on the comments and suggestions of project staff; and
3. Send the completed matrices to the sites for final approval.

4.4 Step 4: Final Report

After all sites have approved their matrices, the information from the matrices will be extracted and used to develop a single cohesive cross-site report of promising practices. This report will be sent to all sites by August 31, 2004, prior to the fall site visits. As requested by individual sites, ASDC will update and revise the report and matrices throughout the contract period to better reflect the work of the sites.

5. REPORT ON STATUS OF CLIENT RECRUITMENT AND RETENTION EFFORTS

Safe Start sites have indicated that the recruitment and retention of children and families for services is an ongoing challenge. To better understand the issues sites are encountering in recruiting and retaining families and children, a systematic examination of the issues will be conducted. Specifically, the types of information of interest are:

- Number of families and children each site expected to serve during the life of the Initiative (through June, 2004);
- Number of families and children actually identified and assessed;
- Number of families and children actually provided services;
- Number of families and children successfully completing services;
- Number of families and children provided follow-up after completion of services;
- Challenges to recruiting and retaining families and children;
- Strategies utilized to overcome challenges; and
- What works and why.

The following protocol will be utilized to examine and understand the issues of recruitment and retention of families and children at the Safe Start sites. In Steps 2 to 4, the above information will be gathered.

1. **Letter of introduction.** OJJDP will send a letter informing the sites that the NET is investigating the specific issues of family and child recruitment and retention for SSI services. The letter will be sent approximately two weeks prior to the time that the NET plans to contact sites for data gathering (Step 3 below).
2. **Document review.** Each site's progress reports will be reviewed to gather any information that may have been reported regarding recruitment and retention issues.
3. **Informal interviews.** Telephone contact will be made with each project director to supplement the information found in the progress reports. In addition to the project director, other staff or clinicians will be interviewed, as necessary. Please see Exhibit 7 for a list of possible interview questions.
4. **Literature review.** A brief literature review will be conducted to draw on the research and practices found to be promising in the area of recruiting and retaining families with multiple challenges in difficult circumstances. This step will occur simultaneously with Steps 1 to 3.

5.1 Report

Upon completion of the data collection, including the literature review, a ten-page report will be written outlining the following:

- The types of recruitment and retention strategies that sites have found to work;
- The types of recruitment and retention strategies that sites have tried and abandoned, and reasons for abandoning them;
- Strategies tested in the literature that have been found to improve recruitment and retention of families for services; and
- Recommendations for improving recruitment and retention strategies based on the findings.

The report will be submitted to OJJDP by August 31, 2004.

6. TIMELINE

Exhibit 8 contains a timeline of all four segments of the national evaluation.

EXHIBITS

EXHIBIT 1- Safe Start Logic Model

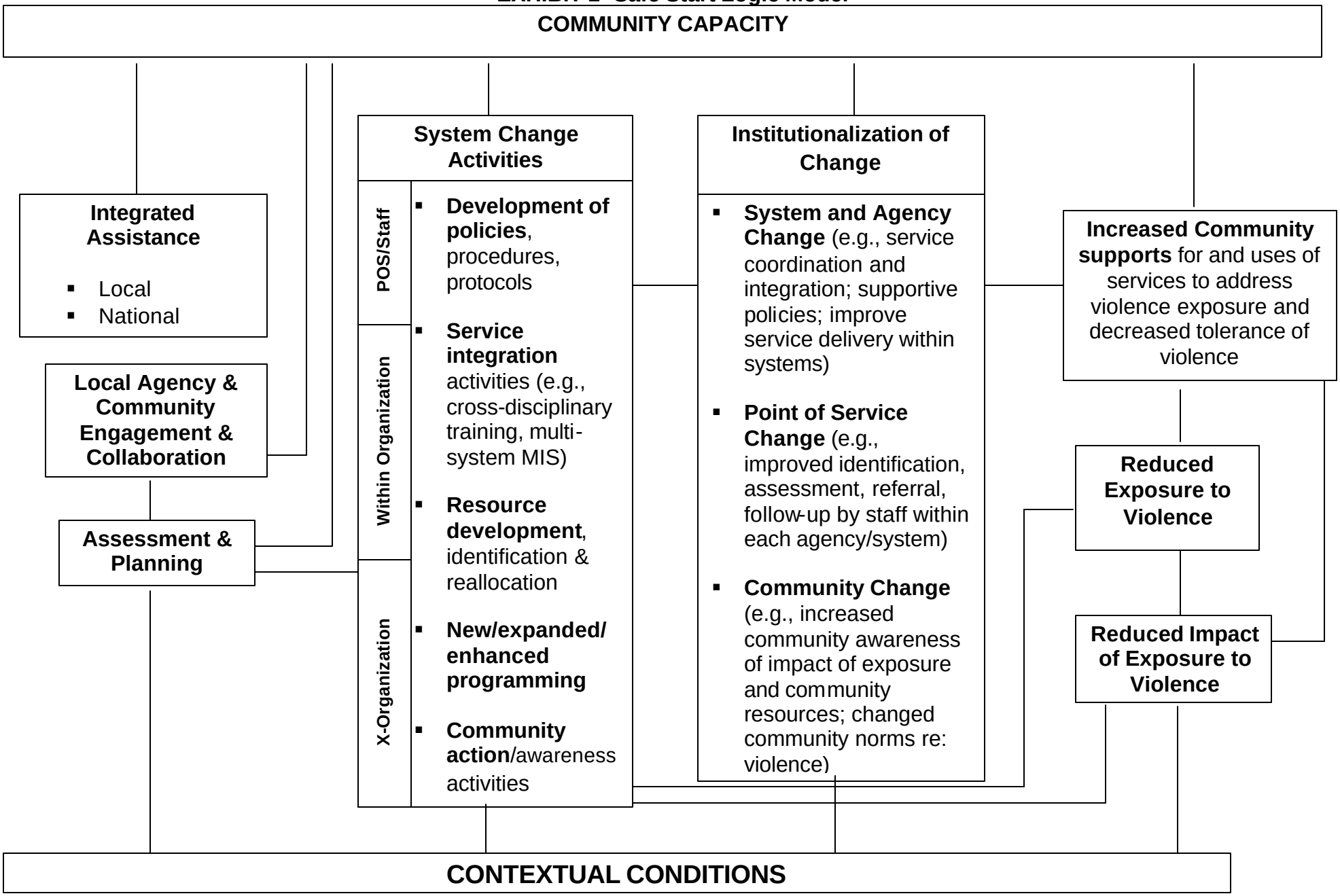

EXHIBIT 2

Safe Start Enhanced Intervention Logic Model

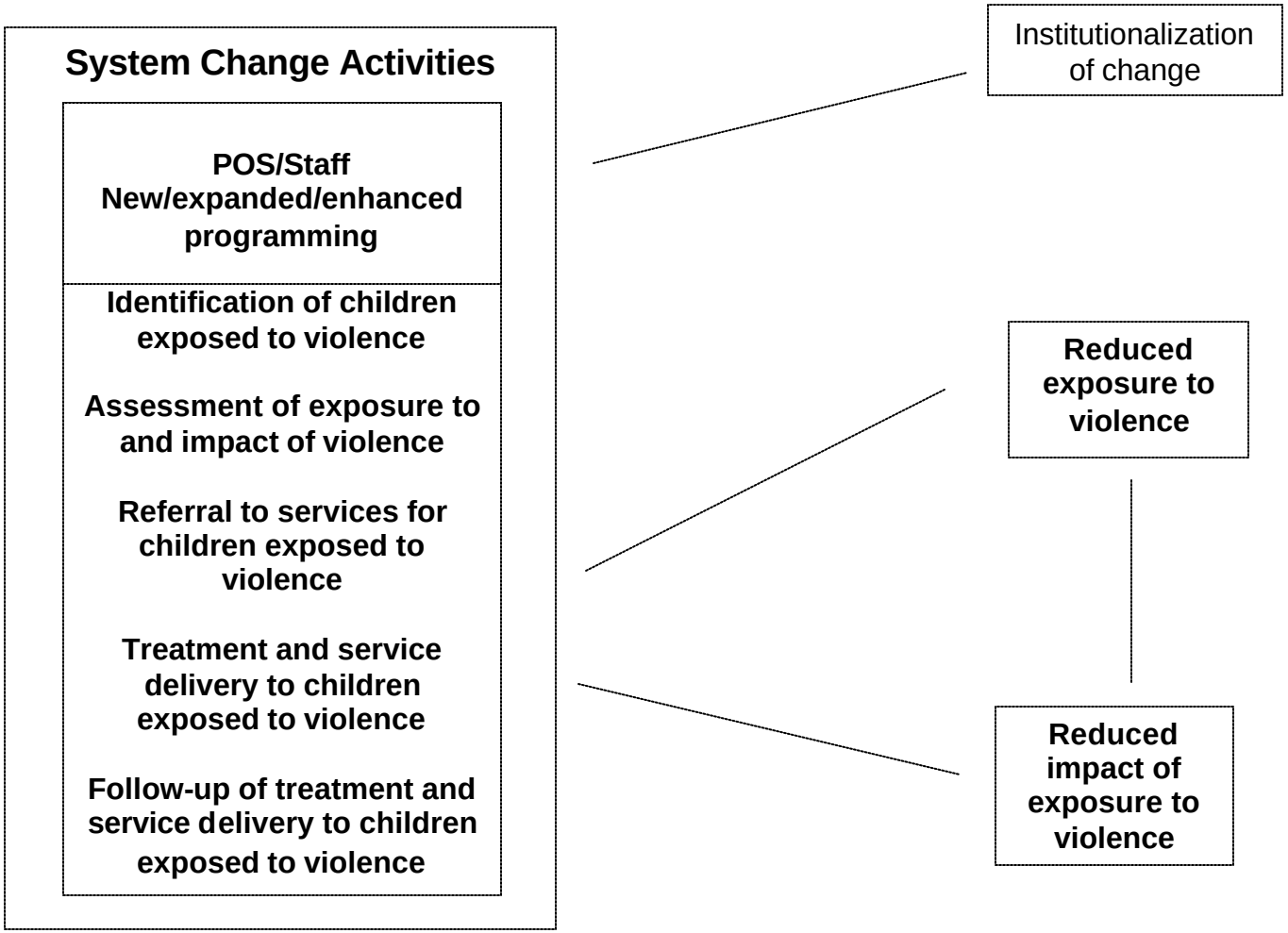

EXHIBIT 3

Safe Start – Variables, Indicators, and Data Sources
REPORTING FRAMEWORK EXAMPLE
For the Overall Logic Model

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	EXAMPLES OF INDICATORS	POTENTIAL DATA SOURCE
CONTEXTUAL CONDITIONS			
Political context	*The political climate that affects reducing the impact of exposure to violence in children and the community's ability to reduce the impact*	Legislation and administrative policies supporting assistance to children exposed to violence Community master planning children and youth services Support of political leaders for addressing the needs of children exposed to violence. Legislation requiring the collaboration of services to help children exposed to violence	Community members, political leaders, legislation Master plans, key informants in government Key informants in government, legislation Review of public official speeches, newspaper and editorial reviews
Economic context	*The economic climate that affects reducing the impact of exposure to violence in children and the community's ability to reduce the impact*	Local, private, and state budgets supporting programming for children exposed to violence Levels of poverty	Government documents, key informants in government United Way Allocations, Foundation reports.
Social context	*The social conditions that affect the impact of exposure to violence in children and the community's ability to reduce the impact*	Amount of community cohesion Ethnic and racial composition of community Level of overall crime in the community Historical public support for recognizing the need to address the impact of exposure to violence in children (recognizing that children exposed are victims.)	Community members, key informants in community Crime statistics, community members, key informants in community Community members, key informants in community Key informants in community, key informants in social service agencies

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	EXAMPLES OF INDICATORS	POTENTIAL DATA SOURCE
Other initiatives	*Past or current efforts that can influence the planning, implementation, or outcomes of the Safe Start initiative*	Perceived seriousness of violence in community Description of the outcomes of past or current efforts on agency relations, community, conditions, service provision, policies, etc.	Key informants in community, key informants in social service agencies Key informants in community, key informants in social service agencies
COMMUNITY CAPACITY			
Services for children's mental health needs	*The knowledge, skills, resources, relations and commitment needed to address children's mental health needs in order to reduce the impact of exposure to violence in children*	# of children's mental health programs available Knowledge of and use of best practices to provide mental health services to children exposed to violence. Adequacy of children's mental health programs to meet needs Financial resources committed to addressing the needs of victims of family violence Formal functional relations among organizations providing mental health services for children exposed to violence	Community members, key informants in community, key informants in social service agencies Community members, key informants in community, key informants in social service agencies Community members, key informants in community, key informants in social service agencies Community members, key informants in community, key informants in social service agencies Community members, key informants in community, key informants in social service agencies
Services for families experiencing violence	*The knowledge, skills, resources, relations and commitment needed to address the needs of families experiencing violence in order to reduce the impact of exposure to violence in children*	# of family violence programs available Knowledge of and use of best practices to service families experiencing violence. Adequacy of family violence programs to meet needs Financial resources committed to addressing the needs of family experiencing violence Formal functional relations among organizations serving families experiencing violence	Community members, key informants in community, key informants in social service agencies Community members, key informants in community, key informants in social service agencies Community members, key informants in community, key informants in social service agencies Community members, key informants in community, key informants in social service agencies Community members, key informants in community, key informants in social service agencies

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	EXAMPLES OF INDICATORS	POTENTIAL DATA SOURCE
INTEGRATED ASSISTANCE			
Local assistance	*Capacity building activities provided by local resources (training, technical assistance, etc.)*	Types of training and technical assistance provided by local providers Evaluations of T & TA	Training recipients, key informants from Safe Start sites and collaborators Training recipients
National assistance	*Capacity building activities provided by national resources including OJJDP, the NET, and program TA providers*	Types of training and technical assistance provided by national providers Evaluations of T & TA	Training recipients, key informants from collaborating agencies and Safe Start sites Training recipients
LOCAL AGENCY & COMMUNITY ENGAGEMENT & COLLABORATION			
Agency engagement in Safe Start's planning and implementation	*How community agencies contribute to and assist in planning for SS services*	Participation in collaboratives Roles played in collaboratives Leadership and decision-making roles played	Community members, Policy makers, Social service providers, meeting notes Community members, Policy makers, Social service providers, meeting notes Community members, Policy makers, Social service providers, meeting notes
Readiness for collaboration	*How partner agencies are prepared to collaborate to provide SS services*	Prior collaboration between agencies around family issues, children's mental health issues, and other issues Identification of common interests in SS	Policy makers, key informants from social service, health, law enforcement, and educational providers Policy makers, key informants from social service, health, law enforcement, and educational providers
System of understanding between domestic violence agencies and child protective agencies	*Amount and nature of collaboration and partnering between child protective agencies and domestic violence organizations*	MOAs between DV and CP agencies for Safe Start Case sharing and collaboration between agencies for Safe Start	Key informants in DV and CP agencies, MOAs, meeting notes Key informants in DV and CP agencies, MOAs, meeting notes

