The author(s) shown below used Federal funds provided by the U.S. Department of Justice and prepared the following final report:

Document Title:	**Tackling Urban Inequalities: A Process Evaluation of the Boston Defending Childhood Initiative**
Author(s):	**Lama Hassoun Ayoub**
Document No.:	**248929**
Date Received:	**June 2015**
Award Number:	**2010-IJ-CX-0015**

This report has not been published by the U.S. Department of Justice. To provide better customer service, NCJRS has made this federally funded grant report available electronically.

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RESEARCH

Tackling Urban Inequalities

A Process Evaluation of the Boston Defending Childhood Initiative

By Lama Hassoun Ayoub

Submitted to the U.S. Department of Justice

June 2015

This project was supported by Grant No. 2010-IJ-CX-0015, awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this report are those of the authors and do not necessarily reflect those of the Department of Justice.

Abstract

As part of the U.S. Attorney General's *Defending Childhood Demonstration Program*, eight sites around the country were funded by the Office of Juvenile Justice and Delinquency Prevention and the Office of Violence Against Women to use a collaborative process to develop and implement programming to address children's exposure to violence in their communities. Boston, Massachusetts was chosen as one of these sites, and, since 2010, has received over $3 million in federal funding for this initiative.

Led by the Boston Public Health Commission, the Boston Defending Childhood Initiative (Boston DCI) implemented a variety of strategies that targeted the highest risk neighborhoods in the city. Working predominantly with communities of color, Boston DCI developed a model for centralizing the importance of racial/social justice and health equity during both planning and implementation in nearly every approach for addressing children's exposure to violence.

The specific strategies implemented include, but are not limited to the following:

- Treatment and Healing: Boston DCI funded to two community health centers in target neighborhoods, which provided clinical and referral services and support families with children exposed to violence.

- Prevention: To prevent children's exposure to violence, Boston DCI funded ten local community organizations to implement family nurturing programs; implemented Coaching Boys into Men with youth at 29 community centers; and engaged youth through healthy relationship leadership promotion projects.

- Community Awareness: Through a youth-led process, a web series, titled "The Halls," was produced and publicized throughout Boston to raise awareness about violence in the lives of youth.

- Professional Training: Boston DCI provided numerous professional trainings, with a focus on long-term training models that ensured that participants were engaged and implementing the training appropriately. Specifically, there were three learning communities on therapeutic interventions with children, as well as youth worker trainings, and a learning collaborative on making early childhood organizations trauma-informed.

There were numerous barriers and challenges to the implementation of each program component; there were also facilitators that helped moved project activities along, such as Boston's resource-rich environment and the political commitment of local leaders, including two successive mayors. Many aspects of this model are replicable and the commitment to health equity and sustainable strategies, such as long-term professional training and capacity building, are part of the notable achievements of the Boston Defending Childhood Initiative.

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Acknowledgements

This study was made possible through a grant from the National Institute of Justice (NIJ) of the U.S. Department of Justice and through the support of the Office of Juvenile Justice and Delinquency Prevention (OJJDP). We are grateful to our grant manager, Dara Blachman-Demner, for her assistance throughout the project. The opinions, findings, and conclusions or recommendations expressed in this publication are those of the author and do not necessarily reflect the positions or policies of the U.S. Department of Justice.

I am thankful for the guidance of Rachel Swaner and Michael Rempel and the gracious assistance of Elise Jensen at the Center for Court Innovation. Thanks to Futures Without Violence staff, including Lonna Davis and Casey Corcoran. Thanks also to Julia Kohn, Kathryn Ford, Peter Jaffe, David Wolfe, and Marcie Campbell for their assistance in the early stages of this project. Thanks to everyone who reviewed earlier versions of this report, including the NIJ reviewers.

And finally, my gratitude goes to the Boston Defending Childhood staff and partners, who have triumphed over many challenges these past few years. Special thanks to Stephanie Doyle for her hard work, patience, and commitment, and Catherine Fine and Betsy McAlister Groves for their leadership. Thanks also to Victor Santana.

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Chapter 1
Introduction

About the Defending Childhood Initiative

A recent national survey found that 60 percent of American children have been exposed to violence, crime, or abuse in their homes, schools, or communities—and that 40 percent were direct victims of two or more violent acts.[1] In an effort to address children's exposure to violence, the United States Department of Justice (DOJ), under the leadership of Attorney General Eric Holder, launched the *Defending Childhood Initiative.* This national initiative aims: 1) to prevent children's exposure to violence; 2) to mitigate the negative impact of such exposure when it does occur; and 3) to develop knowledge and spread awareness about children's exposure to violence. The motto of the initiative is "Protect, Heal, Thrive."

