Evidence-Based Practices for Children Exposed to Violence:
A Selection from Federal Databases

U.S. Department of Justice
U.S. Department of Health and Human Services
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Workgroup Participants
Children Exposed to Violence—Evidence-based Practices

Clare Anderson
Deputy Commissioner
Administration on Children, Youth and Families
U.S. Department of Health and Human Services
1250 Maryland Avenue, SW, Eighth Floor
Washington, DC 20024
(202) 205-8347
clare.anderson@acf.hhs.gov

Brecht Donoghue
Policy Advisor
Office of the Assistant Attorney General
U.S. Department of Justice
810 7th Street, NW
Washington, DC 20531
(202) 305-1270
brecht.donoghue@usdoj.gov

Shania Kapoor
Children Exposed to Violence (CEV) Fellow
Office of Juvenile Justice and Delinquency Prevention
U.S. Department of Justice
810 7th Street, NW
Washington, DC 20531
(202) 305-1270
shania.kapoor@usdoj.gov

Marylouise Kelley, Ph.D.
Director
Family Violence Prevention and Services Program
Family and Youth Services Bureau
Administration on Children, Youth and Families
U.S. Department of Health & Human Services
1250 Maryland Ave., SW, Eighth Floor
Washington, DC 20024
(202) 401-5756
marylouise.kelley@acf.hhs.gov

Kristen Kracke, MSW
Program Specialist
Office of Juvenile Justice and Delinquency Prevention
U.S. Department of Justice
810 7th Street, NW
Washington, DC 20531
(202) 616-3649
kristen.kracke@usdoj.gov

Valerie Maholmes, Ph.D., CAS
Director
Social and Affective Development/Child Maltreatment & Violence Program
Eunice Kennedy Shriver National Institute of Child Health and Human Development
6100 Executive Blvd.
Room 4B05A
Bethesda, MD 20892
(301) 496-1514
maholmev@mail.nih.gov

Karol Mason
Deputy Associate Attorney General
Office of the Associate Attorney General
U.S. Department of Justice
810 7th Street, NW
Washington, DC 20531
karol.v.mason@usdoj.gov

Amanda Nugent
Intern
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
1 Choke Cherry Dr.
Rm 8-1051
Rockville, MD 20857
(240) 276-1875
Debbie Powell
Acting Associate Commissioner
Family and Youth Services Bureau
Administration on Children, Youth and Families
U.S. Department of Health and Human Services
1250 Maryland Avenue, SW, Eighth Floor
Washington, DC 20024
(202) 205-2360
debbie.powell@acf.hhs.gov

Bryan Samuels
Commissioner
Administration on Children, Youth and Families
U.S. Department of Health and Human Services
1250 Maryland Avenue, SW, Eighth Floor
Washington, DC 20024
(202) 205-8347
bryan.samuels@acf.hhs.gov

Janet Saul, Ph.D.
Senior Advisor for Strategic Directions (Acting)
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, Georgia 30333
(770) 488-4733
jsaul@cdc.gov

David DeVoursney, MPP
Program Analyst
Office of Policy, Planning & Innovation
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
1 Choke Cherry Rd.
Room 8-1058
Rockville, MD 20857
(240) 276-1882
david.devoursney@samhsa.hhs.gov

Phelan A. Wyrick, Ph.D.
Senior Advisor
Office of the Assistant Attorney General
Office of Justice Programs
U.S. Department of Justice
810 7th Street, NW
Washington, DC 20531
(202) 353-9254
phelan.wyrick@usdoj.gov
Evidence-Based Practices for Children Exposed to Violence: A Selection from Federal Databases

This package of information summarizes findings and evidence from federal reviews of research studies and program evaluations to help localities address childhood exposure to violence and improve outcomes for children, families, and communities. These evidence-based practices should be reviewed and incorporated as practitioners and policy makers work in multi-disciplinary partnerships to plan and implement services and activities to prevent and respond to children exposed to violence.

Understanding and Integrating Evidence
In general, evidence is drawn from social science research, statistics, and program evaluations, and is distinguished by the systematic methods used to isolate relationships (e.g., between an action and a consequence, or a service and an outcome). This is a different way of understanding the world than the understanding that comes from practical experience. Rigorous social science has the benefit of uncovering relationships and effects that may be difficult to observe through less rigorous methods. Through an understanding and healthy respect for evidence integrated with the knowledge that comes from experience and expertise, practitioners and policy makers are more likely to achieve the results that they seek.

Sources of Evidence
Subject matter experts at the Department of Justice and the Department of Health and Human Services collaborated in preparing this information based on reviews of existing federal databases of evidence-based programs. The review was conducted with a careful eye toward those practices that are most applicable to the challenge of addressing children exposed to violence. In each case, programs and practices that are reviewed are supported by multiple research studies or program evaluations. This package of information is based on reviews of the following databases prepared by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the Substance Abuse and Mental Health Services Administration (SAMHSA): SAMHAs National Registry of Evidence-Based Programs and Practices, SAMHAs National Child Traumatic Stress Network, OJJDPs Model Programs Guide, and OJJDPs Children Exposed to Violence Evidence-Based Guide.

Using Evidence-Based Practices
The best way to assure that evidence-based programs produce results that will be similar to the outcomes documented by past evaluations is to replicate program procedures and activities with high fidelity. Guidance and information about replication can be found in this package under the heading: Supporting High Fidelity Implementation.