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	EXAMPLES OF INDICATORS	POTENTIAL DATA SOURCE
ASSESSMENT & PLANNING			
Safe Start agency planning activities	*Activities in planning to implement SS*	# of planning meetings held Type of planning activities held	Meeting notes Meeting notes, SS strategic plan
Safe Start implementers' knowledge of the community's awareness of impact of exposure to violence	*Understanding the SS planners had of the community's knowledge and understanding of CEV and the obstacles to be overcome within the community*	Knowledge of exposure to violence on children Knowledge of impact of exposure to violence on children Recognition of the gaps in services Recognition of the barriers to services Recognition of initial service system strengths	Key informants in SS agencies Key informants in SS agencies Key informants in SS agencies Key informants in SS agencies Key informants in SS agencies
Safe Start implementers' knowledge of community awareness of child abuse and neglect and impacts	*Understanding the SS planners have of the community's knowledge and understanding of CAN*	Knowledge of child abuse and neglect Knowledge of child development Knowledge of children's mental health	Key informants in SS agencies Key informants in SS agencies Key informants in SS agencies
Safe Start implementers' knowledge of community awareness of family violence	*Understanding the SS planners have of the community's knowledge and understanding of family violence*	Knowledge of family violence Knowledge of impacts of family violence on children	Key informants in SS agencies Key informants in SS agencies
Use of assessment information in Safe Start planning	*How information gathered during assessment activities were used in planning the implementation of Safe Start*	Use of data collected from assessment phase in planning phase	Meeting notes, SS strategic plan

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	EXAMPLES OF INDICATORS	POTENTIAL DATA SOURCE
SYSTEM CHANGE ACTIVITIES			
Development of policies	*Types of policies developed to support and enhance Safe Start planning, goals, and implementation*	Types of formal interagency protocols developed for collaborative efforts Type of national, state, or local policy/legislation developed Types of diversity policies developed	Agency policy and procedure manuals, MOAs Legislation, local statutes and laws Agency policy and procedure manuals, key informants at SS agencies
Service integration	*How non-Safe Start programs support Safe Start services and each other to reduce the impact of exposure to violence on children*	Types of cross-disciplinary training conducted Number of different agencies involved in cross-disciplinary training Types of multi-system MIS protocols developed Improved service coordination and integration	Training participants, training records, MOAs, agency policy and procedure manuals Training participants, training records, MOAs, agency policy and procedure manuals MIS protocols, agency policy and procedure manuals MOAs, meeting notes, key informants in SS agencies, key informants in community agencies
Resource development	*Efforts by Safe Start and the community to enhance program sustainability and ensure program continuation*	Level of funding from other sources Level of grant development Number of corporate sponsorships developed Level of resource sharing across agency Resource allocation to support frontline provision of services Volunteer recruitment and development	Safe Start budgets Grants written Meeting notes, key informants in SS agencies, MOAs Fiscal protocols, MOAs, policy and procedure manuals MOAs, policy and procedure manuals Key informants in SS agencies, policy and procedure manuals Key informants in SS agencies, policy and procedure manuals
New/expanded/enhanced programming	*How services are improved to better serve children in collaboration with Safe Start*	**Please see attached expanded Intervention Model table**	**Please see attached expanded Intervention Model table**

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	EXAMPLES OF INDICATORS	POTENTIAL DATA SOURCE
Community action	*Degree to which community members are aware and involved in the Safe Start initiative*	Types of media campaigns Increased community awareness of impact of exposure to violence on children Increased community awareness of available services for children exposed to violence # of community organizations involved in initiative Increased community resources	Media types and messages, community members Community members Key informants in SS agencies, key informants in community agencies, MOAs Key informants in SS agencies, key informants in community agencies, Key informants in SS agencies, key informants in community agencies,
INSTITUTIONALIZATION OF CHANGE			
System and Agency Change	*Degree to which the system serving children and families has improved in addressing the issue of exposure to violence for children*	Number of interagency MOAs # and type of policies in community agencies supportive of the Safe Start initiative Improved service delivery within systems Increase awareness within agencies of impact of exposure to violence on children	MOAs, Key informants in SS agencies, key informants in community agencies Key informants in SS agencies, key informants in community agencies Key informants in SS agencies, key informants in community agencies Key informants in SS agencies, key informants in community agencies
Point of Service Change	*Sustainable improvements made to provide services to children exposed to violence*	Improved identification of children exposed to violence within each agency/system Improved assessment of children exposed to violence within each agency/system Improved referral processes within each agency/system for children exposed to violence Improved follow-up by staff within each agency/system for children exposed to violence	SS case records, key informants within SS agency, key informants in community agencies, consumers SS case records, key informants within SS agency, key informants in community agencies, consumers SS case records, key informants within SS agency, key informants in community agencies, consumers SS case records, key informants within SS agency, key informants in community agencies, consumers

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	EXAMPLES OF INDICATORS	POTENTIAL DATA SOURCE
Community Change	*Degree to which the community: 1) has become aware of the impact of exposure to violence on children; 2) understands the impacts of exposure to violence on children; 3) supports services for children exposed to violence; and 4) understands where to go for assistance*	Increased community awareness of impact of exposure to violence Increased community awareness of community resources for exposure to violence Changed community norms regarding violence	Community members, key informants in SS agencies, key informants in community agencies Community members Community members
INCREASED COMMUNITY SUPPORTS			
Access to services	*Ability of access to necessary services for CEV.*	Increased availability of services (e.g. expanded service hours, more slots in programs) # of points of entry into services Availability of information about programs	Key informants of SS, key informants in community agencies Key informants of SS, key informants in community agencies Media messages
Specialized programming	*Degree to which community services specialize in serving CEV`*	Increased types of programs dedicated to CEV Expanded programming dedicated to CEV	Key informants of SS, key informants in community agencies Key informants of SS, key informants in community agencies
Tolerance of violence	*Degree to which the community accepts or disavows violence in the presence of young children*	# of reports of DV to police or 211 line # of reports of community violence to police or 211 line Decreased acceptance of violent acts	Police records, 211 call records Police records, 211 call records Community members
Support by community leadership for SS	*How leaders in the community (political, organizational, etc.) support the SS initiative*	Increased attention to CEV in leadership circles Increased financial support to agencies dedicated to reducing CEV	Key informants in community, meeting agenda/minutes Key informants in community, meeting agenda/minutes

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	EXAMPLES OF INDICATORS	POTENTIAL DATA SOURCE
REDUCED EXPOSURE TO VIOLENCE			
Family violence	*Changes in family factors contributing to exposure.*	Decreased levels of violence within families Increased family supports Increased parenting skills	Consumers, key informants within SS agencies, batterers Consumers, key informants within SS agencies Consumers, key informants within SS agencies, SS case records
Community violence	*Level of violence in the community, including inter and extra-personal*	Decreased levels of violence within the community Increased community supports Decreased tolerance for violence in community	Key informants within SS agencies, police records, community members Key informants within SS agencies, key informants within community agencies, community members Key informants within SS agencies, community members
Other forms of protection for children from exposure to violence	*Other ways in which efforts SS or collaborative partners reduce exposure to violence for children*	# of children removed from a violent home	SS case records
REDUCED IMPACT OF EXPOSURE TO VIOLENCE			
Mental health of children exposed to violence	*Degree to which the mental health of children exposed to violence improves due to SS services*	Decreased psychological symptoms Decreased behavioral symptoms Decreased physical symptoms	Consumers, key informants within SS agencies, clinicians, SS case records Consumers, key informants within SS agencies, clinicians, SS case records Consumers, key informants within SS agencies, clinicians, SS case records
Family functioning	*How families have improved their interpersonal dynamics and reduced the tendency toward violence*	Decreased physical abuse Decreased psychological/emotional abuse Decreased sexual abuse Appropriate conflict resolution Appropriate communication and other skills	Consumers, SS case records, clinicians Consumers, SS case records, clinicians Consumers, SS case records, clinicians Consumers, SS case records, clinicians Consumers, SS case records, clinicians

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	EXAMPLES OF INDICATORS	POTENTIAL DATA SOURCE
Protective/resilience factors for children exposed to violence	*Level of protective factors for children exposed to violence developed or enhanced due to SS services*	Increased family functioning Increased environmental supports for children exposed to violence	Consumers, Key informants within SS agencies, Clinicians, SS case records Consumers, Key informants within SS agencies, Clinicians, SS case records

EXHIBIT 4

Safe Start – Variables, Indicators, and Data Sources
REPORTING FRAMEWORK EXAMPLE
Intervention Logic Model

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	EXAMPLES OF INDICATORS	POTENTIAL DATA SOURCES
SYSTEM CHANGE ACTIVITIES			
New/expanded/enhanced programming	*How services are improved to better serve children in collaboration with Safe Start*	Shared case management across agency Level of agency integration in the service of children Expansion of DV programming Expansion of CAN programming Expansion of family programming	Key informants in SS agencies, SS case records, meeting notes, policy and procedure manuals Key informants in SS agencies, meeting notes, policy and procedure manuals Key informants in SS agencies, key informants in community agencies, meeting notes Key informants in SS agencies, key informants in community agencies, meeting notes Key informants in SS agencies, key informants in community agencies, meeting notes
IDENTIFICATION OF CHILDREN EXPOSED TO VIOLENCE			
Identification of children exposed to violence	*Community and SS agencies policies and capacity to identify children who have been exposed to violence*	Standardized screening tool used by SS and primary partners Symptoms/indicators of violence exposure on children are known to primary partners Identification of CEV from a diversity of sources	Police records, collaborative partners' records, SS case/intake records, 211 call records Training records, training surveys SS case/intake records, 211 call records

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	EXAMPLES OF INDICATORS	POTENTIAL DATA SOURCES
Identification of children at risk for exposure to violence	*Community and SS agencies capacity to identify children who are at risk to be exposed to violence*	# of children screened # of children identified Identification of risk of exposure to violence from a diversity of sources	Police records, collaborative partners' records, SS case/intake records, 211 call records Police records, collaborative partners' records, SS case/intake records, 211 call records SS case/intake records, 211 call records
ASSESSMENT OF EXPOSURE TO AND IMPACT OF VIOLENCE			
Use of common instruments to measure exposure to violence	*How SS agency and community partners are using standardized, identified instruments to measure exposure to violence on children*	Common exposure instrument used by SS and primary partners How instruments are used	SS case/intake records SS case/intake records
Use of common instruments to measure impact of exposure to violence	*How SS agency and community partners are using standardized, identified instruments to measure the impact of exposure to violence on children*	Common impact of exposure instrument used by SS and primary partners How instruments are used Types of needs identified	SS case/intake records SS case/intake records SS case/intake records
REFERRAL TO SERVICES FOR CHILDREN EXPOSED TO VIOLENCE			
Referrals made	*Actual referrals made to agencies on behalf of children exposed to violence*	# of referrals made Types of referrals made	SS case records SS case records
Appropriate referrals	*Referrals of children/families to treatment are appropriate to the needs and resources of the children/family*	Staff are aware of the array of services available for CEV Staff are able to link up child/family needs with appropriate services	Key informants within SS agencies, training records Key informants within SS agencies, training records, consumers
Case management	*The monitoring and management of cases in order to make appropriate referrals*	Accurate and complete SS case records Regular contacts with children/families	SS case records, key informants within SS agencies SS case records, key informants within SS agencies

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	EXAMPLES OF INDICATORS	POTENTIAL DATA SOURCES
TREATMENT AND SERVICE DELIVERY TO CHILDREN EXPOSED TO VIOLENCE			
Evidence-based services	*How services to children exposed to violence are based on the available scholarly literature and research in the area*	Demonstrated replication of promises practices Identification of literature that supports program components	Program plans, scholarly literature Scholarly literature
Appropriate services	*How the services contribute to positive outcomes for children exposed to violence*	Attrition rate of clients Progress made by clients Cultural and gender appropriateness of treatment	SS case records, clinicians SS case records, clinicians SS case records, clinicians
Services provided to children and families	*Number of children and families provided the different services aimed at reducing the impact of exposure to violence on children*	# of children and families provided mental health treatment # of families provided skill building services # of families provided crisis intervention	SS case records SS case records SS case records
Case sharing and collaboration	*How treatment partners in team on cases and share information*	# of MOAs that stress case sharing # of SS-based treatment teams Communication among treatment teams	MOAs SS agency records SS agency records, meeting records
FOLLOW-UP OF TREATMENT AND SERVICES TO CHILDREN EXPOSED TO VIOLENCE			
Follow up of children referred to SS-based services	*How the program tracks children's progress in treatment and services*	# of children tracked throughout treatment # of children tracked beyond treatment # of contacts made after initial referral	SS case records, key informants within SS agencies SS case records, key informants within SS agencies SS case records, key informants within SS agencies
Continued referral of children past initial referral phase	*How children are referred to additional services as the need arises*	Number of post-service referrals made	SS case records
Continued training/consultation to providers	*How SS providers are given continuing training or mentoring*	# of providers trained past initial training Amount of SS TA provided to providers	SS training records SS agency records

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	EXAMPLES OF INDICATORS	POTENTIAL DATA SOURCES
REDUCED EXPOSURE TO VIOLENCE			
Family violence	*Changes in family factors contributing to exposure.*	Decreased levels of violence within families Increased family supports Increased parenting skills	Consumers, key informants within SS agencies, batterers Consumers, key informants within SS agencies Consumers, key informants within SS agencies, SS case records
Community violence	*Level of violence in the community, including inter and extra-personal*	Decreased levels of violence within the community Increased community supports Decreased tolerance for violence in community	Key informants within SS agencies, police records, community members Key informants within SS agencies, key informants within community agencies, community members Key informants within SS agencies, community members
Other forms of protection for children from exposure to violence	*Other ways in which efforts SS or collaborative partners reduce exposure to violence for children*	# of children removed from a violent home	SS case records
REDUCED IMPACT OF EXPOSURE TO VIOLENCE			
Mental health of children exposed to violence	*How the mental health of children exposed to violence improves due to SS services*	Decreased psychological symptoms Decreased behavioral symptoms Decreased physical symptoms	Consumers, key informants within SS agencies, clinicians, SS case records Consumers, key informants within SS agencies, clinicians, SS case records Consumers, key informants within SS agencies, clinicians, SS case records