A major component of this initiative is the *Defending Childhood Demonstration Program*, which involved the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the Office of Violence Against Women (OVW) in providing funding to eight sites around the country to address children's exposure to violence in their communities through intervention and prevention programming, community awareness and education, and professional trainings. The eight sites are: Boston, MA; Chippewa Cree Tribe, Rocky Boy's Reservation, MT; Cuyahoga County, OH; Grand Forks, ND; Multnomah County, OR; Portland, ME; Rosebud Sioux Tribe, SD; and Shelby County, TN.

The Center for Court Innovation was funded by the National Institute of Justice to conduct the evaluation of the demonstration program, and Futures Without Violence was funded by OJJDP to serve as the technical assistance provider. The Boston Public Health Commission, in partnership with the Child Witness to Violence Project of Boston Medical Center, was chosen to lead one of the demonstration project sites. This process evaluation report of Boston's Defending Childhood Initiative is one in a series of multi-method process evaluations of six of the chosen sites. A report synthesizing the major cross-site lessons learned from all six process evaluations is issued alongside the individual site reports.[2]

Whereas the current research focuses on the implementation of chosen strategies, a previous report issued in 2011 explored and identified cross-site themes and lessons from the initial strategic planning process.[3]

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[1] Office of Juvenile Justice and Delinquency Prevention. 2009. Children's Exposure to Violence: A Comprehensive National Survey. Available at http://www.ojp.usdoj.gov/ojjdp. Last retrieved 8/14/14

[2] Swaner R, Hassoun Ayoub L, Jensen E, and Rempel M. 2015. *Protect, Heal, Thrive: Lessons Learned from the Defending Childhood Demonstration Program.* New York: Center for Court Innovation.

[3] R Swaner and J Kohn. 2011. *The U.S. Attorney General's Defending Childhood Initiative: Formative Evaluation of the Phase I Demonstration Program*. New York, NY: Center for Court Innovation. Available at http://www.courtinnovation.org/sites/default/files/documents/Defending_Childhood_Initiative.pdf.

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Besides the demonstration program, other components of the larger *Defending Childhood Initiative*, which are outside the scope of the current evaluation, include the Task Force on Children's Exposure to Violence[4] and the Task Force on American Indian and Alaskan Native Children Exposed to Violence.[5]

The Boston Defending Childhood Initiative

Boston is the largest city in New England, with a population of over 618,000.[6] Boston is also the capital of Massachusetts and one of the oldest cities in the United States. The greater metropolitan area, referred to as Greater Boston, is the tenth largest metropolitan area in the country and is home to over 4.5 million people.[7]

In October 2010, OJJDP awarded the Boston Public Health Commission (BPHC), in partnership with the Child Witness to Violence Project, $160,000 to embark on a collaborative process that culminated in a needs assessment and strategic plan for addressing children's exposure to violence in the city of Boston. This was considered Phase I of the *Defending Childhood Demonstration Program*. In October 2011, BPHC was awarded $2 million to implement its strategic plan between October 2011 and September 2013, considered Phase II of the initiative. The city was then awarded an additional $610,000 to continue their work between September 2013 and September 2014. Finally, on October 1, 2014, OJJDP awarded the Boston site a $612,260 grant to support sustainability through September 2017.

Led by the Boston Public Health Commission and Boston Medical Center, the Boston Defending Childhood Initiative (Boston DCI) is an effort to prevent children's exposure to violence (CEV), reduce its negative impact, and increase public awareness. The official goal of the Boston DCI is to prevent and reduce the impact of exposure to violence in homes, schools, and communities for children ages 0 to 17 years.

This process evaluation was prepared by Center for Court Innovation research staff. It is based on data collected and research conducted between October 2011 and September 2014. Research activities included an extensive document review, primary quantitative data collection, two site visits, observations of two collaborative body meetings, multiple conference calls, and 30 interviews with 21 staff members and partners of the Boston DCI.

Social and Historical Context

Boston is known to be a city of neighborhoods, consisting of 15 distinct neighborhoods that vary greatly in culture, racial composition, socioeconomic outcomes, and related measures. The population has become increasingly diverse over time. As of 2010, the city's residents were mostly white (47%), followed by African American/black (22.4%), Hispanic (17.5%), and Asian (8.9%).

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[4] The full report of this task force can be found here: http://www.justice.gov/defendingchildhood/cev-rpt-full.pdf.
[5] The full report of the American Indian and Alaska Native Task Force can be found here: http://www.justice.gov/sites/default/files/defendingchildhood/pages/attachments/2014/11/18/finalaianreport.pdf.
[6] U.S. Census. 2010.
[7] Table 1. Annual Estimates of the Population of Metropolitan and Micropolitan Statistical Areas: April 1, 2010 to July 1, 2011 (CBSA-EST2011-01)" (CSV). United States Census Bureau, Population Division.

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The Hispanic population has nearly tripled since 1980. While English remains the primary language in most Boston homes, 35% of Boston residents report speaking a language other than English at home.