Some argue against anything short of full replication of evidence-based programs. But there are many challenges to full replication, not the least of which is that many programs that have documented results do not have extensive implementation manuals. As a practical matter, users are encouraged to become familiar with the full range of evidence-based programs in this package and consider which provide the best fit for their needs. Users should seek opportunities for replicating or adapting them in ways that are consistent with local circumstances, culture, and resources while still remaining faithful to the program content. For example, the form of the program might be changed (the type of setting in which the intervention is implemented, introduction of meals or transportation, adding cultural activities), while still maintaining the function of the program (e.g., the number of sessions, session content, how often the sessions occur, etc.).
<table>
<thead>
<tr>
<th>Program Name</th>
<th>Age Range</th>
<th>Outcome Indicator</th>
<th>Evidence Standard (Rating)</th>
<th>Increase Resilience</th>
<th>Reduce Trauma Symptoms</th>
<th>Reduce Incidence</th>
<th>Agency Providing</th>
<th>Source of Information (e.g., Model Programs Guide or NREPP)</th>
<th>Program Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBM: Academic problems Aggression/violence Alcohol, tobacco, and other substance use Delinquency Family functioning Academic failure</td>
<td></td>
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<tr>
<td>CASAStART (Shining Stars to Achieve) Rewarding Tomorrows, Together for a Better Future (Children at Risk)</td>
<td>6-12 (children) 13-17 (adolescents)</td>
<td>Violence</td>
<td>CBM: Exemplary</td>
<td>CBM: Exemplary</td>
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<td>Program Name</td>
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<td>Outcome Indicator</td>
<td>Evidence Standard (Rating)</td>
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<tr>
<td>CBTITS</td>
<td>6-12/10-15</td>
<td>PTSD symptoms, depression symptoms, psychosocial dysfunction</td>
<td>Effective</td>
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<tr>
<td>Early Risers</td>
<td>6-12 (children) 26-55 (adults)</td>
<td>1) Academic competency and achievement 2) Behavioral self-regulation 3) Social competency 4) Parental investment in the child</td>
<td>x</td>
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</tr>
<tr>
<td>Familias Unidas</td>
<td>6-12 (children) 13-17 (adolescents) 28-55 (adults)</td>
<td>1) Family functioning 2) Problem behavior 3) Externalizing disorders</td>
<td>x</td>
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</tr>
<tr>
<td>Families and Schools Together (FAST)</td>
<td>0-5 (young children) 6-12 (children)</td>
<td>1) Child problem behavior 2) Child social skills and academic competencies</td>
<td>x</td>
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</tr>
<tr>
<td>Families First: Therapies for Successful Learning (FFT)</td>
<td>6-10-15-31</td>
<td>Reduction in teacher student interactions, reductions in new offending and entry for older addictions for children, treatment costs, foster care, and residential placement</td>
<td>Exemplary</td>
<td></td>
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<tr>
<td>Good Behavior Game (GBG)</td>
<td>6-10</td>
<td>Improvement in early risk behaviors of attention/concentration problems and shy and aggressive behavior, and academic functioning</td>
<td>Exemplary</td>
<td></td>
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<tr>
<td>Healthy Families America (HFA)</td>
<td>0-23-5</td>
<td>Exposure to violence and effects of exposure to violence (e.g., PTSD symptoms)</td>
<td>Effective</td>
<td></td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>Program Name</th>
<th>Age Range</th>
<th>Evidence Standard (Rating)</th>
<th>Increase Resilience</th>
<th>Reduce Trauma Symptoms</th>
<th>Reduce Incidence</th>
<th>Agency Providing</th>
<th>Source of Information (e.g., Model Programs Guide or NREPP)</th>
<th>Program Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homelinkers</td>
<td>0-18</td>
<td>Effective</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>DUD 930160</td>
<td>NREPP: National Registry of Effective Prevention Programs: <a href="http://www.nrepp.samhsa.gov">http://www.nrepp.samhsa.gov</a></td>
<td></td>
</tr>
<tr>
<td>Kids Safe and Main Empowerment</td>
<td>5-8, 10, 15-21</td>
<td>Effective</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>NREPP: Model Programs Guide: <a href="http://www.ojjdp.gov/mpg">http://www.ojjdp.gov/mpg</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Skills Training (LST)</td>
<td>13-17 (adolescents)</td>
<td>Universal violence and defency prevention</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>SAMHSA: MREPP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linking the Interests of Families and Teachers (LIFT)</td>