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	EXAMPLES OF INDICATORS	POTENTIAL DATA SOURCES
Family functioning	*How families have improved their interpersonal dynamics and reduced the tendency toward violence*	Decreased physical abuse	Consumers, SS case records, clinicians
		Decreased psychological/emotional abuse	Consumers, SS case records, clinicians
		Decreased sexual abuse	Consumers, SS case records, clinicians
		Appropriate conflict resolution	Consumers, SS case records, clinicians
		Appropriate communication and other skills	Consumers, SS case records, clinicians
Protective/resilience factors for children exposed to violence (outcome)	*Level of protective factors for children exposed to violence developed or enhanced due to SS services*	Improved family functioning	Consumers, key informants within SS agencies, clinicians, SS case records
		Improved/enhanced/increased resilience within child	Consumers, key informants within SS agencies, clinicians, SS case records
		Increased environmental supports for children exposed to violence	Consumers, key informants within SS agencies, clinicians, SS case records

Exhibit 5
CASE STUDY OUTLINE FOR TIER I SITES

1. Summary of Methods

2. Contextual Conditions
   - ? Political context
   - ? Economic context
   - ? Social context
   - ? Other initiatives that might influence outcomes

3. Community Capacity
   - ? Services for children's mental health needs
   - ? Services for families experiencing violence

4. Integrated Assistance
   - ? Local assistance
   - ? National assistance

5. Local Agency and Community Engagement and Collaboration
   - ? Agency engagement in Safe Start's planning and implementation
   - ? Readiness for collaboration
   - ? System of understanding between violence agencies and child protective agencies

6. Assessment and Planning
   - ? Safe Start agency planning activities
   - ? Safe Start implementers' knowledge of the community's awareness of impact of exposure to violence
   - ? Safe Start implementers' knowledge of community awareness of child abuse and neglect and impacts
   - ? Safe Start implementers' knowledge of community awareness of family violence
   - ? Use of assessment information in Safe Start planning

7. System Change Activities
   - ? Development of policies
   - ? Service integration
   - ? Resource development
   - ? New/expanded/enhanced programming
   - ? Community action

8. Institutionalization of Change
   - ? System and agency change
   - ? Point of service change
   - ? Community Change

9. Increased Community Supports
   - ? Access to services
   - ? Specialized programming
   - ? Tolerance of violence
   - ? Support by community leadership for SS

10. Reduced Exposure to Violence
   - ? Family violence
   - ? Community violence
   - ? Other forms of protection for children from exposure to violence

11. Reduced Impact of Exposure to Violence **(Individual-level Dependent Variables)**
   - ? Mental health of children exposed to violence
   - ? Family functioning
   - ? Protective/resilience factors for children exposed to violence

12. Description of Promising Practices **(if warranted)**
   - Identification of Children Exposed to Violence
     - o Identification of children exposed to violence
     - o Identification of children at risk for exposure to violence
   - Assessment of Exposure to and Impact of Violence
     - o Use of common instrument to measure exposure to violence
     - o Use of common instruments to measure impact of exposure to violence
   - Referral to Services for Children Exposed to Violence
     - o Referrals made
     - o Appropriate referrals
     - o Case management
   - Treatment and Service Delivery to Children Exposed to Violence
     - o Evidence-based services
     - o Culturally and otherwise appropriate services
     - o Services provided to children and families
     - o Case sharing and collaboration
   - Follow-up of Treatment and Services to Children Exposed to Violence
     - o Follow up of children referred to SS-based services
     - o Continued referral of children past initial referral phase
     - o Continued training/consultation to providers
   - Outcomes of Promising Practice, Intervention, or Treatment

13. Lessons Learned in the Implementation and Evaluation of Safe Start Activities

14. Barriers and Challenges

15. Recommendations and Conclusions

Exhibit 6
Tier II Evaluation Enhancement Program Selection Criteria and Initial NET Assessment of Proposals

	BSSI	Chicago	Pinellas	Rochester-BSSI
Stated Criteria				
Knowledge-based approach to child/family-level intervention program?	No; specialized CEV curriculum not used at the 3 POS agencies or by referral providers	No; specialized CEV curriculum not used at POS agency or by referral providers	Yes at 1 of 3 POS programs the clinician has had CEV training	Yes in 1 classroom-based program, teachers are being CEV trained; however, that program is not part of proposed enhancement
Replicable program design for child/family-level intervention?	No; there is no specialized CEV curriculum nor required CEV training for referral providers	No; there is no specialized CEV curriculum nor required CEV training for referral providers	Not sure; no information on the nature of CEV training clinician received	Probably; however, that program is not part of the proposed enhancement
Continuum of services available or provided (within overall SSI)?	Yes; at 2 of 3 POS agencies including the 1 in which enhancement proposed	Yes	Yes; at 1 of 3 POS programs included in proposed enhancement	Yes; but not relevant to proposed enhancement
Culturally appropriate?	Not sure	Not sure	Not sure	Being tested in proposed enhancement
Clientele-specific?	Focus is on identifying CEV from general clients	Focus is on identifying CEV from general clients	Focus is on identifying CEV from general clients	Being tested in proposed enhancement
Part of systems-improvement plan?	Yes, specifically testing for effective intervention features	Yes, specifically testing for effective intervention features	Yes, specifically assessment and referral improvement	Yes, specifically assessment and referral improvement

	BSSI	Chicago	Pinellas	Rochester-BSSI
Enhancement Design Strengths				
Measures outcome changes?	Yes	Yes	Yes	No; not intended to
Contains multiple outcome measures?	Yes; measures for both child and parent	Yes; measures for both child and parent	Yes; measures for both child and parent	No; not intended to
Use or develop valid measures	Yes; measures for both child and parent	Yes; measures for both child and parent	Yes; measures for both child and parent	Yes; focus is on developing measure for younger children
Accepted method for determining outcomes of enhancement?	Yes; part of originally planned non-comparison group, dose-response analysis (Weak causal inference)	Yes; correlational analysis between program components and child/family outcomes	Yes; quasi-experimental comparisons of CEV-trained and non-trained provider in 1 POS agency and pre-post changes in other POS agency	Yes; standard test validation procedures using parent reports on older vs. younger victims
Enhances original outcome evaluation efforts?	Yes; more completed cases with longer post-intervention assessment at 1 POS agency	Yes; adds more cases and (non-SSI) sites, as well as a novel comparative framework for determining "what works"	Yes; (1) adds child outcome measure at both POS agencies; (2) monitors referral results; (3) adds Risk & Resiliency variables to analysis	No; but proposal not intended to

	BSSI	Chicago	Pinellas	Rochester-BSSI
Tier II application questions				
How does the program enhance knowledge?	Is likely to increase statistical power to find significant dose-response relationships (i.e., more service units received, the better the outcomes)	Is likely to increase understanding of salient program elements/ components related to improved outcomes	Is likely to increase understanding of salient risk profiles and program elements/ components related to improved outcomes	Potentially, a reliable and valid CEV measure for younger children, thus improving assessment
Is proposal feasible logistically and analytically?	Timeline, staffing, and tasks seem reasonable; POS agency has sufficient cases, but unclear what % referred will take-up and complete treatment	Timeline, staffing, and tasks seem reasonable; SSI agency has sufficient cases, but unclear what % referred will take-up and complete treatment; No data on non-SSI agencies' case #s	Timeline, staffing, and tasks seem reasonable; POS agencies have sufficient cases for R&R profiling, but real question is whether reliable R& R profiles can be developed	Timeline, staffing, and tasks seem reasonable; BSSI should be able to provide sufficient #s of assessments for analysis
How can funds enhance the evaluation?	Provides leverage for evaluators to "require" collection of post-program data and financial support to POS agency	Provides funds to bring in non-SSI sites and use their data to help develop models of successful program features	Provides funds to obtain more complete outcome data, referral results, and risk-related family variables.	Provides opportunity and incentives for 2 SSI sites to collaborate and improve the assessment process
Additional Questions				
Is budget appropriate for enhancement's scope?	Yes	Yes	Yes; but may include somewhat padded evaluation ODCs and indirect costs	Yes

Summary Recommendations	
BSSI	Should be funded with budget requested. Concerns: 1) Even with additional post-program assessment, a large percentage of referrals for child/family-level intervention may not be taken up or treatment completed which may affect power to determine effectiveness; and 2) without set and specific intervention approach or sessions guide, use of provider checklists may not be sufficient to determine most critical or salient features of the treatment(s)
Chicago	Should be funded with budget requested. Concerns: 1) Even with additional non-SSI program sites, a large percentage of referrals for child/family-level intervention may not be taken up or treatment completed which may affect power to determine effectiveness; and 2) without set and specific intervention approach or sessions guide, use of provider checklists may not be sufficient to determine most critical or salient features of the treatment(s).
Pinellas	Should be funded with budget reductions to eliminate some ODCs and indirects. Concerns: 1) Even with additional child outcome measures, referral tracking and R&R profile development, a large percentage of identified and referred cases for child/family-level intervention may not be taken up or treatment completed which may affect power to determine effectiveness; and 2) without set and specific intervention approach or sessions guide, use of provider checklists may not be sufficient to determine critical elements.
Rochester-BSSI	Should be funded with budget requested. Concerns: 1) Even with sufficient cases, may not be able to validate a psychometrically sound, age-appropriate (self-reported) CEV measure.

Exhibit 7
Potential Interview Questions

Question	Asked of all Key Informants	Asked of Project Director only
What proportion of families/children that you agreed to identify and assess for exposure to violence have you actually been able to identify and assess?		✓
What proportion of families/children that you agreed to provide services for have you actually been able to?		✓
How many children have successfully completed services?		✓
What challenges or barriers have you faced in recruiting or retaining families and children?	✓	
What strategies did you develop to respond to the challenges? How did these strategies differ from your original plan? (probe: Did your strategy include requesting and/or receiving T & TA?)	✓	
What worked? Why do you think it worked?	✓	
What would you recommend to new sites who may be developing recruitment and retention strategies?	✓	

Exhibit 8
National Evaluation Timeline
2004

	May	June	July	August	September	October	November	December
National Cross-Site Evaluation								
Final evaluation plans submitted by Tier II sites		▼						
Tier II sites contracted		▼						
Data collected by Tier II sites			▼	▼	▼	▼	▼	▼
Case study framework and protocol developed and disseminated to Tier I sites								
Core datasets submitted by Tier I sites						▼		
Initial case studies submitted by Tier I sites						▼		
Frameworks and case study reporting protocol revised by the NET							▼	▼
Process Evaluation								
Site implementation and strategic plans reviewed		▼	▼	▼				
Site visit/interview schedule developed			▼					
Interview protocols developed			▼	▼				
Progress reports reviewed/analyzed				▼	▼			
Site visits and National Partner interviews conducted					▼	▼	▼	
Program documents reviewed/analyzed					▼	▼	▼	
Follow-up phone calls to sites made						▼	▼	
Interview transcripts analyzed						▼	▼	▼
Process evaluation report written								▼
Promising Practices Identification and Review								
Data collection matrix developed	▼							
Site implementation plans reviewed		▼	▼					
Current progress report reviewed		▼	▼					
Data with site representatives confirmed			▼	▼				
Promising practices report written				▼				
Report on Client Recruitment and Retention								
Letter of introduction sent		▼						
Informal interview protocol developed		▼						
Current progress report reviewed		▼	▼					
Site representatives interviewed			▼					
Literature reviewed		▼	▼					
Client recruitment and retention report written				▼				

National Evaluation Timeline (continued)
2005

	January	February	March	April	May	June	July	August	September	October	November	December	January 2005
National Cross-Site Evaluation													
National Evaluation conference		▼											
Data collected by Tier II sites	▼	▼	▼	▼	▼	▼	▼	▼	▼				
Core datasets submitted by Tier I sites										▼			
Final case studies submitted by Tier I sites										▼			
Final outcome reports submitted by Tier II sites										▼			
Tier I case study data reviewed and revised with sites										▼	▼		
Tier I case studies written												▼	
Final national evaluation report written and submitted												▼	▼
Process Evaluation													
Final process evaluation report submitted													▼
Promising Practices Identification and Review													
Update report	▼	▼	▼										

APPENDIX A

Spokane Reporting Framework

Spokane Safe Start – Variables, Indicators, and Data Sources

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
CONTEXTUAL CONDITIONS			
Political context	*The political climate that affects reducing the impact of exposure to violence in children and the community's ability to reduce the impact*	1) Legislation and administrative policies. Legislation and administrative policies specifically supporting assistance to children exposed to violence do not exist in the state of Washington. 2) Community master planning for children and youth services. None. 3) Political climate: Washington is divided into two distinct economic, cultural, and political regions. Western Washington is far more urban than Eastern Washington and accounts for about 75% of the state's population and 40% of its land mass. The politics in the Spokane region range from conservative to libertarian and the overall philosophy toward government can be characterized by an absence of trust and a belief that "less is more". 3) Political leaders. There was no support of political leaders for addressing the needs of children exposed to violence. 4) Legislation requiring collaboration. Legislation requiring collaboration of services to help children exposed to violence does not exist in the state of Washington.	**Spokane Safe Start community assessment and policy analysis – Strategic Plan.**
Economic context	*The economic climate that affects reducing the impact of exposure to violence in children and the community's ability to reduce the impact*	1) State. The overall fiscal picture in Washington is bleak. In the 2002 session of the legislature $1.6B was shaved from the budget, in 2003 another $2.6B was cut, and projections for the 2004 session include reductions of $1.2B. 2) Local. Spokane is the trade and cultural center of a large area of the Northwest including Washington State east of the Cascade Mountains, northern Idaho, western Montana, and northeastern Oregon. Due to changes in its industrial base, Spokane has seen a growth in poverty and now has disproportionately high rates of poverty. The median income of households in Spokane County is $36,707 while the median per capita income was $20,312. According to the U.S. Census Bureau, 25% of the county's residents were children under the age of 18. As of 2001, 25% of Spokane's children ages 0-5 and 11% of children ages 5-17 lived below the federal poverty line whereas 12% of all Spokane families lived below the FPL. Likewise, 40% of families with a female head of household lived below the FPL and 20% of the families in Spokane County received some level of governmental financial assistance. Examining the Spokane population by age group and using 200% of federal poverty level as an indicator (which is arguably a more realistic gauge), 35.7% of all Spokane children live in significant economic deprivation and are clearly the poorest residents of the region. The county had an increase in enrollment in the free and reduced lunch program from 36% in 2001 to 39% in 2002. 3) Unemployment. Unemployment continues to be high in the state of Washington and in Spokane County. As of June 2003, Washington State had one of the highest unemployment rates in the nation ranking 41st of 51 states with a current unemployment rate of 7.7%, an increase of .4% from May 2002. The unemployment rate for the Spokane metropolitan area in	1) WA 2003-05 State Budget 2) US Census Bureau. (2001). *2001 Supplemental Survey Profile, Spokane County*. Spokane Regional Health District. (2002). *Facing Spokane Poverty, 2001-2002*. Washington State Office of Financial Management. US Census Bureau, 2001 (Office of Superintendent for Public Instruction, 2002)