When compared to Boston overall, neighborhoods such as Roxbury, North Dorchester, and South Dorchester (circled in red in Figure 1) have greater numbers of families with income below the poverty level and individuals whose educational attainment is less than a high school diploma. These neighborhoods also have higher percentages of residents of color. On the other end of the spectrum, neighborhoods such as South Boston, Back Bay, and Fenway (green arrows in Figure 1) have a significantly higher average median income than Boston overall.

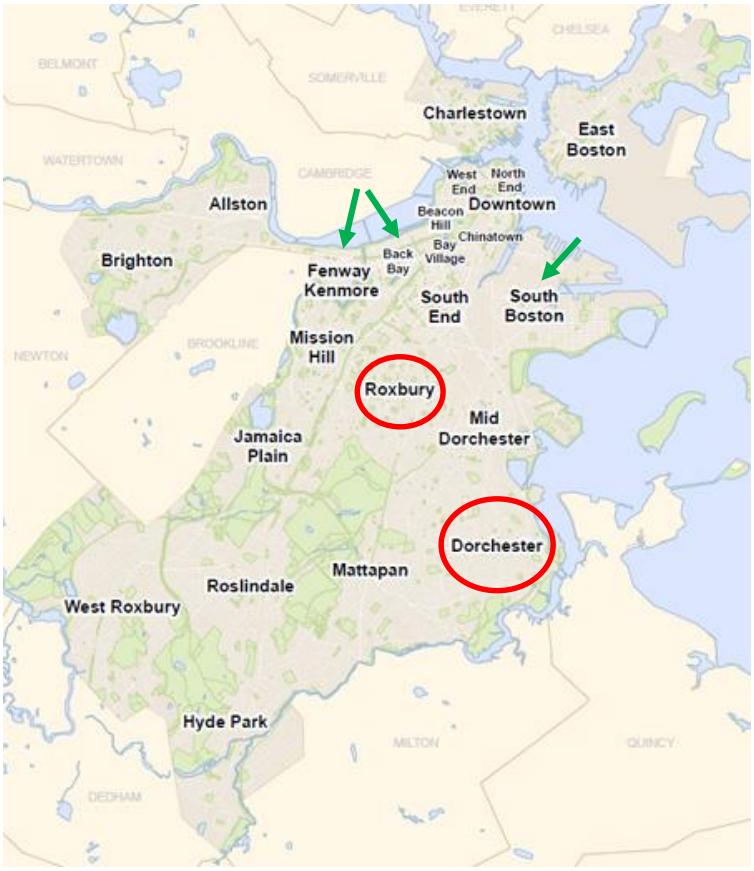

Figure 1. City of Boston and its neighborhoods (Boston Public Health Commission)

Citywide, racial disparities exist in areas such as poverty, median household income, and educational attainment. In 2010, an estimated 23% of Boston residents were living below the poverty line. However, only about 15% of white residents were living below the poverty line, compared to nearly 30% of black residents and 35% of Hispanic residents. While nearly all households experienced a decrease in median annual household income between 2009 and 2010, white Bostonians had the highest median annual income at over $50,000, while all other races were below $50,000. Hispanic households had the lowest median annual income, under $25,000. Black male residents had an unemployment rate of 32%, almost four times the rate of 9% for white

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male residents. Similarly, the percentage of Boston residents with less than a high school diploma was highest among Hispanic adults (32%), followed by Asian adults (24%) and Black adults (20%). By contrast, only 7% of white residents had less than a high school diploma, highlighting racial disparities in educational attainment.[8]

About 17% of Boston residents are under 18, with children younger than five making up the greatest percentage. The child population displays slightly different demographics: one in three children in Boston is black, 30% are Hispanic, 23% are white, and 7% are Asian. Although a quarter of the city's residents were born outside of the United States, 92% of Boston's children were born in the United States. Although 23% of Boston residents are living below the poverty line, 30% of children and youth under 18 are living in poverty. In 2011, 33% of Boston's homeless population consisted of children, a rate that has been increasing since 2004.[9]

Because Boston is one of the oldest cities in the country, it is the home of many of the country's first schools. The first public school in the country was established there in 1635, as well as the first public school system in 1647. There are currently 127 schools in the Boston Public School system with 57,100 students as of 2013-2014 school year. Notably, the demographics of public school children do not represent the city overall. Only 13% of students attending public school are white. About 40% are Hispanic, 36% are black, and 9% are Asian. The majority (75%) of students in the public school system are eligible to receive free or reduced price meals. The school system estimates that about 26% of children living in Boston do not attend Boston public schools and are generally attending parochial schools, private schools, public charter schools, or suburban schools (through a special program).[10]

Children's Exposure to Violence and 2012 Baseline Community Survey Results

The major types of children's exposure to violence in Boston, as identified by key stakeholders, include community violence, family violence, relationship violence, and school violence.[11]

- Community violence, including shootings, is particularly a concern for young black youth, who are disproportionately affected.
- Family violence, including exposure to violence between family members in the household and child abuse and maltreatment such as physical or sexual abuse by a caretaker.
- Relationship violence including teen dating violence and sexual assault.
- School violence refers to exposure to violence in a school environment, including bullying, harassment, or being threatened or injured with a weapon on school property.