<td>6-11</td>
<td>Exemplary</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>NREPP: National Registry of Effective Prevention Programs: <a href="http://www.nrepp.samhsa.gov">http://www.nrepp.samhsa.gov</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>18-25 (adolescents)</td>
<td>x</td>
<td>x</td>
<td>SAMHSA: MREPP</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Multidimensional Treatment Foster Care (MTFC)</td>
<td>3-18</td>
<td>x</td>
<td>x</td>
<td>SAMHSA: MREPP</td>
<td></td>
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<thead>
<tr>
<th>Program Name</th>
<th>Age Range</th>
<th>Outcome Indicator</th>
<th>Evidence Standard (Rating)</th>
<th>Increase Relevance</th>
<th>Reduce Trauma Symptoms</th>
<th>Reduce Incidence</th>
<th>Agency Providing</th>
<th>Source of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multisystemic Therapy (MST)</td>
<td>12-17</td>
<td>By population of focus: Juvenile offenders 1) Perceived family functioning-cohesion 2) Post-treatment arrest rates 3) Long-term arrest rates 4) Long-term incarceration rates 5) Self-reported criminal activity</td>
<td>Exemplary</td>
<td>X</td>
<td>X</td>
<td>SAMHSA NREPP</td>
<td>MPG/OJJDP CEV EBG</td>
<td></td>
</tr>
<tr>
<td>Nurse-Family Partnership</td>
<td>0-5 (young children), 13-17 (adolescents), 18-25 (young adults), 26-55 (adults)</td>
<td>1) Child injuries and maltreatment 2) Perinatal health problems, including infant mortality, days of hospitalization due to injuries; lower rates of CANS, fewer child abuse and neglect cases, and substance use problems among mothers</td>
<td>Exemplary</td>
<td>1.5</td>
<td>3.5</td>
<td>SAMHSA NREPP</td>
<td>MPG/OJJDP CEV EBG</td>
<td></td>
</tr>
<tr>
<td>Nurturing Parenting (NPP)</td>
<td>6-12 (children), 26-55 (adults)</td>
<td>1) Family interaction 2) Recidivism of child abuse and neglect 3) Children's behavior and attitudes toward parenting</td>
<td>Exemplary</td>
<td>1.5</td>
<td>3.2</td>
<td>SAMHSA NREPP</td>
<td>MPG/OJJDP CEV EBG</td>
<td></td>
</tr>
<tr>
<td>Olweus Bullying Prevention Program</td>
<td>6-14</td>
<td>Decrease in perpetration and victimization; decrease in fighting and vandalism; increase in positive social climate in school; order, and discipline in school; and better social relationships and attitudes toward school</td>
<td>Effective</td>
<td>1.2</td>
<td>2.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent-Child Interaction Therapy (PCIT)</td>
<td>0-5 (young children), 6-12 (children), 26-55 (adults)</td>
<td>1) Parent-child interaction 2) Recurrence of physical abuse</td>
<td>Exemplary</td>
<td></td>
<td></td>
<td>SAMHSA NREPP</td>
<td></td>
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<th>Reduce Trauma Symptoms</th>
<th>Reduce Incidence</th>
<th>Agency Providing</th>
<th>Source of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting Through Change (PTC)</td>
<td>3-17 (children)</td>
<td>1) Child problem behaviors 2) Parental knowledge, beliefs, and behaviors 3) Parental sense of competence</td>
<td>1) 2.7 2) 2.7 3) 2.8</td>
<td>x</td>
<td>x</td>
<td>SAMHSA</td>
<td>NREPP</td>
<td></td>
</tr>
<tr>
<td>Perry Preschool Project (High Scope Curriculum)</td>
<td>3-4</td>
<td>Less antisocial behavior and misconduct Delinquency and crime rates for the children in the program were significantly lower than for those in the control group</td>
<td>Exemplary</td>
<td>x</td>
<td>x</td>
<td>OJJDP</td>
<td>MPG/OJJDP CEV EBG</td>
<td></td>
</tr>
<tr>
<td>Primary Project</td>
<td>0-5 (young children), 6-12 (children)</td>
<td>1) Peer sociability 2) Behavioral control 3) Adaptive assertiveness</td>
<td>1) 3.2 2) 3.5 3) 3.3</td>
<td>x</td>
<td>x</td>
<td>SAMHSA</td>
<td>NREPP</td>
<td></td>
</tr>
<tr>
<td>Project Support</td>
<td>3-5, 6-12</td>
<td>Child/family well-being, safety</td>
<td>Effective</td>
<td>x</td>
<td>x</td>
<td>OJJDP/OCTF</td>
<td>OJJDP CEV EBG</td>
<td></td>
</tr>
<tr>
<td>Prolonged Exposure Therapy</td>
<td>13-21</td>
<td>1) Emotion dysregulation, depression symptoms, social functioning</td>
<td>Exemplary</td>
<td>x</td>
<td>x</td>
<td>OJJDP</td>
<td>MPG/OJJDP CEV EBG</td>
<td></td>
</tr>
<tr>
<td>Promoting Alternative Thinking Strategies (PATHS)</td>
<td>6-12 (children)</td>
<td>1) Emotional knowledge 2) Internalizing behaviors 3) Externalizing behavior 4) Depression 5) Neurocognitive capacity 6) Learning environment 7) Social-emotional competence</td>
<td>1) 2.5 2) 2.5 3) 2.9 4) 3.2 5) 3.8 6) 3.8 7) 2.8</td>
<td>X</td>
<td>X</td>
<td>SAMHSA</td>
<td>NREPP</td>
<td></td>
</tr>
<tr>
<td>Reconnecting Youth: A Group Approach to Building Life Skills (RY)</td>
<td>13-17 (adolescents), 18-25 (young adults)</td>
<td>1) School performance 2) Mental health risk and protective factors</td>
<td>1) 3.5 2) 3.4</td>
<td>x</td>
<td>x</td>
<td>SAMHSA</td>
<td>NREPP</td>
<td></td>
</tr>
</tbody>
</table>