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
(Continued)		June 2003 was 6.7%. 4) Funding streams. During the community assessment phase, a funding stream analysis and fiscal review was conducted of public systems relevant to the Safe Start initiative and was submitted with the first iteration of the strategic plan.	3) Bureau of Labor Statistics, 2003. Public system record reviews, key informant interviews, WA State OFM.
Social context	*The social conditions that affect the impact of exposure to violence in children and the community's ability to reduce the impact*	1) Population statistics. According to the Washington State Office of Financial Management, the 2003 population projection for Spokane County is 428,700; 308,756 and 119,844 in incorporated and unincorporated areas respectively. The City of Spokane population is 195,629, the newly incorporated City of Spokane Valley is 82,005, and the remainder of the county is 150,966. Spokane County (in total) is 91.4% white, 1.6% Black, 1.4% native American/Alaska native, 2% Asian/Pacific Islander, 8% other, 2.8% mixed race. 2) Crime statistics. As of 2001, the most common crimes in the City of Spokane are as follows: larceny/theft 63.21%, burglary 18.16%, vehicle theft 10.37%, aggravated assault 5.17%, robbery 2.58%, rape .46%, and murder .04%. Between the county and city, there were 14,585 DV calls for service. 3) Historical public support and integrated services models. Spokane has had significant success with developing local applications of integrated services treatment models for high-risk children and families. 'Integrated services' in Spokane refers to cross-disciplinary and often co-located service delivery strategies using a client-empowerment strategy referred to as Individualized and Tailored Care (ITC).	1) Washington State Office of Financial Management. U.S. Census Bureau 2) City of Spokane Police Dept. 3) Key informant interviews, committee meeting minutes, focus groups
Other Initiatives	Past or current efforts that can influence the planning, implementation, or outcomes of the Safe Start Initiative.	1) Perceived seriousness of violence in the community. Spokane citizens fear gang violence, murder, rape, and robbery crimes at the community level. However, these fears do not translate to the neighborhood level in which vandalism, uncontrolled parties, loud noise, and traffic violations are more of a concern. 2) Description of past/current efforts. The Spokane Safe Start Initiative is an outgrowth of coordinated community work directed through the Breakthrough Community Coalition. Breakthrough was formed after the brutal murder of a young teen, Rebecca Hedman, who had been living on the streets in Spokane. Breakthrough is a voluntary, informal coalition that includes participation of senior management and line staff from the principal regulatory and service agencies addressing children's issues in Spokane. Leaders from education, advocacy, nonprofit service providers, and private citizens also participate. Breakthrough, using an informal collegial strategy, has brought significant resources to Spokane. Over eight years, Breakthrough has directly helped with the planning and partnerships that have created over $6,000,000 in new direct service resources for children and families in the community. Breakthrough continues to serve as the sponsoring community coalition for Spokane Safe Start.	1) Spokane Regional Health District *Fabric of Fear: Interpersonal Violence in Spokane County – (1999-2000)*. Spokane Police Department Key informant interviews, committee meeting minutes, focus groups.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
(Continued)		The Breakthrough Executive Committee serves as the primary advisory body for Safe Start. Additional past efforts include: "Team 51" that coupled police and mental health that worked as domestic violence victim advocates co-responded to reports of domestic violence. Casey Family Partners -- Casey Family Partners-Spokane has been funded by a partnership of the two local medical centers and The Casey Family Program of Seattle and the State's child welfare system to develop integrated services addressing chronic child neglect. Casey Family Partners-Spokane has co-located child welfare, mental health (Spokane Mental Health), substance abuse (Deaconess Medical Center), legal (Columbia Legal Services), and medical staff from multiple agencies working in a single clinic location. Casey is one of 12 sites in the national Starting Early Starting Smart longitudinal initiative testing integrated services for high-risk children. Dr. Blodgett, Safe Start Principal Investigator, is the Principal Investigator for this research program in Spokane. Casey serves approximately 550 children annually through its sexual abuse and integrated services programs. Youth Gang Violence Funded by Health and Human Services, Youth Gang Drug Prevention Program was intended to become a risk-focused collaboration rooted in prevention. The project objective was to construct developmentally appropriate implementation plans for improved prevention/intervention with a target group between 9 and 12 years of age in specific poverty-level neighborhoods and elementary schools. Regional DV Team -- This team is comprised of representatives from the Spokane Police and Spokane Sheriff's Departments, Spokane City/County Probation, Spokane City Prosecutor's Office, Spokane County Prosecuting Attorney's Office, Spokane County District Court, Spokane Municipal Court, YWCA Alternatives to Domestic Violence and the Spokane Sexual Assault Center. Funded in part by federal grant dollars from VAWA and VAWGO as well as county and city current expense funds, the mission of this team is to increase victim safety and confidence in the criminal justice system and to increase offender accountability through a collaboration of resources. Through vertical case management, officer training, increased victim contact and offender accountability, the team is credited with improved, more efficient services and increased victim safety. Spokane County Domestic Violence Consortium -- The Consortium is a CDC Coordinated Community Response to Prevent Intimate Partner Violence grantee. The Consortium, having a membership over 200 professionals and organizations, is now an acknowledged leader in the region on policy and the professional development efforts related to domestic violence. COPS/SCOPE -- The City of Spokane has been recognized nationally and internationally for its strength around issues such as community policing, neighborhood decentralization, and the proliferation of neighborhood action. The community impact of COPS (Community Oriented Police Services) and SCOPE (Sheriff's Community Oriented Policing Effort) in the local	

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
(Continued)		service array is significant. For calendar year 2000, COPS had 533 volunteers who dealt with 15,853 incidents (complaints, information calls, criminal complaints), provided 52,537 volunteer hours (includes Block Watch, Board of Director hours & volunteer program/project hours, and shop desk duty). For Spokane City, the volunteer commitment results in the equivalent to 24.4 full-time Clerk II (city) employees. The SCOPE program has for calendar year 2000 had 475 active volunteers who contributed time reporting a remarkable 61,387 volunteer hours. This is accomplished with an annual cost to the City of less than $250,000 per year and less than $50,000 in personnel costs for the County.	
COMMUNITY CAPACITY			
Services for children's mental health needs	*The knowledge, skills, resources, relations and commitment needed to address children's mental health needs in order to reduce the impact of exposure to violence in children*	1) Number of programs. Spokane Mental Health is the largest single provider of mental health services overall and provides 48% of public outpatient services to children. Lutheran Social Services, Children's Home Society, and Family Services Spokane to combine provide 49%. Three of the four agencies accounting for 91% of the public mental health service delivery for children in Spokane. 2) Promising practices. Lutheran Social Services provided the only formal program for child witnesses to domestic violence. The center-based program had capacity for approximately 100 children per year. There were no other formal child treatment services for domestic violence trauma in Spokane. It should be noted that there are no 'best practices' identified in the research literature for this population. 3) Adequacy of programs to meet needs. By statute, all children with serious emotional disorders (SEDs) in Washington State are eligible for publicly funded mental health supports. Unfortunately, the extension of eligibility to caregivers is not automatic and this can create eligibility barriers for family-centered care. There is also evidence that the service rates for eligible children in Spokane lag significantly behind other Washington urban areas. Further, the state mental health system budget is only adequate to meet the needs of 7% of the identified child population needing mental health services. 4) Financial resources for CEV. Prior to Safe Start, there were no formal financial resources committed to CEV. 5) Formal relations between MH services for CEV. Prior to Safe Start, there were no formal functional relations between mental health agencies in service to CEV.	1) Spokane County. Key informant interviews, social service providers, literature review. JLARC Audit of Mental Health in Washington State

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
Services for families experiencing violence	*The knowledge, skills, resources, relations and commitment needed to address the needs of families experiencing violence in order to reduce the impact of exposure to violence in children*	1) Number of programs. The YWCA's Alternative to Domestic Violence serves as the primary domestic violence service agency for the County. The YWCA reports approximately 3,000 duplicated annual contacts for client-initiated requests for help. In addition, the YWCA has helped provide legal advocacy in its partnership with the courts for roughly 700 protection orders and 1,200 no contact orders (these involve duplicated counts of individual contact). 2) Promising practices. There are no 'best practices' identified in the research literature for this population. 3) Adequacy of programs to meet needs. Focus group and work group participants shared a common concern that there is a major lack of support for violence-specific treatment services. In Spokane, specialty services have included advocacy programs and domestic violence perpetrator treatment program 4) Financial resources. Prior to Safe Start, with the exception of a small fund of state dollars that support a domestic violence shelter for women through the YWCA's Alternative to Domestic Violence Program (ADVP), there were no state or county funded social services targeted to Spokane's Safe Start population. Federal funds from a DOJ VAWA grant to the Spokane Police Department provided funding for a small advocacy program. Further, HHS/CDC resources through the Spokane County Domestic Violence Coalition have been used for community education, a small juvenile perpetrator treatment program, and a small child witness to domestic violence treatment program. 5) Formal relations between MH services for FV. Prior to Safe Start, formal relationships between MH agencies to provide services for family violence were extremely limited. The Regional Support Network (County funder of mental health services) had an agreement with Lutheran Community Services and the other MH providers that CEV would be referred to LCS first prior to other services. However, this agreement was not implemented.	1) YWCA and Spokane County Domestic Violence Team. 2) Literature review. 3) Focus groups, committee meeting minutes, key informant interviews. 4) Focus groups, committee meeting minutes, key informant interviews. 5) Focus groups, committee meeting minutes, key informant interviews, subcontract between WSU and service providers.
INTEGRATED ASSISTANCE			
Local assistance	*Capacity building activities provided by local resources (training, technical assistance, etc.)*	1) During the planning process, the Spokane Safe Start Initiative provided T&TA in the form of two large community retreats to educate the professional community about the effects of the exposure to violence on children. One hundred and one attended the first meeting and 91 attended the second meeting.	Meeting notes, records, and attendance.
National assistance	*Capacity building activities provided by national resources including OJJDP, the NET, and program TA providers*	1) During the planning phases, representative from NCCEV visited Spokane to provide CDCP training to law enforcement and human service personnel.	Meeting notes.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
LOCAL AGENCY & COMMUNITY ENGAGEMENT & COLLABORATION			
Agency engagement in Safe Start's planning and implementation	*How community agencies contribute to and assist in planning for SS services*	1) Participation, roles, and leadership in the collaborative. The formal process outlined in the application included the use of formal work groups that were to plan toward the achievement of Safe Start goals across seven assigned dimensions. Work groups were named based on the planning functions they were to serve and included Family Identification, Service Integration, Family Support, Professional Development, Policy, Data Integration and Resource Development. Individuals with current or recent leadership experience associated with administering publicly funded systems served as work group facilitators. To that end, the Chief Health Officer of the Spokane Regional Health District agreed to lead the Family Identification work group. Similarly, the Director of the Spokane County Departments of Community Services and Community Development agreed to take on the issue of Service Integration. The Director of the Spokane County Domestic Violence Consortium graciously consented to lend her leadership and the expertise of her agency's Services Committee to the area of family support. In the area of professional development, the Dean of Eastern Washington University's School of Social Work consented to serve as group facilitator. Serving as leader of the Policy discussion was a former Director of Spokane County Corrections who functions currently as Director of the Organizational Management Program at Whitworth College. In addition, the Director of Assessment Services for the Regional Health District led the Data Integration work group. Absent from the above list is any mention of Resource Development. Broadly, over 250 individuals including representation from over 70 agencies participated in the planning process.	Community members, policy makers, social service providers, private citizens, meeting minutes and notes.
Readiness for collaboration	*How partner agencies are prepared to collaborate to provide SS services*	1) Prior collaborative efforts and common interests. The Spokane Safe Start Initiative is an outgrowth of coordinated community work directed through the Breakthrough Community Coalition. Breakthrough was formed after the brutal murder of a young teen, Rebecca Hedman, who had been living on the streets in Spokane. Breakthrough is a voluntary, informal coalition that includes participation of senior management from all the principal regulatory and service agencies addressing children's issues in Spokane. Leaders from education, advocacy, nonprofit service providers, and private citizens also participate. Breakthrough, using an informal collegial strategy, has brought significant resources to Spokane. Over eight years, Breakthrough has directly helped with the planning and partnerships that have created over $6,000,000 in new direct service resources for children and families in the community. Breakthrough continues to serve as the sponsoring community coalition for Spokane Safe Start. The Breakthrough Executive Committee serves as the primary advisory body for Safe Start.	Community members, policy makers, social service providers, private citizens, meeting minutes and notes,