[8] Health of Boston 2012-2013: A Neighborhood Focus. 2013. Boston, MA: Boston Public Health Commission Research Office.
[9] Health of Boston 2012-2013: A Neighborhood Focus. 2013. Boston, MA: Boston Public Health Commission Research Office.
[10] Boston Public Schools at a Glance 2012-2013. 2013. Boston, MA: Boston Public Schools.
[11] Boston Defending Childhood Strategic Plan.

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According to Boston's Youth Risk Behavior Surveillance Survey (YRBS), in 2011, 8% of students did not go to school because they felt that they would be unsafe at school or on their way to/from school. About 15% of students reported carrying a weapon and 6% reported carrying a weapon on school property. When asked about bullying, 14% of students reported being bullied on school property, and 11% reported being electronically bullied during the past year.

With all of these types of violence, children of color in Boston are disproportionately affected. In terms of community violence, the victimization rate for black males is 14 times greater than that of white males. The neighborhood of Roxbury, which is a predominantly lower income community of color, has nearly two and half times the violent victimization rate of Boston overall (23.1 victims per 10,000 compared to 9.6 victims per 10,000). Roxbury also has the highest rate of non-fatal gunshot and stabbing victims of all Boston neighborhoods. In 2011, 40% of Boston's high school students identified gunshots, shootings, and gun violence as a "big problem" in their neighborhood. This percentage was higher in Roxbury (54%), but other neighborhoods facing above-average socioeconomic disadvantages, Dorchester, Mattapan, Mission Hill, and the South End, saw similar percentages reporting violence as a big problem to Boston overall.[12]

As part of the outcome evaluation of the *Defending Childhood* demonstration projects, the Center for Court Innovation conducted a baseline and 2.5-year follow up telephone survey. While the full description of the methods and results of these surveys will be reported in a separate forthcoming outcome evaluation report in 2015, a summary of the key baseline results for the Boston site is included here to provide context for the underlying need and development of strategies related to children's exposure to violence in the city.

The Boston baseline survey yielded a total sample of 1,001 completed phone interviews. The sample included adults aged 18 to 97, with a mean age of 43.7 years. Fifty-three percent of respondents were female, and most (75%) had lived in Boston for more than 10 years. About a third of the sample identified as African American or Black (32%), 47% identified as White, 8% identified as Hispanic or Latino and 5% identified as Asian.

Fifty-three percent of adults said they had been exposed to violence in the past year, with 51% having witnessed violence and 17% having been a direct victim. The most common exposure was seeing someone else threatened with physical harm (42%), followed by seeing someone else slapped, punched, or hit (35%). Parents and caregivers were asked about children's exposure to violence. Fifty-four percent of these respondents reported that at least one of their children had been exposed (as a victim or witness) to any type of violence in the past year, with the most common perpetration from peers and siblings. Twelve percent reported that someone close to their child (such as a friend, neighbor, or family member) had been murdered in the last year.

Respondents who identified as Black or Hispanic were more likely to report exposure to violence in the past year (59% for both groups) compared to their white counterparts (50%). Fifty-two percent of Black or Hispanic parents and caregivers reported that at least one of their children had

[12] Health of Boston 2011. 2012. Boston, MA: Boston Public Health Commission Research and Evaluation Office. The Health of Boston Reports can be found at: http://www.bphc.org/healthdata/health-of-boston-report/Pages/Health-of-Boston-Report.aspx

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been exposed (as a victim or witness) to any type of violence in the past year, compared to 55% of white parents and caregivers.

History of Related Programs

Despite the high levels of poverty and violence, Boston has many community resources and programs. The city has numerous existing intervention services for children and families exposed to violence. The Child Witness to Violence Project at Boston Medical Center provides trauma-focused therapy to children affected by violence. Boston Medical Center is located in the South End and on the outskirts of Dorchester, two of the neighborhoods with high socioeconomic need and crime. The BPHC, through its Division of Violence Prevention, also oversees the Family Justice Center, a one-stop resource center for victims of violence and their families. The Family Justice Center, also located near Boston Medical Center, houses the Children's Advocacy Center, which provides a multidisciplinary response to child victims of sexual and physical abuse, as well as a group of partner agencies who provide services on site, including representatives from the Boston Police Department, the district attorney's office, LGBTQ agencies, and advocacy organizations.

The BPHC also has a history of collaboration to address violence-related issues in Boston. One key example is the city's Violence Intervention and Prevention (VIP) initiative—a program to reduce youth violence and promote healthy and safe neighborhoods in area "hot spots" through coalitions in each neighborhood. Boston Public Schools have long had a behavioral health department that seeks to address the needs of children in the schools through service provision.

Despite extant strong programs in the city, there remained a large gap in services because of the particular needs of communities of color and those with concentrated disadvantage. Many of the communities most affected by violence had much fewer resources or access to resources than the rest of the city. This is the gap that the Boston Defending Childhood Initiative was designed to fill.