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## Children Exposed to Violence Program Matrix: Effective Programs

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<thead>
<tr>
<th>Program Name</th>
<th>Age Range</th>
<th>Outcome Indicator</th>
<th>Evidence Standard (Rating)</th>
<th>Increase Resilience</th>
<th>Reduce Trauma Symptoms</th>
<th>Reduce Incidence</th>
<th>Agency Providing</th>
<th>Source of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Richmond Comprehensive Homicide Initiative</strong></td>
<td>12-30</td>
<td>Decreased homicide rate, decreased rate of violent crime</td>
<td>Effective</td>
<td>x</td>
<td>JJDP</td>
<td>Effective</td>
<td>JJDP</td>
<td>NREPP</td>
</tr>
<tr>
<td><strong>SAFEChildren</strong></td>
<td>6-12 (children)</td>
<td>1) Child problem behaviors 2) Parental involvement in child’s education</td>
<td>Exemplary</td>
<td>x</td>
<td>SAMHSA</td>
<td>Effective</td>
<td>SAMHSA</td>
<td>CEV EBG</td>
</tr>
<tr>
<td><strong>Safe Dates</strong></td>
<td>12-14 (8th and 9th graders)</td>
<td>Sexual violence perpetration; findings consistent at 4-year follow-up</td>
<td>Effective</td>
<td>x</td>
<td>JJDP</td>
<td>Effective</td>
<td>JJDP</td>
<td>CEV EBG</td>
</tr>
<tr>
<td><strong>San Diego Breaking Cycles (SDBC)</strong></td>
<td>13-21</td>
<td>Children’s peer relationships, school attendance and performance, decreased delinquent behavior; reduced likelihood of drug use over 16 months</td>
<td>Effective</td>
<td>x</td>
<td>SAMHSA</td>
<td>Effective</td>
<td>SAMHSA</td>
<td>CEV EBG</td>
</tr>
<tr>
<td><strong>Strengthening Families Program</strong></td>
<td>6-12 (children)</td>
<td>1) Children’s internalizing and externalizing problems 2) Parenting practices/parenting efficacy 3) Family relationships</td>
<td>Exemplary</td>
<td>x</td>
<td>SAMHSA</td>
<td>Effective</td>
<td>SAMHSA</td>
<td>CEV EBG</td>
</tr>
<tr>
<td><strong>Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)</strong></td>
<td>3-21</td>
<td>1) Child behavior problems 2) Child symptoms of PTSD 3) Parental emotional reaction to child’s experience of sexual abuse 4) Parental coaching behaviors</td>
<td>Exemplary</td>
<td>x</td>
<td>SAMHISA/CUID</td>
<td>Effective</td>
<td>SAMHISA, CDC</td>
<td>JJDP</td>
</tr>
<tr>
<td><strong>Triple P (Positive Parenting Program)</strong></td>
<td>0-6 (young children)</td>
<td>1) Negative and disruptive child behaviors 2) Negative parenting practices as a risk factor for later child behavior problems 3) Positive parenting practices as a protective factor for later child behavior problems</td>
<td>Exemplary</td>
<td>X</td>
<td>SAMHSA/CDC</td>
<td>Effective</td>
<td>NREPP</td>
<td></td>
</tr>
</tbody>
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# Children Exposed to Violence Program Matrix: Promising Programs

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<tr>
<th>Program Name</th>
<th>Age Range</th>
<th>Outcome Indicator</th>
<th>Source of Information</th>
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</thead>
<tbody>
<tr>
<td><strong>Prevention/ Promotion</strong></td>
<td></td>
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</tr>
<tr>
<td>Child and Family Traumatic Stress Intervention (CFTSI)</td>
<td>7-18</td>
<td>Reduce incidence of chronic PTSD in children</td>
<td>Promising</td>
</tr>
<tr>
<td>Combined Parent Child CBT</td>
<td>4-17</td>
<td>Reduce incidence of trauma-related symptoms</td>
<td>Promising</td>
</tr>
<tr>
<td>DV Home Visitation</td>
<td>0-18</td>
<td>Reduce trauma-related symptoms</td>
<td>Promising</td>
</tr>
<tr>
<td><strong>Intervention/ Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Centered Treatment (FCT)</td>
<td>5-21</td>
<td>Lower residential placement and decrease in duration of placement in first year</td>
<td>Promising</td>
</tr>
<tr>
<td>Multidisciplinary Trauma Treatment: Focused Coping (MBT-T)</td>
<td>3-5</td>
<td>Benefits effects of treatment for reducing PTSD, depression, anxiety, and anger</td>
<td>Promising</td>
</tr>
<tr>
<td>Partners with Families and Children: Spokane</td>
<td>5-11 (Male/ Female)</td>
<td>Stress, depression, anxiety, anger, and external locus of control</td>
<td>Promising</td>
</tr>
<tr>
<td>Program Name</td>
<td>Age Range</td>
<td>Outcome Indicator</td>
<td>Evidence Standard (Rating)</td>
</tr>
<tr>
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</tr>
<tr>
<td>Real Life Heroes</td>
<td>6-12 (Child/Adolescent)</td>
<td>1) Feelings of security with primary caregiver</td>
<td>Promising</td>
</tr>
<tr>
<td>Second Step</td>
<td>6-12 (Child/Adolescent)</td>
<td>1) Social competence and prosocial behavior</td>
<td>Promising</td>
</tr>
<tr>
<td>SAFE-T</td>
<td>6-12 / 13-21</td>
<td>Reduced recidivism for sexual assault charges; reduced criminal behavior; reduced exposure and ameliorated effects of exposure</td>
<td>Promising</td>
</tr>
<tr>
<td>SPARCS</td>
<td>12-19</td>
<td>Overall functioning, conduct-related problems, coping responses, PTSD symptoms</td>
<td>Promising</td>
</tr>
<tr>
<td>TST</td>
<td>6-19</td>
<td>Traumatic stress symptoms, family and school-related problems</td>
<td>Promising</td>
</tr>
</tbody>
</table>
Service Characteristics with Evidence-Based Support for Children Exposed to Violence

Service characteristics are the distinguishing features of a program or program component. Service characteristics include the length, intensity and frequency of service, the service recipient, the type of approach or modality, the location, the combination of various program components and characteristics, etc. In reviewing the research literature on evidence-based programs, common characteristics have emerged in the findings that have been shown to support success or reduce the effectiveness of programs.

This paper highlights two types of service characteristics. The first list below is of facilitators, those characteristics that are common across a range of programs that are associated with better outcomes. The second list is of barriers, or those characteristics that can prevent programs from being successful. The third list included below is of common service and system gaps documented as practical implications discussed in the research literature. These are areas that are underdeveloped in many systems, which you may consider addressing through the adoption of new evidence-based practices or shifts in your system and currently offered services.

Facilitators – These are characteristics common across successfully implemented evidence-based practices.

- Combined Home and Center-based approaches

- Multi-Modal Treatment Approaches— The combination of more than one type of treatment such as individual, family, and advocacy services.