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
System of understanding between domestic violence agencies and child protective agencies	*Amount and nature of collaboration and partnering between child protective agencies and domestic violence organizations*	1) MOUs between DV and CP agencies for Safe Start do not exist. 2) Case sharing and collaboration between agencies for Safe Start do not exist.	Key informants in Safe Start agencies, focus groups, work group meeting minutes.
ASSESSMENT & PLANNING			
Safe Start agency planning activities	*Activities in planning to implement SS*	1) Number and types of planning meetings. There were 59 meetings between the seven work groups described above. Three larger community meetings were convened with attendance ranging 85-100 for each. In addition, during the planning and implementation phases the project director and co-principle investigators attended 3-6 meetings per week.	Community members, policy makers, social service providers, private citizens, meeting minutes and notes.
Safe Start implementers' knowledge of the community's awareness of impact of exposure to violence	*Understanding the SS planners had of the community's knowledge and understanding of CEV and the obstacles to be overcome within the community*	1) Community knowledge of CEV. The community assessment and planning process indicated that the community had only anecdotal knowledge about CEV prior to Safe Start. There was no mechanism in place to conduct surveillance of CEV. 2) Community knowledge of impact for CEV. Similarly, the Spokane community had very limited knowledge about the impact of exposure to violence on children. 3) Gaps in service. The focus and work groups indicated that a major gap in services to CEV includes the lack of capacity for existing systems to respond to children who do not meet criteria for mandated intervention. Further, the group participants shared a common concern that there is a major lack of support for violence-specific treatment services. 4) Barriers to service. Any existing responses (e.g., CPS, law enforcement, adult mental health, and urgent medical services) are further confounded by the categorical nature of the funding that supports them. In Spokane, specialty services have included advocacy programs and domestic violence perpetrator treatment programs. Because public categorical funding streams largely dictate social services in Spokane, local efforts to address family violence have been only marginally funded. Family violence advocacy services, respite services for parents, crisis housing, and domestic violence perpetrator systems have depended on grants, limited fee for service, and small contracts to fund program services. The result is that the capacity of these systems is far less than the demand. Notably, these systems are too small to support data management efforts to demonstrate the scope of the unmet need. 5) Service strengths. Despite barriers and limitations, Spokane has had significant success with developing local applications of integrated services treatment models for high-risk children and families. 'Integrated services' in Spokane refers to cross-disciplinary and often co-located service delivery strategies using a client-empowerment strategy referred to as Individualized and Tailored Care (ITC).	Key informants in Safe Start agencies, focus groups, work group meeting minutes. Key informants in Safe Start agencies, focus groups, work group meeting minutes.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
(Continued)		At the time of the first iteration of the strategic plan the following were noted as strengths: Casey Family Partners-Spokane has been funded by a partnership of the two local medical centers and The Casey Family Program of Seattle and the State's child welfare system to develop integrated services addressing chronic child neglect. Spokane County Head Start is a countywide program providing early childhood education and social services through nine neighborhood sites. This county program was one of the original Early Head Start sites and continues to provide Early Head Start services under continuing grants. Spokane Mental Health created a family support program to expedite access to assessment and services for families with children in dependency proceedings through the Juvenile Court. Co-located partners include substance abuse staff. Deaconess Medical Center has co-located 10 FTE staff for mental health and substance abuse services in two school districts. This represents a recent and significant commitment of internal resources to co-location strategies and out-stationing of staff. A number of noteworthy programs are using integrated service program models on smaller scales. Breakthrough for Families provides integrated services to homeless teens and their families. The West Valley School District employs ITC principles in its Multidisciplinary Teams for complex children. The YWCA has participated in co-location strategies with the city schools for homeless children and is a principal partner in the team strategies of the Regional Domestic Violence Team.	
Safe Start implementers' knowledge of community awareness of child abuse and neglect and impacts	*Understanding the SS planners have of the community's knowledge and understanding of CAN*	1) Knowledge of child abuse and neglect. The Safe Start project director was the formal regional administrator for child welfare and possesses extensive local and state knowledge regarding child abuse and neglect. Nevertheless, the planning process indicated that the community had only a general awareness of CA/N issues. 2) Knowledge of child development and children's mental health. Again, the planning process indicated that even professionals in the field of human services possess only cursory knowledge regarding child development and children's mental health.	Key informants in Safe Start agencies, focus groups, work group meeting minutes.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
Safe Start implementers' knowledge of community awareness of family violence	*Understanding the SS planners have of the community's knowledge and understanding of family violence*	1) Knowledge of family violence. During the community assessment we attempted to analyze data about outcomes from systems that have some level of responsibility for the issue of family violence. It was clear, however, that while an incredible volume of data is collected, most is not immediately or easily retrievable to answer the simplest of questions. We further found that multiple systems often collect the same data for broadly disparate purposes and that organization and storage problems confound effort to retrieve even the most common elements. Moreover, while some pieces of data collected by county administered systems (e.g., mental health) may be comparatively accessible, data from corresponding systems administered at the state level (e.g., child welfare is not accessible at all at the local level). Therefore, it was impossible to engage in a basic pathway analysis or aggregated descriptive information about families exposed to violence. 2) Knowledge of impacts of family violence on children. The Spokane community had very limited knowledge about the impact of exposure to violence on children prior to Safe Start.	Key informants in Safe Start agencies, work group meeting minutes, agency document and MIS review.
Use of assessment information in Safe Start planning	*How information gathered during assessment activities were used in planning the implementation of Safe Start*	1) Use of data collected from assessment phase. It was the unanimous recommendation of citizen groups participating in the Safe Start planning process that we address the ability of the community to provide crisis intervention to reduce trauma due to violence exposure. The Spokane Safe Start strategic plan is a direct result of the community assessment phase. The six-month planning process within the community resulted in the following themes: Crisis response services must be mobile and immediately available to families 24-7. Services must center on the child needs, but focus on the entire family with safety as the paramount consideration. A co-located, neighborhood based wrap around approach should be used. Once safety has been established the purpose of initial contact must be voluntary engagement with a focus on child and family assessment. All contacts with the family must be culturally sensitive and responsive. While substance abuse and mental health assessment and treatment services must be immediately available they cannot serve as a proxy for addressing violence and its immediate impact on family members. Services to the primary victim and the child should be integrated. Ongoing, supportive, case management services must be available to the family when the family is ready to engage.	Community members, key informants, policy makers, social service providers, private citizens, meeting minutes and notes, strategic plan.
SYSTEM CHANGE ACTIVITIES			
Development of policies	*Types of policies developed to support and enhance Safe Start planning, goals,*	1) Types of formal interagency protocols developed for collaborative efforts. None. The only "formal" interagency protocols developed for collaborative efforts are our subcontracts with the service providers. The culture of services in Spokane does not support MOA/MOU generation. Rather, partnerships and collaborations are fostered through the long-term development and	Key informants in Safe Start agencies, work group meeting minutes.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
(Continued)	*and implementation*	maintenance of relationships between agencies. Being a small community, the tradition in Spokane relies on one's word and a hand shake and partnerships may be characterized as being "relational" and horizontal in nature. 2) Types of national, state, or local policy/legislation developed. None. 3) Types of diversity policies developed. None.	
Service integration	*How non-Safe Start programs support Safe Start services and each other to reduce the impact of exposure to violence on children*	1) Types of cross-disciplinary training conducted. Numerous trainings have been conducted and/or sponsored by Safe Start. During the planning and implementation phases Safe Start conducted three community-wide trainings/meetings, a week-long training at Yale for our collaborative partners including law enforcement, and an Immersion training for clinical staff and law enforcement prior to implementation of the model. Other trainings have included DC: 0-3 and attachment, ongoing child witness trainings with the DV Consortium, attachment and the developing mind. Additionally, all law enforcement personnel in the county and city were provided training in the purpose and use of Safe Start. 2) Number of different agencies involved in cross-disciplinary training. Over 70 agencies in the Spokane region have received training. 3)Types of multi-system MIS protocols developed. The following efforts are underway in an effort to develop multi-system MIS protocols: MH surveillance study -- This study is intended to be a descriptive study of a representative sample of families engaged in publicly-funded mental health services in Spokane to screen for family violence prevalence, identify types of violence, and identify the prevalence of child witnessing and associated child maltreatment. Further, the study will attempt to determine if there is a correlation between mental health diagnosis, service utilization, and treatment outcome. Analyses will include correlational techniques and descriptive statistics. At the time of this writing, 90 child therapists (approximately 95% of the child therapists in Spokane) in the four main child-serving mental health agencies: Spokane Mental Health, Lutheran Community Services, Family Services Spokane, and Children's Home Society. We hope to initially screen a minimum of 300 children during the first phase. We fully expect this effort to result in a plan to create a CEV screening protocol within the mental health system. A second example of enhanced integration relates to the process associated with developing the SANCA grant application in which Safe Start was directly involved. The Juvenile Court Administrator used this as an opportunity to seek the direct participation of the Child Welfare Director in order to create a web-based system that would contain both child welfare and juvenile court data. While the grant was not funded, the Child Welfare Director committed to a level of financial participation apart from what the grant would have provided to the development effort. Safe Start has been in relationship development with the new Sacred Heart Children's hospital to implement a pilot study that will explore the feasibility of universal screening in primary care	Safe Start case records Community members, key informants, policy makers, social service providers, private citizens, meeting minutes and notes, strategic plan.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
(Continued)		settings for CEV, directly involve referrals to the Safe Start clinical operation, and create a relationship with the Spokane County Domestic Violence Consortium for the purpose of training and marketing. A five to ten-year plan is in the process of development, which includes the development of grant requests to several federal and private entities. This relationship will be one of two major springboards from which additional planning will be launched in the interest of a second-generation Safe Start effort on behalf of CEV. 4) Improved service coordination and integration. To be determined.	
Resource development	*Efforts by Safe Start and the community to enhance program sustainability and ensure program continuation*	1) Level of funding from other sources. The Regional Support Network (Spokane Co.) has committed $185,000 annually to the lead contractor, Casey Family Partners, in support of the service provision for CEV. 2) Level of grant development. Since the implementation of Safe Start, CAFRU has secured three major grants related to the creation of capacity to address the CEV agenda. A Systems of Care Grant was written but was not accepted. A SANCA grant proposal was submitted with the purpose of creating closer relationship between the juvenile court and the child welfare system on behalf of ASFA requirements. Other funded grants include the following: Head Start – WSU is the administrator of a three year, $400K/year, grant to engage in on school readiness, social functioning and developmental progress with the Head Start/Early Head Start population. A major portion of the grant targets the development of screening questions related to CEV and the isolation of violence exposure in this population as a developmental factor. NIH/CDC Workplace Domestic Violence -- CAFRI and the SCDVC were notified in October they would receive a $1.3 M, three-year grant to develop trainings, interventions, and research related to workplace violence. The Spokane Community Network in partnership with Safe Start received a $220K grant from the Family Policy Council. This grant targeted CEV aged 6-12 years and has served 185 children in 61 families since last July. Services have included counseling, tutoring, in-home visits, and respite services. Most of this work has occurred in the Valley catchments area and has involved partnerships with the Children's Home Society, schools and the Spokane Valley Community Center. CAFRU is currently involved in two grant development projects. The first involves a grant application to HHS the development of a Family Justice Center. The second grant application will be made to the CDC for the continuation and further development of Teen PEACE, a psychoeducation intervention targeting adolescents perpetrating domestic violence. 3) Number of corporate sponsorships developed. None. 4) Level of resource sharing across agencies. Resources are shared informally between agencies. 5) Volunteer recruitment and development. We had assumed that a robust relationship with COPS/SCOPES and community centers would have developed around this activity but this was	Meeting minutes and notes, strategic plan, progress reports.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
(Continued)		not the case. The scope of volunteer activity in those systems/agencies is broad and despite multiple efforts to involve them in CEV discussion we were unable to create a core of focused concern and commitment.	
New/expanded/ enhanced programming	*How services are improved to better serve children in collaboration with Safe Start*	Prior to Spokane Safe Start, crisis response and home-based services targeting violence-exposed children and families were not available. Child Outreach Specialists (COSs) provide early intervention services and treatment to families with young children who are identified by law enforcement or other community agency. Four Child Outreach Specialists and one part-time clinical supervisor are funded for service provision during Phase III. Each clinician is an experienced professional (Master's level or equivalent experience) in working with children and families. Child Outreach Specialists work days, weekends and flexible shifts based on client needs and calls for service. Clinicians have on-call schedules on a rotating basis to provide a 24-hour/7 day week crisis-response capacity. All participation in the program is voluntary for all families. Four levels of treatment services are available including acute crisis contact, crisis intervention, engagement/brief treatment support to link clients to resources within the community, and intensive treatment support that is based on a wraparound treatment model. The crisis contact involves the information available from the systems (law enforcement, child serving agencies) that identify the family for possible clinical intervention. Because families have to voluntarily accept contact with Safe Start Child Outreach Team (COT), information for a large but unknown percentage of families will be limited to what agencies know and can legitimately share with us about the families. Crisis Intervention involves the actions/outcomes with voluntary families that address the crisis events that brought the family to the attention of Safe Start. Following the Crisis Intervention, some number of families will be willing to receive ongoing supports from the CRT specialists through an Engagement/Brief Treatment Support set of activities. Based on the engagement efforts of the clinical specialists, some percent of families will have complex needs and will be willing to participate in extended services.	Community members, key informants, policy makers, social service providers, private citizens, meeting minutes and notes, strategic plan, Spokane Safe Start strategic plan.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
Community action	*Degree to which community members are aware and involved in the Safe Start initiative*	1) Types of media campaigns. The Spokane Domestic Violence Consortium is a CDC Coordinated Community Response to Prevent Intimate Partner Violence grantee. The Consortium, having a membership over 200 professionals and organizations, is now an acknowledged leader in the region on policy and the professional development efforts related to domestic violence. Part of its mission is to conduct extensive media campaigns (television, radio, print) to educate the Spokane community about family violence and CEV. Dr. Blodgett, Principal Investigator of Safe Start is also Principal Investigator for the DV Consortium. 2) Increased community awareness of impact of exposure to violence on children. The evidence from the random digit dial Spokane Survey (funded through the CDC; see above) is that IPV is a widespread event with significant health, employment, and legal impact in the lives of a significant minority of residents. In 2003, we began to ask about minor children in the home as a means of looking at child witness concerns more systematically. In both Spokane and Snohomish Counties, 41% of participants report that minor children lived in their household in the past 12 months. Based on the estimates of lifetime prevalence and annual incidence described below, we estimate that 15% of households have children who live with an adult who has been a lifetime victim of IPV. On an annual basis, 6-9% (the Snohomish and Spokane percents respectively for the percent of adults with children reporting IPV in the past 12 months) of the community's households with children have an adult who has been a victim of intimate partner violence in the past 12 months. The research finding support that community awareness has increased due to the media campaigns produced by the Spokane DV Consortium. 3) Increased community awareness of available services for children exposed to violence. Within the professional community, specifically among child-serving agencies, there is significant increased awareness of the Safe Start services for children exposed to violence. This is reflected in the steady increase in referrals from program inception to present. 4) Number of community organizations involved in the initiative. Over 70 agencies/organizations have been involved in the Safe Start initiative.	Community members, key informants, policy makers, social service providers, private citizens, meeting minutes and notes, strategic plan, Spokane Safe Start strategic plan. Blodgett (2000-2003), Spokane Random Digit Dial Survey. Safe Start case records, training records.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
INSTITUTIONALIZATION OF CHANGE			
System and Agency Change	*Degree to which the system serving children and families has improved in addressing the issue of exposure to violence for children*	1) Number of interagency MOAs. None. The only "formal" interagency protocols developed for collaborative efforts are our subcontracts with the service providers. The culture of services in Spokane does not support MOA/MOU generation. Rather, partnerships and collaborations are fostered through the long-term development and maintenance of relationships between agencies. Being a small community, the tradition in Spokane relies on one's word and a hand shake and partnerships may be characterized as being "relational" and horizontal in nature. MOUs are not regarded as a useful tool for the furthering of collaborations. 2) Number and types of policies in the community agencies supportive of the Safe Start initiative. The child welfare system is exploring ways to create activity in the area of early intervention on behalf of potential CPS clients with CEV. The Juvenile Court Administrator and his presiding Juvenile Court Judge adopted a policy structure for decision making within the Juvenile Court. Further, the commitment was made to create information systems that will be used to provide judicial officers with better information about the movement of children through the system. The collaborative relationship between Safe Start and the Juvenile Justice system assisted in this overall process and will be tapped to provide ongoing training and technical assistance to judicial officers within that system. Juvenile Court and child welfare agencies are working to find ways to share data related to case movement and ASFA compliance. If we are successful in planning, a major strategic objective is to convince the Superior Court Judges to end the practice of rotating judges into the Juvenile Court for one-year assignments. The current judge is committed to finding ways to work more closely with child welfare and is asserting her leadership to move the dependency agenda in that direction. Mental Health policy as it relates to children has been an area of significant activity over the last six months and the inertia in that system has begun to change in order to embrace the CEV agenda. We believe that institutionalizing screening for CEV/IPV will significantly change policy in this arena and we expect to accomplish that within the year. Corresponding discussions have occurred during this period in the area of chemical dependency and primary care. The OAC database, discussed in previous reports, has been validated and work to analyze 1100 prosecutions has been completed. We are currently working with the Justice Committee of the DV Consortium to determine next steps. This research into prosecution/sentencing outcomes carries specific implications for decision making among judges. 3) Improved service delivery within systems. To be determined. 4) Increased awareness within agencies of impact of exposure to violence on children. Over 70 agencies including nearly 3000 individuals from the fields of law enforcement, mental health,	Community members, key informants, policy makers, social service providers, private citizens, meeting minutes and notes. Training notes, records, and curriculum.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
(Continued)		substance abuse, education, child welfare, and the justice system have received training in CEV in Washington State. This is a direct outcome of the Spokane Safe Start community.	
Point of Service Change	*Sustainable improvements made to provide services to children exposed to violence*	1) Improved identification of children exposed to violence within each agency/system. Through the MH Surveillance Study described above, we hope to initially screen a minimum of 300 children seeking mental health in four agencies. At this time, over 90 therapists in these four agencies have received training in the effects of chronic violence exposure on children and the screening protocol. We fully expect this effort to result in a plan to create a CEV screening protocol within the mental health system (and possibly the chemical dependency and developmental disabilities systems) so that all children seeking services through the public mental health system will be screened for chronic exposure to violence. We expect that identification of children will increase engagement, assessment, and referrals to appropriate services for CEV within the agencies receiving public funding. 2) Improved assessment of children exposed to violence within each agency/system. See above. 3) Improved referral processes within each agency/system for children exposed to violence. See above. 4) Improved follow-up by staff within each agency/system for children exposed to violence. See above.	Spokane strategic plan, training records, training curriculum.
Community Change	*Degree to which the community: 1) has become aware of the impact of exposure to violence on children; 2) understands the impacts of exposure to violence on children; 3) supports services for children exposed to violence; and 4) understands where to go for assistance*	1) Increased community awareness of impact of exposure to violence. The random digit dial research findings support that community awareness has increased due to the media campaigns produced by the Spokane DV Consortium. 2) Increased community awareness of community resources for exposure to violence. Within the professional community, specifically among child-serving agencies, there is significant increased awareness of the Safe Start services for children exposed to violence. This is reflected in the steady increase in referrals from program inception to present. 3) Changed community norms regarding violence. Unknown.	Blodgett (2000-2003), Spokane Random Digit Dial Survey. Safe Start case records, training records.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
INCREASED COMMUNITY SUPPORTS			
Access to services	*Ability of access to necessary services for CEV.*	1) Increased availability of services. The presence of Safe Start in the Spokane community has significantly increased the availability of services to families and children affected by domestic violence. The majority of the Safe Start families were previously unknown to the formal social service system and many were unaware of the services available to them. The Child Outreach Team has engaged families in multiple services in the areas of trauma de-brief mental health and counseling, substance abuse, health, education, career development, subsistence needs, domestic violence advocacy, and legal assistance. 2) Number of points of entry into services. Safe Start has received referrals from law enforcement, child welfare, public health, Head Start, education, and the justice system. 3) Availability of information about programs. The Child Outreach Team actively conducts outreach to program providers and law enforcement about the Safe Start program.	Safe Start case records, staff interviews. Safe Start case records, staff interviews.
Specialized programming	*Degree to which community services specialize in serving CEV*	1) Increased types of programs dedicated to CEV. Currently, Safe Start is still the only program specializing in serving CEV although there have been discussions between juvenile justice, child welfare, and Safe Start to develop future programs. 2) Expanded programming dedicated to CEV. The Spokane Community Network in partnership with Safe Start received a $220K grant from the Family Policy Council. This grant targeted CEV aged 6-12 years and has served 185 children in 61 families. Services were delivered during 2001-2002.	Community members, key informants, policy makers, social service providers, private citizens, meeting minutes and notes.
Tolerance of violence	*Degree to which the community accepts or disavows violence in the presence of young children*	1) Number of reports of DV to police. Approximately 16,000 reports of domestic violence related crime is reported to law enforcement annually in Spokane County. 2) Number of reports of community violence to police. Unknown; data unavailable. 3) Decreased acceptance of violent acts. Unknown.	Spokane Police Department