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Chapter 2
The Oversight and Staffing Structure of the Initiative

This chapter provides a brief overview of the two central structures that oversee and operate the Boston Defending Childhood Initiative: a *Collaborative Body* that meets regularly and, with the help of a smaller Leadership Team and a Core Management Team, provides general planning, oversight, and coordination; and dedicated *project staff* members who are charged with implementing the everyday work of the initiative.

The Collaborative Body and Leadership Team

Led by the Boston Public Health Commission (BPHC), the Boston Defending Childhood Initiative (Boston DCI) is a collaborative effort of over 65 organizations designed to prevent children's exposure to violence (CEV), reduce its negative impact, and increase public awareness. The Initiative is housed at the Boston Public Health Commission and is led by a Collaborative Body and Leadership Team.

The Collaborative Body

The Collaborative Body involves over 65 partners that represent an expansive range of sectors, areas of concern (i.e., types of violence addressed by the organization), state and local agencies, and diverse cultural groups and vulnerable populations. Appendix A provides a full list of partners, organized by area of expertise. Key city agencies including Boston Public Schools and the Boston Police Department, as well as large non-profits such as Boston Medical Center, Boston Area Rape Crisis Center, Child Witness to Violence Project, and the Boston Center for Youth and Families, are involved. Most of the Collaborative Body members are high-level representatives from their home agencies who generally possess the requisite authority to make or recommend changes where necessary to better address CEV.

The Collaborative Body holds quarterly meetings for planning and to provide guidance and recommendations on general project initiatives. A full list of meetings can be found in Appendix B. In Year One, the Collaborative Body played an important role in determining the priorities, strategies, and activities deployed by Boston DCI. As implementation began, the Collaborative Body meetings became more focused on oversight, ongoing management, and problem solving. During the quarterly meetings, members received a report from the Leadership Team about the Initiative in general and also learned about specific aspects of the work that was underway. The Collaborative Body meetings also usually involved breaking out into discussion groups and/or brainstorming sessions.

The Leadership Team and the Collaborative Body have worked to include three youths and three parents in the planning and oversight of the initiative. The youths are peer leaders from Start

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Strong[13] and were instrumental in developing aspects of the initiative related to youth programs. The parents are from Mothers for Justice and Equality, a grassroots organization of mothers working to combat violence and advocate for safe neighborhoods for children. Their motto is "Violence is not acceptable in any child's life." The organization has a subcontract from the Defending Childhood Initiative to coordinate the Parent Council, an advisory council of parents. This council involves 10 women and a few men; three representatives of the council attend the Boston DCI Collaborative Body's quarterly meetings. The Parent Council meets bi-monthly, and discusses Collaborative activities.

In general, Collaborative Body members indicated that they were satisfied with the work accomplished by the Boston DCI and through their participation in the Collaborative. Because of the comprehensive nature of the Collaborative Body, most of those interviewed believed that all relevant organizations and fields were represented. A few partners felt that the youth voice was lacking; it was difficult to maintain continuous youth involvement on the Collaborative Body throughout the years. Additionally, while Boston Police Department representatives indicated that they were heavily involved and that they felt the Collaborative Body was inclusive, other partners felt that there could be more of a criminal justice presence, including representatives from juvenile detention or probation. Other suggestions for additional Collaborative Body members included local politicians, foundations and other funders, more hospitals, and more universities.

The Leadership Team

The Leadership Team is a group of 15 members from the larger Collaborative Body, who meet monthly to oversee the development and implementation of the project's Strategic Plan. This multidisciplinary group provides direction for and feedback on all needs assessment, planning, and implementation initiatives.

The Core Management Team

The core management team (CMT) consists of three people who are responsible for implementing and supporting all aspects of the initiative, as well as monitoring performance measures. The Boston Defending Childhood Project Director, Training Manager, and the Chair of the Collaborative Body compromise the Core Management team, and they meet weekly. The CMT members are physically located at the Boston Public Health Commission offices and are in constant contact about the initiative, working together to plan Collaborative Body meetings, monitor program implementation, and troubleshoot problems.

Project Staffing

The OJJDP funding to Boston DCI went through the Boston Public Health Commission (BPHC), specifically the Division of Violence Prevention. The staffing structure of the project has included the following positions, all of whom are employed by the BPHC.

[13] Start Strong is a Robert Wood Johnson Foundation-funded program focusing on the primary prevention of teen dating violence, and healthy relationships among middle schoolers ages 11 to 14.

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- Project Director: The project director provides oversight of the project; sits on both the Collaborative Body and Leadership Team; and is part of the Core Management Team. The project director is responsible for the implementation of the overall vision and for the day-to-day operations of the project. This position is usually the main contact for OJJDP as well as the technical assistance providers and the evaluation team. The project coordinator is part of the Core Management Team, coordinates meetings for the Collaborative Body and the Leadership Team, and reports to the Boston Public Health Commission's Director of the Division of Violence Prevention.