- Parent-Child Dual approach— Both in ensuring safety of all and in effective service delivery, a combined parent-child approach is essential. Simultaneous treatment of mothers and children is consistently documented as an key service feature in a large number of studies in prevention and intervention.

- Parent Training and Psycho-Educational Services— In both Prevention and Intervention, it is important for all providers to share critical information with parents about signs, symptoms and impacts of exposure to violence as well as strategies for providing appropriate support and services.

- Developmentally and culturally appropriate services

Barriers – These are barriers that may hinder progress in service and system reforms.

- Attrition and Retention as a barrier to both practice and research: The difficulty of engaging and retaining families in services is a critical service barrier across all types of services. It is particularly challenging when children have been exposed to violence because families with co-occurring violence experiences have many safety concerns and pressing needs.
• **Mandated Reporting:** One critical service barrier in the area of CEV, particularly in the area of treatment, is the concern by providers that having to make a referral for child maltreatment will dissolve the treatment relationship between the provider and the caregiver and will result in attrition however some early evidence is emerging that demonstrates that with proper training on when and how to report with families in treatment, families can be effectively retained in services and reporting can be effectively managed without sacrificing treatment.

• **Parental Motivation and Expectations May Effect Participation:** Emerging evidence suggests that parents are more likely to stay engaged in services for children with externalizing behaviors. Psycho-educational supports to parents regarding the identification and understanding of their children’s internalizing behaviors may be specifically needed.

• **Lack of Evidence in Practice:** More information, training and awareness about evidence-based practice is needed. Currently, emerging evidence suggests that evidence-informed practices are underutilized and that it is important to integrate research knowledge with the judgment and expertise that comes from practice.

*Common service and system gaps*

There are several common gaps across the service systems that are supported in the literature as practical implications in the research that bear highlighting in an evidence-informed approach. Service delivery systems including providers and advocates need to reorient and reframe work in the area of children's exposure to violence from the perspective of the child and their family using a set of key principles: trauma-informed; safety-focused; culturally and developmentally appropriate.

• **Safety and well-being first:** Not all children exposed to violence will develop trauma or trauma symptoms however their violence exposure and these incidences matter. All children who are exposed to violence are at increased risk for further violence incidences and other types of violent incidents. The more types of exposures a youth has the higher the risks and the greater the likelihood of trauma and other negative outcomes. Service providers and systems need to ask a broad range of questions to fully understand the scope of violence experiences for children and families and to ensure safety for all---the safety of the child and the safety of any other victims in the child’s family. In cases of domestic violence, ensuring the dual safety of both the child and the adult victim is paramount.

• **Trauma-informed and trauma-specific care:** Children exposed to violence are often involved in service systems that serve populations with high rates of exposure to traumatic events. Children who have experienced a traumatic event or multiple events and are experiencing negative psychological symptoms may need trauma specific treatment such as Trauma Focused Cognitive Behavior Therapy or Exposure Therapy. At the same time,
services should be trauma-informed, with an appreciation for the high prevalence of traumatic experiences in persons receiving them, and a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on individuals. A trauma-informed approach can help staff reduce rates of re-traumatization and engage children and families that have experienced trauma.

- **Programs that address the substance abuse and mental health needs of parents:** The substance use and mental health problems of parents can interfere with their ability to parent, and may be related to child maltreatment. Systems should take steps to get parents connected to screening and services for behavioral health problems.

- **Supports for parents:** Formal and informal supports for parents can improve outcomes for children. This can come through evidence based practices like the Strengthening Families Program, specific services like respite care, or parent support groups through community organizations.

- **Strong connections across education, health and social service systems, providers and advocates:** Better service coordination can enable earlier identification of problems, reduced service redundancy, and improved quality of care through wraparound or similar models. Schools especially play a key role for children, given the large amount of time that children spend in school and the strong potential for service delivery and coordination in the school setting.

- **Availability of personnel to serve minority populations:** The lack of providers with the necessary background and skills necessary to provide culturally appropriate care can inhibit the success of programs. Service systems can work to address this issue by providing training about cultural differences, ensuring that services are offered by staff who speak the language of those being served, and working to recruit workers with a similar background to the population being served.
Glossary of Terms

These definitions are intended for practical usage and to support the terms and language used in this evidence-based tool. They are not official definitions of the U.S. Department of Justice or the U.S. Department of Health and Human Services and do not supersede any existing statutory or regulatory definitions.

**Assessment**

Assessment may be either formal or informal. Formal assessment involves the use of tools such as questionnaires, surveys, checklists, and rating scales. Informal assessment usually lacks such structure or organization and may include an interview and series of questions. Assessments are used to gain an understanding of an individual’s current level of functioning or symptoms to guide service planning needs.

**Child Maltreatment**

Child maltreatment includes all types of abuse and neglect of a child younger than 18 by a parent, caregiver, or another person in a custodial role (e.g., clergy, coach, teacher). There are four common types of abuse:

- **Physical abuse** is the use of physical force, such as hitting, kicking, shaking, burning, or other show of force against a child.
- **Sexual abuse** involves engaging a child in sexual acts. It includes fondling, rape, and exposing a child to other sexual activities.
- **Emotional abuse** refers to behaviors that harm a child’s self-worth or emotional well-being. Examples include name calling, shaming, rejection, withholding love, and threats.
- **Neglect** is the failure to meet a child’s basic needs. These needs include housing, food, clothing, education, and access to medical care.

**Children’s Exposure to Violence (CEV)**

Broadly defined, CEV involves being a direct victim of or a witness to violence, crime, abuse, or other violent incidents in the home, school, or community. Exposure may also include being exposed to the aftermath of a violent incident or event.