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
Support by community leadership for SS	*How leaders in the community (political, organizational, etc.) support the SS initiative*	1) Increased attention to CEV in leadership circles. The leadership in the Spokane human services and law enforcement communities demonstrate support of the Safe Start initiative through continued participation in community meetings. Further, leaders in the fields of juvenile justice, mental health, child welfare, and Spokane County have committed to partnership and program development. 2) Increased financial support to agencies dedicated to reducing CEV. The Spokane Community Network in partnership with Safe Start received a $220K grant from the Family Policy Council. This grant targeted CEV aged 6-12 years and has served 185 children in 61 families. The Regional Support Network (Spokane Co.) has committed $185,000 annually to the lead contractor, Casey Family Partners, in support of the service provision for CEV.	Community members, key informants, policy makers, social service providers, private citizens, meeting minutes and notes.
REDUCED EXPOSURE TO VIOLENCE			
Family violence	*Changes in family factors contributing to exposure.*	TBD through the outcome evaluation.	
Community violence	*Level of violence in the community, including inter and extra-personal*	1) Decreased levels of violence within the community. There has been a general decrease in violence in the community but this not likely due to Safe Start. 2) Increased community supports. None known. 3) Decreased tolerance for violence in the community. Unknown.	Spokane Police Department.
Other forms of protection for children from exposure to violence	*Other ways in which efforts SS or collaborative partners reduce exposure to violence for children*	Number of children removed from a violent home. Although Safe Start is a mandated reporter of abuse and neglect, removal of children from the home is outside the purview of Safe Start and is the responsibility of local law enforcement and the state of Washington.	
REDUCED IMPACT OF EXPOSURE TO VIOLENCE			
Mental health of children exposed to violence	*Degree to which the mental health of children exposed to violence improves due to SS services*	TBD through the outcome evaluation.	Spokane Safe Start Evaluation Plan, Spokane Safe Start Strategic Plan.
Family functioning	*How families have improved their interpersonal dynamics and reduced*	TBD through the outcome evaluation.	Spokane Safe Start Evaluation Plan, Spokane Safe Start Strategic Plan.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
(Continued)	*the tendency toward violence*		
Protective/resilience factors for children exposed to violence	*Level of protective factors for children exposed to violence developed or enhanced due to SS services*	TBD through the outcome evaluation.	Spokane Safe Start Evaluation Plan, Spokane Safe Start Strategic Plan.
SYSTEM CHANGE ACTIVITIES			
New/expanded/ enhanced programming.	*How services are improved to better serve children in collaboration with Safe Start.*	1) Shared case management across agencies. Within the Safe Start Initiative, three agencies share clinical responsibility to provide services to CEV and their families. These agencies (through the Child Outreach Team) conduct regular meetings at least twice weekly to staff new and current cases. Once monthly, the management, COT, and law enforcement meet to discuss cases and model development. 2) Level of agency integration in the service of children. DSHS has launched an "integration" initiative, which seems targeted toward the goal of seamlessness between the child and family serving administrative entities within the state system. This process is being piloted in two sections of the state and it is noteworthy that the Breakthrough-Safe Start coalition succeeded in having Spokane identified as one of those sites. It is also noteworthy that the local child welfare director sought and was given responsibility to preside over this effort to integrate services and functions within the state system. Work groups were formed and some portion of the non-profit sector and county government is involved in discussions, including several leaders from the Breakthrough-Safe Start coalition. While a significant portion of this effort seems to be focused on realigning functions across systems within the state bureaucracy, there seems to be a corresponding effort to create capacity in the private sector to achieve better outcomes for children and families through better integration and coordination of service planning and delivery. Casey Family Partners (CFP), the lead clinical entity for Safe Start, will receive additional funds from the state based on the success of outcome research CAFRU has completed related to the CPS population CFP serves. The additional contract funds total more than $200K over and above the existing commitment from child welfare. Part of the rationale the state has used in making this decision relates to the success of the wraparound model CFP has used and currently employs with Safe Start families. Further, the CFP expertise in the area of CEV and the CFP record of accomplishment in coordinating and integrating services among child welfare, mental health, and chemical dependency systems built a very strong case for a funding enhancement.	Meeting minutes. Community members, key informants, policy makers, social service providers, meeting minutes and notes. Community members, key informants, policy makers, social service providers, meeting minutes and notes. Training records, staff interviews, meeting minutes. Community members, key informants, policy makers, social service providers, meeting minutes and notes. Meeting minutes and notes, strategic plan,

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
(Continued)		Additionally, CFP leadership has been very involved in support of the state's interest in integrated services and as the primary agency in Spokane that has modeled this approach, it was well positioned to be a primary recipient of additional resources. It appears the state is looking to unusual non-profit agencies that have a demonstrated record of outcomes with families and is attempting to develop discussion that results in the creation of capacity at the local level. Safe Start and the Breakthrough coalition are working deliberately to increase the state's involvement and participation in local discussion and we are cautiously optimistic about outcome. 3) Expansion of DV programming. All Child Outreach Specialists have been trained in safety planning by a DV advocate and the Spokane County Regional Domestic Violence Team has become a rich source of referrals for Safe Start. In addition, we are in early discussions with the main DV provider, YWCA, to co-locate advocacy and Safe Start services. 4) Expansion of CAN programming. A second example of enhanced integration relates to the process associated with developing the SANCA grant application in which Safe Start was directly involved. The Juvenile Court Administrator used this as an opportunity to seek the direct participation of the Child Welfare Director in order to create a web-based system that would contain both child welfare and juvenile court data. While the grant was not funded, the Child Welfare Director committed to a level of financial participation apart from what the grant would have provided to the development effort. 5) Expansion of family programming. Spokane Safe Start is family-focused, child-centered program that meets with families in their homes and in the community. Safe Start is a departure fromthe traditional center-based model. The Spokane Community Network in partnership with Safe Start received a $220K grant from the Family Policy Council. This grant targeted CEV aged 6-12 years and has served 185 children in 61 families since last July. Services have included counseling, tutoring, in-home visits, and respite services. Most of this work has occurred in the Valley catchment area and has involved partnerships with the Children's Home Society, schools and the Spokane Valley Community Center.	progress reports.
IDENTIFICATION OF CHILDREN EXPOSED TO VIOLENCE			
Identification of children exposed to violence	*Community and SS agencies policies and capacity to identify children who have been exposed to violence*	1) Standardized screening tool used by SS and primary partners. Not applicable. Provision of services is available to any child and family experiencing trauma. 2) Symptoms/indicators of violence exposure on children are known to primary partners. All primary partners have been extensively trained in symptoms and indicators of trauma exposure. Additionally, all partners are provided with a monthly update of symptoms and protective factors of the children and their families. 3) Identification of CEV from a diversity of sources. Referrals have been received from law enforcement, public health, Head Start, mental health, education, and the DV Team.	Spokane Safe Start Strategic Plan. Training records, meeting minutes, Safe Start case records. Safe Start case records.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
Identification of children at risk for exposure to violence	*Community and SS agencies capacity to identify children who are at risk to be exposed to violence*	1) Number of children screened. See above. 2) Number of children identified. As of December 31, 2003, 719 children from 236 families were contacted by Safe Start staff.	Safe Start case records.
ASSESSMENT OF EXPOSURE TO AND IMPACT OF VIOLENCE			
Use of common instruments to measure exposure to violence	*How SS agency and community partners are using standardized, identified instruments to measure exposure to violence on children*	1) Common exposure instrument used by SS and primary partners. The partners are not currently using a standardized instrument to measure exposure as instruments specifically targeting children exposed to violence have not been published.	Literature review.
Use of common instruments to measure impact of exposure to violence	*How SS agency and community partners are using standardized, identified instruments to measure the impact of exposure to violence on children*	1) Common impact of exposure instrument used by SS and primary partners. See above.	
REFERRAL TO SERVICES FOR CHILDREN EXPOSED TO VIOLENCE			
Referrals made	*Actual referrals made to agencies on behalf of children exposed to violence*	1) Number of referrals. From 12/2001 through 12/03, 284 families were referred for services, 236 families were contacted, and 719 children were seen. Eighty-three percent of the families referred to Safe Start received some level of contact. Families were not contacted by Safe Start if there was no entrée made by referring agency, no verbal consent from the families for contact by Safe Start, or the family declined services. 2) Types of referrals. The majority of the cases the (COT) responded to involved intimate partner violence, intimate partner violence and suicide, intimate partner violence and child abuse/neglect, suicide, suicide attempts, and homicides.	Safe Start case records.
Appropriate referrals	*Referrals of children/families to treatment are*	1) Staff are aware of the array of services available for CEV. Staff are fully aware of the array of services available to children and families at the local, state, and national level. 2) Staff are able to link up child/family needs with appropriate services. All referrals to services	Staff interviews, Safe Start case records.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
(Continued)	*appropriate to the needs and resources of the children/family*	are made with the permission of the primary caregiver. Referrals are made for a variety of needs including subsistence, financial and medical assistance, housing, mental health, chemical dependency, specialized child assessments (e.g., developmental, auditory, speech, etc.) education, career planning, medical, dental, DV advocacy, etc.	
Case management	*The monitoring and management of cases in order to make appropriate referrals*	1) Accurate and complete SS case records. Through the insight gained from the comprehensive record review and subsequent analyses as well as meeting with the Child Outreach Team on a regular basis to gain their input and approval, we developed and implemented the first version of a clinical database and service-planning program used by the (COT) on their individual notebook computers. The program was designed in ACCESS using a forms view interface for easy data input which includes fill-in blanks, pull-down menus, and yes/no responses for a majority of the information. There are 17 forms linking to individual tables for each caretaker, child, family risk and protective factors, service planning (with goals, objectives, and target dates), client contacts, case disposition, etc. Evaluation staff and the (COT) are meeting on a bi-weekly basis to conduct data downloads and to engage in quality assurance activities regarding client information. Evaluation staff are in the process of developing queries to extract data regarding demographic characteristics, family system and child characteristics, clinical histories, and service provision to conduct descriptive trend analyses. Information obtained from this process has enabled continued refinement of the electronic client log. Evaluation staff has created numerous queries and macros to extract data regarding demographic characteristics, family system and child characteristics, clinical histories, and service provision to conduct clinical treatment planning as well as descriptive trend analyses. Additionally, client report functions were added to the user interface to allow the (COT) members to generate a hardcopy client record via a unique client identification number. Prior to printing the report, staff may wish to view the report in a separate function. This report function ensures compliance with the various licensing and funding requirements of the collaborative partners. The quality of data collection, although somewhat imprecise during the early stages of service delivery, is improving over time. 2) Regular contacts with families and children. The COT maintains consistent contacts with the families and children until the family decides they no longer need or desire services. If the family discontinues contact for any reason staff continue to periodically send or provide subsistence services (e.g., food vouchers for the food bank). The "door" is always open and families may choose to resume services at anytime.	Safe Start case records (written and electronic).
REFERRAL TO SERVICES FOR CHILDREN EXPOSED TO VIOLENCE			
Evidence-based services	*How services to children exposed to violence are based on the available*	1) Demonstrated replication of promising practices. To be determined. 2) Identification of literature that supports program components. Safe Start conducts extensive literature reviews on an ongoing basis. We now have approximately 1500 research articles, books, and videos in our library. Topics include child witnesses, domestic violence, children's	Safe Start library database.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
(Continued)	*scholarly literature and research in the area*	mental health, child welfare, child abuse and neglect, juvenile justice, adolescents and family violence, model courts, community development, risk and protective factors, crisis intervention, family support/preservation, service integration, infant and child development, systems of care and other models of service delivery, trauma practice, perpetrator treatment, program evaluation, poverty, TANF, and community policing.	
Appropriate services	*How the services contribute to positive outcomes for children exposed to violence*	1) Attrition rate of clients. The Spokane program is based upon voluntary engagement and there is no pre-determined treatment period. 2) Progress made by clients. The development of a treatment plan with goals and objectives occurs shortly after intake. Long-term outcomes will be evaluated through the outcomes research using a number of standardized instruments. 3) Cultural and gender appropriateness of treatment. All services are culturally and gender appropriate.	Safe Start case records, Spokane Evaluation Plan.
Services provided to children and families	*Number of children and families provided the different services aimed at reducing the impact of exposure to violence on children*	1) Number of children and families provided mental health treatment. 236 families, 719 children through 12/03. 2) Number of families provided skill building services. From 12/2001 through 12/03, 284 families were referred for services, 236 families were contacted, and 719 children were seen. Eighty-three percent of the families referred to Safe Start received some level of contact. Families were not contacted by Safe Start if there was no entrée made by referring agency, no verbal consent from the families for contact by Safe Start, or the family declined services. 3) Number of families provided crisis intervention. 189 families, or 66%, were provided with crisis intervention. This includes staff being present on scene (60%) and/or provided crisis contact via phone (6%).	Spokane Safe Start case records.
Case sharing and collaboration	*How treatment partners in team on cases and share information*	1) Number of MOAs that stress case sharing. None. 2) Number of Safe Start -based treatment teams. One. 3) Communication among treatment teams. Within the Safe Start Initiative, three agencies share clinical responsibility to provide services to CEV and their families. These agencies (through the Child Outreach Team) conduct regular meetings at least twice weekly to staff new and current cases. Once monthly, the management, COT, and law enforcement meet to discuss cases and model development.	Meeting minutes and notes, staff interviews.
FOLLOW-UP OF TREATMENT AND SERVICES TO CHILDREN EXPOSED TO VIOLENCE			
Follow up of children referred to SS-based services	*How the program tracks children's progress in treatment and services*	1) Number of children tracked throughout treatment. 719. 2) Number of children tracked beyond treatment. At this time children are not tracked beyond treatment unless enrolled in the outcome studies program. 3) Number of contacts made after initial referral. The average number of contacts per family is 8.25 with a range of 1 to 132.	Spokane Safe Start records.