- Training Manager: The training manager, hired in January 2013, oversees all professional training efforts at Boston DCI as well as the direct service provision. This position is fully funded by the grant, is also based at the BPHC offices, and reports to the project director. In 2014, this position became fully funded by a new grant received from Children's Hospital, Boston, but continued to operate in the same capacity.

- Project Manager/Policy Analyst: The policy analyst of the BPHC Division of Violence Prevention spent about 50 percent of her time on the Defending Childhood Initiative as a project manager (in kind). In this role, she assisted with policy-related issues and managed both the requests for proposals, subcontracts, and the trainings for two training efforts of Boston DCI (described below). This position reported to the project director.

- Chair of the Collaborative Body: The position of the Chair of the Collaborative Body and the Leadership Team (also part of the Core Management Team) was a part-time position, fully funded through Boston DCI. The Chair leads, and facilitates meetings, and ensures that the mission of the project is met. Although not involved in the details of day-to-day operations, the Chair is heavily involved in decision-making.

- Consultants: During Phase I of the project, Boston DCI engaged two external consultants to assist with the strategic planning process and two evaluation consultants who assisted with research and evaluation considerations (November 2010 – May 2011). Additionally, in December 2011, Boston DCI employed a consultant to lead the development and implementation of the Breakthrough Series Learning Collaborative, described in Chapter 3.

All of these positions were fully or partially funded by the Department of Justice grant. The training manager was hired late in the project, in 2013, but otherwise, there have been no changes in the individuals who fill these roles.

Primarily, Boston DCI has developed subcontracts with local and grassroots organizations in its target areas in order to accomplish its goals. While the exact nature of those subcontractors and their work is discussed in Chapter 3, the funding has led to the creation of several full-time positions at the subcontracting agencies, fully funded by the Defending Childhood grant:

- Clinician (2): Clinicians provide direct social and mental health services at health centers that received subcontracts from Boston DCI. Clinicians are trained to apply evidence-based trauma treatment and receive additional training by the organizations where they work.

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- Family Partner (2): Family partners are a parent, guardian, grandparent, or caregiver with the decision making responsibility of raising a child AND lived experience navigating systems related to being exposed to trauma. They are not in current crisis and have had success managing and advocating for personal family needs; child and family could still be in services. They work closely with the clinician to ensures family voice in team meetings, provides family support services, leads family engagement activities, and coordinates community-based services. They have also received training in evidenced based trauma treatments.

For the purposes of this study, programs and interventions with at least two strong evaluation designs (randomized trials or quasi-experiments) are considered evidence-based. Programs with research supporting their effectiveness that do not reach this threshold are considered promising.[14]

[14] The cross-site report has more information on the definition of evidence-based used in this evaluation: Swaner R, Hassoun Ayoub L, Jensen E, and Rempel M. 2015. *Protect, Heal, Thrive: Lessons Learned from the Defending Childhood Demonstration Program.* New York: Center for Court Innovation.

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Chapter 3
The Boston Defending Childhood Program Model

The Boston Defending Childhood Initiative (Boston DCI) determined early on that multiple strategies were necessary to fully address issues around children's exposure to violence in Boston. Boston DCI developed a unique approach, using a social justice and health equity lens to target their strategies in select neighborhoods, including Dorchester and Roxbury, which have a disproportionately high incidence of violence, poverty, and crime. As articulated in their official strategic plan, project stakeholders believed that "equity and justice require that these communities be first in line for the resources to help them defend their children." In general, the Boston Public Health Commission's violence prevention strategies are rooted in the conviction that violence and trauma are both indicators of health inequities and have ripple effects that contribute to other poor health outcomes. Therefore, many of the interventions described below focus especially on several low-income, predominantly minority neighborhoods in Boston that have been disproportionately affected by various forms of violence. In order to ensure community buy-in and engagement, Boston DCI's strategy for addressing violence and health inequities involved releasing of most of the DCI funding to local organizations, specifically neighborhood-based providers. This strategy allowed the initiative to bring services into communities in a way that was best suited to their needs and to ensure that the funding was used most effectively. It also helped ensure that any potential barriers related to social or cultural factors were mitigated through funding local organizations to engage their own communities.