**Complex Trauma**

Complex trauma refers to the dual problem of exposure to traumatic events and the impact of this exposure on immediate and long-term outcomes. Complex trauma can refer to experiences of multiple traumatic events that occur within a care-giving system including the social environment that is supposed to be a source of safety and stability for children. Often complex trauma exposure refers to the simultaneous or sequential occurrences of child maltreatment that may include emotional abuse and neglect, sexual abuse, physical abuse, and exposure to domestic violence that is chronic and begins in early childhood. Moreover, the initial traumatic experiences (e.g., parental neglect, emotional abuse) and the resulting emotional dysregulation, loss of a safety, loss of direction, and inability to detect or respond to danger cues often lead to subsequent trauma exposure (e.g., physical and sexual abuse, community violence).
• **Continuum of Care**

Continuum of care includes a system of service providers and first responders working together to provide a smooth transition of services for children and families. Communities provide different types of treatment programs and services for children and families experiencing trauma or other mental health issues. The complete range of programs and services is referred to as the continuum of care, usually following a model from identification and referral to assessment, intervention, and treatment. Prevention and crisis response may also be included as part of the continuum addressing children exposed to violence.

• **Crisis Response**

Crisis response is the first responders’ approaches to a crisis and includes two components: (1) reducing trauma with immediate intervention and support and (2) increasing families’ access to services.

• **Domestic Violence**

Domestic violence can be defined as a pattern of abusive behaviors in any relationship that is used by one intimate partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone (Office on Violence Against Women [OVW] definition).

Incidents of inter-spousal physical or emotional abuse perpetrated by one spouse or parent figure on the other spouse or parent figure in the child’s home environment (U.S. Department of Health and Human Services definition).

*Note: Domestic violence is often used interchangeably with family violence or intimate partner violence. OVW makes a clear distinction between domestic violence and family violence; the latter refers to violence between or against family or household members rather than one intimate partner against another. See Intimate Partner Violence below.*

• **Effective**

In general, when implemented with sufficient fidelity, effective programs demonstrate adequate empirical findings using a sound conceptual framework and a high-quality evaluation design (quasi-experimental). This definition is used by the CEV Program Matrix in the *Model Programs Guide* (MPG) and the Office of Juvenile Justice and Delinquency Prevention's (OJJDP’s) *Children Exposed to Violence Evidence-Based Guide* (CEV EBG).
• **Evidence Based**

Evidence-based approaches to prevention or treatment are based in theory and have undergone scientific evaluation. Different levels of evidence exist based on how many and what types of evaluation have been done. For example, a strategy that was tested with two randomized controlled trials has a higher level of evidence than a strategy that was tested in one quasi-experiment. Evidence-based approaches differ from approaches that are based on tradition, convention, or belief or approaches that have never been rigorously evaluated.

• **Exemplary**

In general, when implemented with a high degree of fidelity, exemplary programs demonstrate robust, empirical findings using a reputable conceptual framework and an evaluation design of the highest quality (experimental). This definition is used by the CEV Program Matrix in the MPG and the OJJDP’s CEV EBG.

• **Experimental Design**

An experimental design is one in which the intervention is compared with one or more control or comparison conditions, subjects are randomly assigned to study conditions, and data are collected at both pre-test and post-test or at post-test only. The experimental study design is considered the most rigorous of the three types of designs (experimental, quasi-experimental, and pre-experimental).

• **Incidence**

Incidence indicates the frequency or rate of occurrence of a health-related event or episode during a particular period and usually refers to the number of new episodes of the event during that period.

• **Intervention**

The standard definition for intervention consists of influencing forces or acts that may modify a given state of affairs. In behavioral health, an intervention may consist of an outside process that effects or modifies an individual’s behaviors, situations, cognitions, or emotional states. Intervention is often used interchangeably with the terms treatment and therapy, general terms referencing sessions held between a professional (which may include a mental health professional such as a psychiatrist, psychologist, social worker, or nurse with training and expertise in the art of helping a patient psychologically) and a client.
• Intimate Partner Violence (IPV)

IPV is a serious, preventable public health problem that affects millions of Americans. The term intimate partner violence describes physical, psychological, or sexual harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. IPV can vary in frequency and severity. It occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, severe battering. There are four main types of intimate partner violence:

- **Physical violence** is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one’s body, size, or strength against another person.

- **Psychological/emotional violence** involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources.

- **Psychological/emotional violence** is thought to have occurred when there has been prior physical or sexual violence or prior threat of physical or sexual violence. Stalking is often included among this type of IPV. Stalking generally refers to “harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person’s home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person’s property” (Tjaden & Thoennes, 1998).

- **Sexual violence** is divided into three categories: (1) use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; (2) an attempted or completed sexual act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act (e.g., because of illness, disability, the influence of alcohol or drugs, intimidation or pressure); and (3) abusive sexual contact.

- **Threats** of physical or sexual violence use words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm.

• National Registry of Evidence-based Programs and Practices (NREPP) Evidence Standard Rating

NREPP evidence standard rating measures the quality of research for an intervention’s reported results using the following criteria: (1) reliability of measures; (2) validity of measures; (3) intervention fidelity; (4) missing data and attrition; (5) potential confounding variables; and (6) appropriateness of analysis. Each intervention outcome is rated on a 4-point scale for each criterion; the points are added to create an overall score for each outcome. For more information, go to [http://www.nrepp.samhsa.gov/ReviewQOR.aspx](http://www.nrepp.samhsa.gov/ReviewQOR.aspx).
• **Observational Study**

An observational study observes individuals or measures certain outcomes. No attempt is made to affect the outcome (e.g., no treatment is given).