LOGIC MODEL CONSTRUCT/ VARIABLE	DEFINITION	INDICATORS	DATA SOURCE
Continued referral of children past initial referral phase	*How children are referred to additional services as the need arises*	1) Number of post-service referrals made. A case will be reopened if new/additional referrals are necessary.	Safe Start model protocol.
Continued training/consultation to providers	*How SS providers are given continuing training or mentoring*	1) Number of providers trained past initial training. All of the child outreach specialists receive ongoing training in a variety of areas including cultural competency, brain development, attachment, stalking, domestic violence, perpetrator treatment, chemical dependency, criminal justice and children, crisis intervention, ADHD, fatherhood, and the NCAST assessment.	Training records, staff interviews.

APPENDIX B

Tier II Site Proposals

Bridgeport Safe Start Initiative Tier II Proposal

Background of Enhancement Approach

One of the Bridgeport Safe Start (BSSI) funded programs is the Child & Family Interagency Resource, Support, and Training (Child FIRST) Program. Child FIRST is a collaborative, multi-disciplinary 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.

ChildFirst provides young children exposed to violence in their homes and their families with a comprehensive assessment, case management and referral to services within the Bridgeport community. Data from the first year of the program has revealed that the Child FIRST staff are providing the families who exhibit the greatest difficulties at intake (as assessed on the Parenting Stress Index, TESI and the Traumatic Symptom Checklist for Young Children) with more services (increased service hours) and are referred to and connected with more services. In other words, the clinical intuition of staff is accurate and they are providing more intensive services to the families most in need.

Current Evaluation Plan

In the existing evaluation for Child FIRST, outcome instruments are administered to clients/families at intake. This assessment battery includes: Traumatic Events Screening Inventory – Parent Report Version (Ford, 2002); Trauma Symptom Checklist for Young Children (Briere, 2001); and the level of parenting stress will be assessed using the Parenting Stress Index – Short Form (Abidin, 1995). Additionally, client satisfaction is assessed at discharge using the Patient Satisfaction Questionnaire III (Marshall, Hays, Sherbourne and Wells, 1993). The analyses are based on a Pretest-Posttest (Intake and 3-month or longer Follow-up), No-Comparison Group design. Multivariate methods such as regression with time covariates will be used to assess child and parent outcomes over time and dose-response correlational approaches.

Tier II Enhancement

When BSSI first began funding Child FIRST, the director of the program estimated that the average length of stay in the program was between four and six weeks. Due to this short duration of services, we did not request re-administration of outcome instruments at discharge. A review of the first year of data revealed that the average length of stay is actually more than twelve weeks. This time frame does allow for re-administration of the outcome measures at follow-up.

What we are proposing is that we re-administer the TESI, TSCYC and PSI at discharge for BSSI families served by Child FIRST. We have discussed this proposal with the Director of Child

FIRST and she is quite willing and interested in participating in this. We anticipate that 200 children and families will be served by Child FIRST over the next 2 years.

It is hypothesized that the comprehensive assessment and intensive case management provided by ChildFirst will provide the needed supports so that family symptomatology will decrease over time. The collection of follow-up data will enable us to examine this empirically. Baseline data is collected as part of the standard services. This proposal asks for funds to collect discharge data and to analyze the data.

Child FIRST staff will administer the follow-up assessment battery to families and they will utilize their data entry staff to enter the data. Evaluation staff from Yale will modify the existing database to allow for the follow-up measures to be entered, train staff on data collection and data entry and provide technical assistance to Child FIRST staff regarding the database. Additionally, the Yale evaluation team will clean and analyze the data using our original pre-post changes in outcomes and dose-response frameworks to assess program impact, and then provide summaries of the findings to ASDC and OJJDP.

Time-Line for Bridgeport Safe Start Initiative Tier II Proposal
Collection of Outcome Data for ChildFirst

May 2004

- Formalize agreement between BSSI and Child FIRST
- Modify instruments (e.g., TESI) to capture any changes over the last 3 months (versus lifetime)
- Meet with Yale Human Investigations Committee (HIC) to see if protocol will have to be revised and re-submitted. With only aggregate data being released to the NET this will probably not be necessary as current IRB language allows for follow-up assessment of families.
- Modify ACCESS database to allow Child FIRST staff to enter follow-up data into existing data base
- Train data entry staff on modified ACCESS database
- Meet with Child FIRST clinical staff to review follow-up assessment battery

June 2004-December 2005

- Receive quarterly data pulls from Child FIRST that will include baseline and follow-up data for all families served
- Run analyses yearly to examine any changes in parenting stress, child PTSD symptoms and exposure to violence over time. These analyses will include looking at the intensity of the intervention received (dosage) and the array of services received to determine what service array and intensity has the most impact for families. Once the sample size is large enough we will run multiple regression analyses to examine the impact of family characteristics, strengths and risk factors on outcomes over time. Additionally, we will be happy to run any analyses requested by the NET or OJJDP.

Chicago Safe Start's Tier II Proposal

Overview of Evaluation Enhancement

Chicago Safe Start (CSS) has a unique opportunity to collaborate with the Illinois Violence Prevention Authority's (IVPA) *Safe from the Start (SFS)* project to expand the evaluation of direct services provided to children exposed to violence and their families. Beginning in FY 05, IVPA will begin to provide some level of funding to CSS for direct services. By establishing a collaborative evaluation, data from as many as 9 different interventions for children exposed to violence from across Illinois can be analyzed simultaneously. The three CSS direct services sites are currently in their second year of implementation, three SFS sites are currently in their third year of implementation, and the final three SFS sites will begin their second year of implementation in
FY 05.

In addition to potentially increasing our ability to add to the available knowledge about best intervention practices for children exposed to violence, this enhanced evaluation will strategically focus increased statewide attention on the issue of children's exposure to violence at a time when Chicago Safe Start is beginning to focus on a city and statewide 'roll-out' of CSS policies and practices and working towards long-term sustainability. Coordinating the CSS outcome evaluation with a state-funded initiative will not only enhance the current evaluation, but will help to sustain the CEV evaluation efforts beyond the OJJDP funding period.

Funds from the OJJDP Tier II Enhancement Grant will be used to fund collaborative activities including developing common evaluation methods and measures, completing necessary IRB amendments, and coordinating data sharing, analysis, and report writing. Approximately $40,000 is being requested to hire an evaluation assistant for the CSS Project and to hire the evaluator from SFS as a collaborator and consultant to this collaborative project.

Proposed Measurement/Assessment Tools

Potential measures include the SFS Background Information Form, the TSCYC, the CBCL (1 ½ - 5), Ages and Stages, the CSS Questionnaire, and the CSS Professional Summary Report. A likely subset of common measures includes the CBCL and the CSS Professional Summary Report.

Proposed Program Elements/Components Service Provision Coding Scheme

The basic idea is that for each family seen, the service provider will complete a form that describes the services provided to that family. A final scheme will incorporate salient input from all 9 service providers and be dictated by the types of services the each agency provides to make sure that the form captures all of the diversity among the interventions. The final form will be Items included in such a form are likely to contain:

Length and number of each type of service provided (individual; group, family, multiple family, PCIT)
Total number of service hours provided
Total number of sessions provided
Number of sessions missed
Location of services (agency, home, other)
Theoretical orientation of services (if any)
Curricula used (if any)
Educational videos used (if any)
Counselor characteristics (age, education, experience, and racial match with family)
Additional referrals provided (we'll probably use the CSS "family referrals" form).

Proposed Analysis Plan

We anticipate that each of the nine sites will be able to contribute 50 cases to this analysis, for a total of 450 cases. Data will be recorded at the level of the individual child so we can look at characteristics across agencies that are associated with success (more sessions, home visitation, etc). Multivariate methods such as regression with time covariates will be used to assess child and parent outcomes over time, using (newly developed) Provider/Program Characteristics profiles as additional predictors/covariates.

We will also simply look at differences in outcomes between agencies in order to identify which agency was most successful at achieving positive outcomes, so that other agencies can examine their practices and possibly modify their interventions.

Please note: At this point it may not be possible to share raw data from the IVPA sites to OJJDP.

Proposed Timeline for the CSS/SFS Collaboration

April 2004	- SFS and CSS staff and evaluators meet to discuss collaborative outcome measures and develop a recommended set of measures. These conversations have already begun. Consult with OJJDP's National Evaluation Team (NET) regarding these recommendations.
May 2004	- SFS and CSS evaluators will convene a direct services/evaluation meeting to present the recommended set of outcome measures to direct service staff for their input and recommendations. - Upon sites' approval, submit IRB amendments under expedited approval procedures for changes that do not alter the risk-benefit analysis of the research.
June 2004	- Train sites in the use of new measures, as applicable. - Upon IRB approval, distribute new measures to sites and instruct them to begin using them. - Modify existing databases to incorporate new outcome measures and to accommodate data from additional sites.
Sept. '04 – Aug. '05	- Collect and enter data from sites. Periodic reporting of data to CSS and SFS staff and direct service providers.
Aug. '05 – Oct. '05	- Conduct final data analysis and develop final reports.

Pinellas Safe Start Tier II Evaluation Proposal

Overarching Research Question

Does an evaluation that utilizes the principles of family support and customer service to improve assessment and referral processes lead to greater family engagement and linkage to services, thus leading to improved outcomes?

Contributions of the Enhanced Evaluation

This proposed evaluation enhancement will inform Safe Start research on two levels. At the systems level, if useful Family Support risk and resiliency (R&R) profiles can be constructed, the findings will assist the partnership team in further refining their service decision tree by providing a better basis for service referral. At the individual client level, there are at least two benefits: (1) the additional data collection and analysis will assist in piloting a child measure to determine the project's effectiveness in alleviating child symptoms associated with exposure to violence; and (2) the analysis can identify and verify risk and resiliency profiles of the individuals (parents and children) who are (more) successful in achieving program goals. The enhancement funds will provide the evaluation team the additional resources needed to combine several data sources for analyses. The analyses will assist local providers in determining what works in engaging families with children exposed to violence in treatment interventions.

Logic Model Outcome Informed by Enhancement

Outcome 6, Improve Identification, Assessment and Referral through Safe Start Partnership Center.