In this chapter, we describe the program activities in each of the key areas that comprise the initiative: treatment and healing (direct intervention services for children exposed to violence); prevention; community awareness and education; professional training; and system infrastructure and capacity building. In each area, challenges to implementation are also discussed. Figure 2 below shows the different program model components of Boston DCI, and the goals it hoped to achieve through these activities:

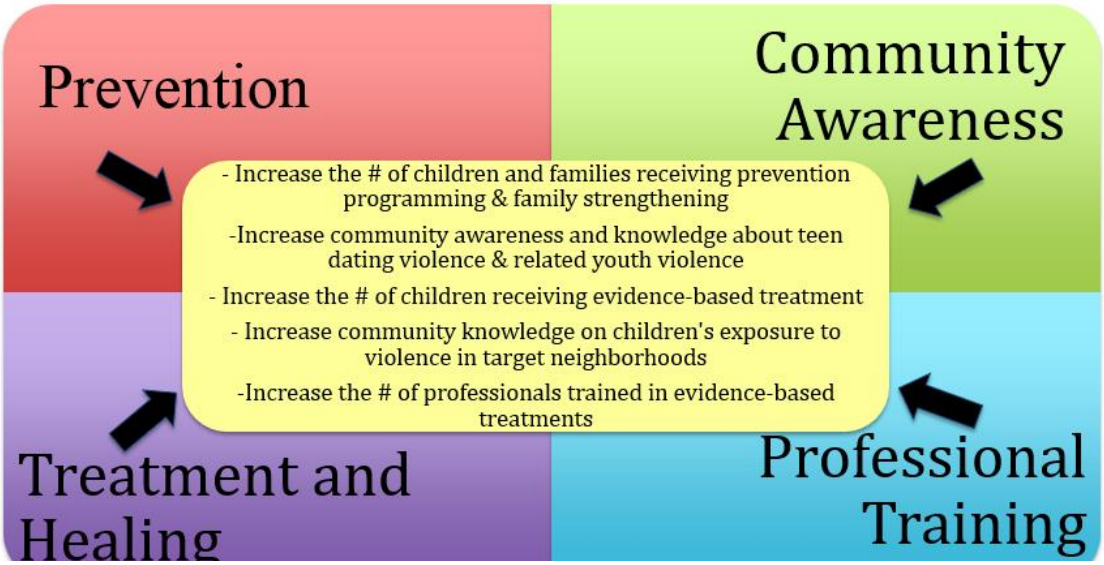

Figure 1. Boston DCI Program Model

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Treatment and Healing

In Boston, therapeutic programs designed for children who have been exposed to violence were provided through two community health centers. The Boston DCI Collaborative Body decided that funding community health centers, preferably in or around target neighborhoods, would be the ideal strategy for ensuring that children who needed the most help would receive it.

In April 2012, Boston DCI released a request for funding proposals (RFPs) targeted at local direct service providers to expand their abilities to address the needs of children exposed to violence. The RFP stated that applicants must be community health centers located in the city of Boston and must demonstrate experience in providing direct behavioral and mental health services to children/adolescents. The applicants also had to show that there was a need for these services in the client population served and that they had strong relationships with grassroots, social service, community development and/or faith-based organizations in the community. Applicants also had to show experience in conducting outreach and education. The RFP defined exposure to violence to include children's direct and indirect exposure to all types of crime, violence, and abuse experiences: child maltreatment, domestic and teen dating violence, sexual assault, stalking, school violence, and community violence. Although the RFP did not include location as part of its application process, Boston DCI target neighborhoods were given priority during the review and selection process.

Collaborative Body members were involved in the initial development of the RFP and were invited to sit on a temporary review board. The review board reviewed, discussed, and scored all of the applications and provided their recommendations for the two organizations with the top scores to the Core Management Team. The Boston Public Health Commission, as the granting agency, did the fiscal review.

In July 2012, after a competitive process involving eight applications, two grants of $130,000 each were awarded to community health centers to provide direct evidence-based behavioral health services: the Whittier Street Health Center (Whittier) and Bowdoin Street Health Center (Bowdoin). Whittier is a health organization that offers comprehensive primary care and community-responsive social services.[15] It is located in Roxbury and its mission is to "provide high quality, reliable and accessible primary health care and support services for diverse populations to promote wellness and eliminate health and social disparities." Bowdoin is operated by Beth Israel Deaconess Medical Center in the Dorchester neighborhood.[16] Its mission is to "provide excellent, compassionate care to our patients and support the health of the entire community."

Direct Service Delivery and the Family Partner-Clinician Model

Boston DCI developed a direct service delivery model that incorporates a mental health clinician and a family partner. The staff developed a proposed service delivery model and convened a group of Boston area community health centers to obtain input and feedback on the model. The model is

[15] Learn more about the Whittier Street Health Center at http://www.wshc.org/.
[16] Learn more about the Bowdoin Street Health Center at: http://www.bidmc.org/CentersandDepartments/Departments/CommunityHealthCenters/BowdoinStreetHealthCenter.aspx.

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based on the MYCHILD and Project LAUNCH programs that currently exist at Boston Medical Center, both of use family partners to connect families with services.[17] The complete delivery model can be found in Appendix C.