• **Post-Traumatic Stress Disorder (PTSD)**

The American Psychiatric Association defines PTSD as having specific symptoms. For example, the child continues to experience the event through nightmares, flashbacks, or other symptoms for more than a month after the original experience; the child has avoidance or numbing symptoms (he or she will not think about the event, has memory lapses, or feels numb in connection with the events); or the child has feelings of arousal, such as increased irritability or difficulty sleeping. Every child diagnosed with PTSD is experiencing child traumatic stress, but not every child experiencing child traumatic stress has all the symptoms of a PTSD diagnosis.

• **Prevalence**

Prevalence refers to the total number of people with a disease or condition in a given population at a specific time and is often used as an estimate of how common a condition is within a population.

• **Prevention**

Prevention is an act of impeding or intervening to stop a problem before it occurs or to reduce the impact of the problem. Prevention is achieved through the application of strategies or interventions, which are used to address a broad range of problems such as violence, physical disease, and mental disorder.

• **Promising Programs**

In general, when implemented with minimal fidelity, promising programs demonstrate promising empirical findings using a reasonable conceptual framework and a limited evaluation design (e.g., single group pre-/post-test) that requires rigorous experimental techniques (see Effective and Exemplary entries) to demonstrate outcomes. This definition is used by the CEV Program Matrix in MPG and the OJJDP’s CEV EBG.

• **Promotion**

Promotion involves intervening at the individual, group, or population level to optimize functioning by addressing determinants of resilience and positive functioning with the ultimate goal of improving outcomes.

• **Protective Factors**

Protective factors include those aspects of the individual and his or her environment that buffer or moderate the effect of risk of a developing a problem.
• **Public Health Approach**

A public health approach to children’s mental health requires that there be a population focus that balances addressing children’s mental health issues with optimizing children’s positive mental health. It maintains that collaborative efforts of a broad range of formal and informal systems and sectors impact children’s mental health and increase emphasis on creating environments that promote and support optimal mental health and development of skills that enhance resilience. It also requires that the approach is adapted to fit different settings and contexts.

• **Quasi-Experimental Design**

A quasi-experimental design (1) compares the intervention with one or more control or comparison conditions, (2) does not randomly assign subjects to study conditions, and (3) collects data at pre-test and post-test, at post-test only, or in a time series study. The quasi-experimental design provides strong but more limited scientific rigor relative to an experimental design.

• **Randomized Experiments (sometimes called randomized controlled trials or RCTs).**

RCTs randomly assign individuals to different groups. Usually, one group is exposed to an intervention treatment and one group is not. RCT interventions can range from individualized treatment to school-wide prevention programs. Data are collected on both groups before and after the intervention to measure the effects of the intervention. Randomized experiments give the most confidence that an intervention is making a difference.

• **Research Design**

Research and evaluation can be conducted in many different ways. The type of design used determines how confident researchers can be in their results. In evaluation, strong research designs confidently show that changes in the desired outcomes are because of the strategy under evaluation.

• **Resilience**

Resilience is the qualities and factors that may help an individual withstand many negative effects of adversity. These factors include self-esteem, healthy attachment and relationships, autonomy, environmental factors, and other factors that balance exposure to negative or traumatic events. Children’s resilience usually consists of “bouncing back” after exposure to violence or traumatic event, sharing feelings about the event, and motivation and courage to move forward.

• **Reliability**

Reliability is the repeatability and accuracy of measurement or the degree to which an instrument measures the same thing each time it is used under the same condition with the same subjects.

• **Risk Factors**

Risk factors are conditions in the individual or environment that can predict an increased likelihood of developing a problem.
• **Stress to Trauma Continuum**

Stress to trauma continuum looks at the individual’s response to stress by the systems’ effects on the body, not the stressful event itself. It distinguishes different types of stress:

- **Positive stress response** is a normal and essential part of healthy development, characterized by brief increases in heart rate and mild elevations in hormone levels. Situations that trigger a positive stress response are the first day with a new caregiver or receiving a vaccination.

- **Tolerable stress response** activates the body’s alert systems to a greater degree because of more severe, longer lasting difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury. If the activation is time limited and buffered by relationships with adults who help the child adapt, the brain and other organs recover from what might be damaging effects.

- **Toxic stress response** can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems and increase the risk for stress-related disease and cognitive impairment well into adulthood.

• **System Response**

System responses to CEV include responses from health care providers, law enforcement, courts and criminal justice systems, domestic violence services, child protective services, and first responders in crisis situations. In the continuum, the agencies serve as a responder, crisis manager, or partner in what is intended to be a safety structure to protect adult and child victims.

• **Trauma**

Children and adolescents experience trauma under different sets of circumstances. Traumatic events involve (1) personally experiencing a serious injury or witnessing a serious injury to or the death of someone else, (2) facing imminent threats of serious injury or death to oneself or others, or (3) experiencing a violation of personal physical integrity. These experiences usually call forth overwhelming feelings of terror, horror, or helplessness. Because these events occur at a particular time and place and are usually short lived, they are referred to as **acute traumatic events**. These kinds of traumatic events include the following:

- School shootings
- Gang-related violence in the community
- Terrorist attacks
- Natural disasters (e.g., earthquakes, floods, hurricanes)
- Serious accidents (e.g., car or motorcycle crashes)
- Sudden or violent loss of a loved one
- Physical or sexual assault (e.g., beatings, shootings, or rapes)
Exposure to trauma can occur repeatedly over long periods. These experiences call forth a range of responses, including intense feelings of fear, loss of trust in others, decreased sense of personal safety, guilt, and shame. These are chronic traumatic situations and include the following (http://www.nctsnet.org/nccts/nav.do?pid=faq_def):

- Some forms of physical abuse
- Long-standing sexual abuse
- Domestic violence
- Wars and other forms of political violence

**Trauma-informed Care**

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma plays in their lives. When a human service program takes the step to become trauma informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual who is seeking services.