We anticipate the information gleaned from the evaluation enhancement will provide the data necessary for developing an identification, assessment and referral decision tree for CEV. This goal is worthy of additional support in that it will create an opportunity to develop a tool that systematically assists in CEV identification, assessment and referral decisions that we currently have not had the time or resources to develop.

Partners Involved in the Process

Coordinated Child Care (CCC), Help-A-Child (HAC), Juvenile Welfare Board, the Ounce of Prevention Fund of Florida

Expected Number of Cases

We anticipate coding Family Support framework variables (from Case Plans) and adding Child Outcome measures for 100 total cases from the CCC and HAC agencies.

Proposed Measurement/Assessment Tools:

Parenting Stress Index; Ages and Stages Questionnaire-Social Emotional Domains (ASQ-SE) or Temperament and Atypical Behavior Scale, Early Childhood Indicators of Developmental Dysfunction (TABS); and a Family Service Plan, Risk & Protective Factor Data Matrix.

Proposed Methods

Using resilience as a framework for evaluating Safe Start outcomes was proposed in a report developed by ASDC for OJJDP Safe Start Projects in July 2003. The report outlines protective and risk factors at multiple levels of influence. At the individual level the report documents the risk and protective factors generated from the literature that are related to resilience. It proposes resilience is the process through which the effects of exposure to adversity are modified by protective or vulnerability factors in positive or negative directions.

The Safe Start enhancement dollars will be used to augment the current data collection and analysis activities. Specifically, the evaluation team will develop a resiliency matrix that will be used to extract data from client case plans (Family Service Plans) and for follow-up with service providers to determine if the clients linked to the referred services and clients to determine if they met the objectives of their case plans. A tentative coding scheme would include:

Characteristics of the Family:

Household composition
Ages of Child(ren) at time of exposure
Support systems in place
Demographics including race, employment, education level, education involvement
Assessment results at intake

Characteristics of Services/Intervention:

Type of service (mh, med, ed, fin, other)(These would come from the Family Support Plan)
Length and number of services provided to the client (family)
Number of sessions and type of sessions provided
Location of services (agency, home, other)
External referrals and linkages recommended to clients (mh, med, ed, fin other)
External referrals and linkages received by client (including frequency, duration, priority level as described in Family Support Plan)

Characteristics of the Violence:

Type of violence exposure
Location of violence
Relationship of perpetrator to victim

Ultimately, these data will be combined with the NET database variables, PSI scores (the primary individual outcome measure), as well as another outcome tool such as the ASQ-SE or the TABS that will be used as a child measure.

Proposed Analysis Plan

The analyses at CCC will continue to be based on a Pretest-Multiple Posttest (Intake, Linkage point, and Follow-up), No-Comparison Group design. Multivariate methods such as regression with time covariates will be used to assess child and parent outcomes over time, using (newly developed) Family R& R profiles as additional predictors/covariates.

The analyses at HAC will continue to be based on a Pretest-Multiple Posttest (Intake, Linkage point, and Follow-up), quasi-experiment in which the CEV trained social worker/case manager is compared with a non-specialized care group of CEV-identified clients. Multivariate methods such as analysis of covariance and regression will be used to assess changes in child and parent outcomes over time between groups, and using (newly developed) Family R& R profiles as additional predictors/covariates.

Time Frame for Research

Data Collection: May 2004 to September 2005
Data Analysis & Reporting: May-December 2005

Pinellas Safe Start
Proposed Timeline for Enhancement Implementation

Task	May 2004	June 2004	July 2004	August 04-Aug 05	Sept 05-Dec 05
Tool Design & Development					
Literature Review					
Develop Matrix					
Develop Protocols					
Pilot Test Tools					
Revise Tool based on Pilot Tests					
IRB Approval					
Planning Meetings & Communications with SS Stakeholders					
Training Extractors (includes preparation time, on-site training & follow-up with extractors for Q&A)					
Data Collection					
Case File Extractions					
Follow-up with service providers					
Follow-up with clients					
Data Entry, Review & Transfer (this may change based on extraction format)					
Data analysis					
Data cleaning and set up for analyses					
Preliminary data analysis runs					
Review of preliminary analyses w/Safe Start & ASDC					
Final data runs					
Reporting Results					
Report Writing					
Meetings with SS on results					
Communicating Results					

Research Proposal Outline for Tier II Safe Start Funding

Rochester Safe Start (RSS) and Bridgeport Safe Start (BSSI) propose a joint study to validate the RSS Early Childhood Education Parent Survey ("Survey" hereafter).

Rationale for Enhancement

Dr. Joy Osofsky, a leading scholar in the area of children's exposure to violence, told us early on in the Safe Start Initiative that there doesn't exist a reliable, valid, practical screener for young children's exposure to violence. We learned then that development of such an instrument would be a wonderful legacy of the Initiative. The legacy would be varied. In a 1995 article in *The American Psychologist*, Osofsky wrote that "inclusion of information on violence exposure would be useful to include in national surveys," for epidemiological purposes. A reliable, valid, practical screener for exposure would lead to better classification of cases, and more timely, earlier referral to service and treatment, where appropriate.

Just to consider one example, if the RSS instrument is validated, Children's Institute will push to add it to the Parent Appraisal of Children's Experiences (PACE), a survey filled out by over 90 percent of parents of entering kindergarteners in the City. A reliable, valid screener will add to the City's ability to identify potential problems early and take care of them before they grow in harm and expense, outcomes that are beneficial to the identified children, their families and peers, and taxpayers in general.

Psychometrics on Survey data collected by RSS from 2002 to 2003 suggest that the Survey has great potential to fill the void. The symptoms scale, compiled from the literature by Dr. A. Dirk Hightower of Children's Institute, has alpha scores ranging from .65 to .8, depending on the group studied, and exposure is strongly related to symptoms (statistically significant difference between exposed and non-exposed children on symptoms scale at $p<.000$ for all types of violence, with effect sizes ranging from .42 to .55, depending on type of violence). The proposed study will provide the opportunity to validate the Survey against an established measure. If the Survey is found valid, the contribution will be exactly the type of instrument for which Osofsky and other experts have been calling, a valuable legacy for the Initiative.

Proposed Measurement/Assessment Tool

We propose to add the Survey to BSSI's current measurement protocol, which includes the Traumatic Event Screening Inventory (TESI) – Parent Report Revised – Brief Version (e.g., Ford *et al*. 2000).[1] During rolling administration of the TESI among incoming service recipients in Bridgeport Safe Start, Bridgeport will administer the Survey. Since each survey has its own opening paragraph and thus its own tone, the Survey will be administered as a stand-alone instrument despite minor redundancies in the instruments. Both instruments will be administered

[1] Ford, J.D., R. Racusin, C.G. Ellis, W.B. Davis, J. Reiser, & A. Fleischer. "Child Maltreatment, Other Trauma Exposure, and Posttraumatic Symptomatology Among Children with Oppositional Defiant and Attention Deficit Hyperactivity Disorders." *Child Maltreatment, 2000, 5*(3), 205-217.

at the same meeting with the client. BSSI will share with RSS TESI and Survey data on all families enrolled.

Methods

This collaborative effort involves *concurrent* validity, both convergent and divergent. Standard techniques in concurrent validation will be employed (e.g., examination of the item- and scale-level inter-correlations).

To establish concurrent *convergent* validity, we will examine r-scores for related variables. For example, we would expect a high r between TESI item 17 "Has your child seen or heard people *outside your family* fighting, hitting, pushing, or attacking each other? Or seen or heard about violence such as beatings, shootings, or muggings that occurred in settings that are important to your child, such as school, your neighborhood, or the neighborhood of someone important to your child?" and Survey item 3 "On a scale of one to four, where one is no exposure at all and four is a high level of exposure, please tell me about your child's exposure to violence in the neighborhood," assuming TESI's "Yes" is coded "1" and its "No" is coded "0," of course.

Since Pearson's r is inappropriate as a measure of the correlation between a dichotomous variable (as the TESI variables are) and a categorical variable with greater than two categories (as the Survey variables all), we will dichotomize the Survey items prior to calculating the correlation matrix. Dichotomization will be done the same way in the validity study as it was previously by RSS (1 equals no exposure and is coded "0", while ratings of 2 through 4 equal exposure and will be coded "1"). An analogous procedure will be employed when investigating relationships between TESI items and the Survey's symptoms items.

Other factors that affect r scores will be investigated systematically. Scatterplots will be examined for outliers, which can dramatically affect r. In addition, we will examine variable distributions for the extent of heterogeneity, another influence on r.

Regarding *divergent* validity, there are many appropriate data available for Survey data collected in Rochester, since parents who provided Survey data also consented to our use of RECAP data (discussed with ASDC previously). RECAP data include established measures like the Teacher-Child Rating Scale. One example of a T-CRS variable we will use to establish divergent validity is task orientation, which should be correlated with *many* variables (e.g., ADHD).

Finally, the two sites will co-author intended publications resulting from the collaboration.

BSSI/ RSS
Timeline

Pending approval of the necessary agencies, BSSI will begin administering the Survey with the TESI in July 2004, and will continue to do so through the end of Safe Start funding in December 2005. BSSI will send TESI and Survey data quarterly to RSS, anticipating approximately 40 per quarter and approximately 225 overall, based on experience to date.

A detailed timeline follows:

April 2004

- BSSI evaluators meet with funded programs to get buy-in to add the new measure (this has been completed already with one program)
- BSSI evaluators modify ACCESS database to enable service staff to enter screening data
- BSSI evaluators train staff on new tool
- BSSI evaluators review new tool with Yale Human Investigations Committee, which might request an amended protocol. Approval of an amended protocol would take four to six weeks.

June 2004 - December 2005

- BSSI evaluators receive quarterly data pulls for the BSSI funded programs
- Submit quarterly data pulls of the TESI and screening tool to RSS

December 2005 - January 2006

- Data analysis, reporting of results to NET, and article submission by both sites

APPENDIX C

Core and Secondary Questions for 2004 Process Evaluation

Safe Start Process Evaluation Core and Second Level Questions
For Year Four

1. **How did the composition and process of the collaborative in each site influence the types of strategies implemented, and as a result, the system change outcomes?**

    A. Who are the essential members of the collaborative?

    B. What is the impact of the membership composition on the strategies implemented and outcomes achieved?

    C. How does the collaborative's decision-making process and role assignment (as well as assignment process) affect its strategies and outcomes?

    D. What are the sources of conflict for the collaborative? How have they been addressed?

    E. How has conflict impacted the strategies implemented and outcomes achieved?

    F. How do the collaborative's systems of communications impact the strategies implemented and outcomes achieved?

    G. Are the collaborative's members involved in other collaboratives currently? If yes, what types of collaboratives?

Potential data sources and methods: Key collaborative members (interviews; meeting minutes)
Project Director (interviews)

2. **How has SSI changed the service delivery system for children exposed to violence and their families?**

    A. What is the process (or service pathways) that children exposed to violence undergo after they are identified?

    B. How are children who are identified as being exposed to violence tracked after identification?

    C. What have been the challenges in providing services for children exposed to violence?

    D. How many children exposed to violence have been assessed for services since the beginning of the Initiative

    E. How many children exposed to violence are being provided intervention services since the beginning of the Initiative?

    F. What are those services that SSI has initiated or enhanced?

Potential data sources and methods: Project Director (interviews and progress reports)
Service providers (interviews)
Key staff members (interviews)

3. What organizational, community, POS and collaborative capacities (knowledge, skills, resources, and relationships) are required for successful implementation and sustainability of the system changes at each site?

A. What are the essential capacities for successful implementation and sustainability of the SSI?

B. Did the SSI sites have the capacities (knowledge, skills, resources, relationships) needed to implement and sustain the Initiative over the past year? What was/is missing? How did the sites compensate for that lack?

C. How do the sites plan to increase capacity to better meet their goals?

Potential data sources and methods: Key collaborative members (interviews; semiannual report)
Project Director and key staff (interviews; semiannual report)
National Civic League (archival documents)

4. What were strategies developed to respond to external changes (e.g., fluctuations in the economy, political changes, etc.) affecting the successful implementation and goal achievement of the Safe Start Initiative in each site?

A. What were the external factors (barriers) that impacted SSI's ability to successfully implement the Initiative or meet its goals?

B. How were the factors overcome (proactively or retroactively)?

C. What capacities are required by the Safe Start Initiative to respond to the factors?

Potential data sources and methods: Key collaborative members (interviews; semiannual report)
Key agency and community leaders – both involved and not involved in SSI (interviews; semiannual report)
Project Director and key staff (interviews; semiannual report)
National Civic League (archival documents)

5. How did each site handle anticipated or unanticipated critical changes at the program level when they occurred?

A. What were the critical changes that affected the SSI's programmatic activities?

B. How did the changes affect the SSI's ability to achieve its goals?

C. How were the changes overcome (proactively or retroactively)?

D. What capacities were required by the Safe Start Initiative to respond to the changes at the program level?

Potential data source and methods: Project Director and key staff (interviews; semiannual report)
Providers at key points of services (focus groups)
National Civic League (archival documents)

6. What were the milestones reached, goals attained, and indirect impacts of the Safe Start Initiative in the past year?

A. What goals and milestones were achieved in 2004?

B. What new (first time) activities took place in 2004?

C. What were the unanticipated or indirect impacts of the SSI in 2004?

Potential data sources and methods: Project Director and key staff (interviews; semi-annual report)
Key collaborative members (interviews)
Key agency and community leaders (interviews)

7. What strategies are being used to achieve sustainability in policies, procedures, and practices?

A. How have SSI sites worked to change local policies, procedures, or practices?

B. What is being done to ensure/enhance institutionalization of Safe Start's policies, procedures, and practices?

C. What is being done to ensure fiscal sustainability?

D. What practices or policies initiated by SSI have been adopted by other agencies or extended beyond the Safe Start target area?

Potential data sources and methods: Project Director and key staff (interviews)
Key collaborative members (interviews)
National Civic League (archival documents and interview)

8. What are the lessons learned about the implementation and replication of a national initiative such as Safe Start?

A. Are different capacities (knowledge, skills, resources, relationships) required for implementation versus replication? What are they? How can they be developed?

B. What types of technical assistance and other knowledge development support are required and how are they best delivered (e.g., cross-site meetings, conference calls, TA assessments, listserv, evaluation)?

C. What types of strategies and activities, including collaborative processes, appear to be most effective for building local capacity to reduce children's exposure to violence?

D. What barriers might be/were encountered and how can they/were they addressed?

Potential data sources and methods: Project Director and key staff (interviews)
Key collaborative members (interviews)
Local evaluators (interviews)
National Civic League (archival documents and interview)

SAFE START LOGIC MODEL: QUESTIONS FOR PROCESS EVALUATION