Trauma-informed treatment programs generally recognize the following:

- The survivor’s need to be respected, informed, connected, and hopeful regarding his or her recovery
- The relationship between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, anxiety)
- The need to work collaboratively with survivors, family members and friends of the survivor, and other human services agencies in a manner that empowers the survivor and other consumers

**Trauma Symptoms**

When children have a traumatic experience, they react in both physiological and psychological ways. Their heart rate may increase, and they may begin to sweat, feel agitated and hyperalert, feel “butterflies” in their stomach, and become emotionally upset. These reactions are distressing, but they are normal. They are the bodies’ way of protecting and preparing to confront danger.

However, some children who have experienced a traumatic event will have longer lasting reactions that can interfere with their physical and emotional health. Children who suffer from child traumatic stress have been exposed to one or more traumas over the course of their lives and have developed reactions that persist and affect their daily lives after the traumatic events end. Traumatic reactions can include a variety of responses such as intense and ongoing emotional upset, depressive symptoms, anxiety, behavioral changes, difficulties paying attention, academic difficulties, nightmares, physical symptoms such as difficulty sleeping and eating, and aches and pains, among others. Children who suffer from traumatic stress often have these symptoms when reminded of the traumatic event. Many adults may experience these reactions from time to time; however, when a child experiences child traumatic stress, these reactions interfere with the child’s daily life and ability to function and interact with others. Some children may develop ongoing symptoms that are diagnosed as PTSD.
• **Treatment**

Treatment may come in many forms, but all methods have the goal of improving a situation, relieving symptoms, managing crisis, or dealing with an issue through communication with and attention given to the individual experiencing the issue. Treatment usually involves a developmentally appropriate intervention or therapy.

• **Validity**

Validity is the truthfulness of the study's measurement or the degree to which an instrument measures what it is supposed to measure.

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*The definitions for prevention, intervention, and treatment reflect the operational use of the terms in the matrix of evidenced-based programs provided; however, it is recognized that different service sector use different terminology to refer to prevention, intervention, and treatment components. These other common terms are provided below for clarification purposes.*

• **Primary Prevention**

Approaches that attempt to prevent the problem from ever occurring. In violence, this would include strategies that attempt to prevent initial victimization or perpetration.

• **Secondary Prevention**

Approaches that occur immediately after the problem occurs to deal with short-term consequences or to keep the problem from getting worse.

• **Tertiary Prevention**

Approaches that focus on the long-term response to the problem to deal with lasting consequences or to prevent recurrence.

• **Universal Interventions**

Approaches that are aimed at helping entire groups or the general population regardless of individual risk for violence perpetration or victimization. Groups can be defined geographically (e.g., entire school or school district) or by characteristics (e.g., ethnicity, age, gender).

• **Selected Interventions**

Approaches that are aimed at helping those who are thought to have a heightened risk for violence perpetration or victimization.

• **Indicated Interventions**

Approaches that are aimed at helping those who have already perpetrated violence or have been victimized.
High Fidelity Implementation of Evidence-based Practices

Delivery of an evidence-based practice (EBP) with fidelity is correlated with intervention success. Hallmarks of high fidelity implementation of EBPs as identified in the National Implementing Evidence-Based Practices Project, supported by SAMHSA, the John D. and Catherine T. MacArthur Foundation, the Robert Wood Johnson Foundation, and a variety of additional public and private funders include:

COORDINATED, MULTI-LEVEL SUPPORT
Dedicated leadership, skilled supervision, and effective service provision are each essential to the delivery of EBPs. Research indicates that alignment of resources and priorities across these levels is a key factor in high fidelity implementation of EBPs.

TOOLKITS
Toolkits for implementation aimed at a variety of stakeholders can support consistent, high-quality delivery of an EBP. Practice-specific materials can include workbooks, instructional videos, informational brochures for clients and community members, and tools for quality improvement. Articles explaining the scientific support for the EBP and testimonials from past participants allow practitioners to understand the effectiveness of the practice from both an empirical perspective and a personal, real-world one.

CONSULTATION & TRAINING
Skilled Consultant/Trainers (CATs) provide ongoing instruction and consultation to practitioners, supervisors, and administrators to support preparation for and delivery of an evidence-based practice. A CAT delivers customized support for a site implementing an EBP, providing bi-monthly site visits during the first year of implementation, participating in group supervision and team meetings, delivering trainings, and problem-solving to increase fidelity and improve service quality.

http://rsw.sagepub.com/content/19/5/569
FIDELITY MEASUREMENT

Ongoing monitoring helps practitioners know how they are doing in delivering an evidence-based practice according to its model and what they can do to improve implementation. Assessment scales can illuminate achievement of fidelity in specific core elements of a model, both structural and clinical. Other methods of data collection, including practice observations and interviews with key stakeholders, can help tell the story behind the numbers. Model developers will be instrumental in developing fidelity scales (if they have not already been created).

Implementation monitors carry out two-day, on-site fidelity assessments, which include stakeholder interviews, shadowing, and completion of fidelity scales.

IMPLEMENTATION MONITORS

Implementation monitors collect qualitative and quantitative information about the process and outcomes of the implementation of an evidence-based practice. Implementation monitors make monthly visits to sites to check on progress, gather data, talk with practitioners and consumers, and answer any questions they may have. Every six months, the implementation monitors work with the CATs to conduct a fidelity review for each site. After one year of implementation, a detailed fidelity assessment is completed. Implementation monitors prepare a report, craft recommendations for improving fidelity, and discuss their feedback with each site’s steering committee.