To implement the direct service delivery model, each health center hired a full-time mental health clinician and a full-time family partner, both fully funded by the Boston DCI grant. Even though the individual centers led most of the hiring process, the Boston DCI Core Management Team reviewed job descriptions and participated in interviews with the final candidates. The clinician was required to be a licensed clinician (LICSW, LMHC or equivalent, PhD or PsyD), and the family partner had to be a paraprofessional who has relevant lived experience as a parent or caregiver of a child or youth who has experienced trauma or exposure to violence. The family partner structured support, training, and education to caregivers in home, community and clinic settings. It was recommended that they be employed for at least one year, since the work involved becoming personally connected to the issue of children's exposure to violence. The family partner and clinician received basic training from their respective community health centers, as well as additional training through Boston DCI. They participated in the ARC learning community, described later, and received clinical consultation from Child Witness to Violence, a project of Boston Medical Center. They also received training on the service delivery model, as well as other aspects of their positions such as community outreach and assessment.

The mental health clinician provides direct care and/or provides referrals to the appropriate clinical provider for a given child. The family partner provides caregiver support, skill building, and care coordination for families of children exposed to violence. As a team, they also collaborate with community partners to offer training and consultation to staff, such as case managers, social workers, or community members, and parents and to offer preventative and therapeutic groups. Family partners may connect families with other social services as needed and may also work with the children's schools. For example, family partners often communicate with school counselors and teachers for children who may need additional support. They also help schedule clinician appointments with school schedules and extracurricular activities in mind.

Integration of a Place-Based Approach

According to the Boston DCI implementation plan, children are to be referred from community partners, including Boston DCI. For the Whittier Street Health Center, the clinician and family partner were based at their existing Vibrant Communities program, located on-site at five public housing developments and at a local shelter for families affected by domestic violence in Roxbury. This allowed Whittier to target the housing developments and surrounding area, with a focus on the Lenox, Camden and Orchard Gardens developments, which are known for gang activity, street violence, and domestic violence. Bowdoin worked with two local teen centers and local schools as well as attended community meetings as part of their outreach efforts within their Dorchester catchment area. Both teams worked within their health centers to provide basic training to doctors, other providers, and case managers on prevention and intervention with children exposed to violence.

[17] MYCHILD is a collaboration of families, health centers, and child serving agencies, which aims to address the needs of children aged 0-5 with significant behavioral and emotional needs. Project LAUNCH aims to promote healthy social and emotional development for children birth through age 8. More information at: http://www.ecmhmatters.org/AboutUs/Pages/MYCHILD.aspx

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The Screening, Assessment, and Treatment Planning Process

Referrals of specific cases come from Boston DCI, local providers and pediatricians, and behavioral and social health workers. After a referral to either Whittier or Bowdoin, an initial visit is scheduled, which can occur at home, the health center, or at a community organization. Both the clinician and family partner conduct the initial visit, with the goal of understanding the full picture of a family's needs and strengths. They also implement the Child and Adolescent Needs and Strengths (CANS) assessment tool, which is designed to support decision making about level of care and service planning and for monitoring of outcomes of services.[18] Staff also complete three validated instruments: Trauma Events Screening Inventory (TESI),[19] Parental Stress Index,[20] and the UCLA PTSD Index for Children.[21]

Both health centers received funding to implement evidence-based or promising treatment services, and elected to implement Attachment, self-Regulation, and Competency (ARC). ARC is a comprehensive framework for intervention with youth exposed to complex trauma, discussed in further detail in the Professional Training section.[22] ARC is applicable to a range of clinical modalities (e.g. individual or group therapy with children; individual or group psycho-education with caregivers; sessions with child and parent together; workshops with staff who interact with families) ARC provides a framework for tailoring specific clinical interventions to be trauma-informed in supporting client's needs and may include individual and group therapy for children, education for caregivers, parent-child sessions, and parent workshops. The framework is designed to be adaptable to needs and real-life circumstances of clients. It allows for the identification of culturally relevant caregiver supports; working with a variety of caregivers and family support systems, including non-traditional ones. The framework also specifically targets the child's surrounding system (caregiver(s), treatment system, community), thus attempting large-scale change.

Based on initial screening and assessment results, two plans are created: The clinician develops the Child's Clinical Treatment Plan and the family partner develops the Family's Resource and Support Plan. As part of the clinical treatment plan, the clinician may provide one-on-one sessions and/or therapy through group sessions. Both the family partner and the clinician conduct subsequent home visits. The family partner works with the /caregiver to engage in their child's clinical treatment plan. The family partner also ensures that family voice is represented in both plans and identifies additional needs and resources for the family. The clinicians and family partners also hold group sessions, including a parenting group at Whittier for parents whose children had been exposed to violence. The group is seven sessions and focuses on effective discipline, expectations, reflections, and supporting their children.

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[18] Anderson, R.L., Lyons, J.S., Giles, D.M., Price, J.A. & Estle, G. 2003. Reliability of the Child and Adolescent Nees and Strengths – Mental Health (CANS-MH) Scale. *Journal of Child and Family Studies*, 12(3), 279-289.
[19] Available at: http://www.ptsd.va.gov/professional/assessment/child/tesi.asp
[20] Available at: http://www4.parinc.com/Products/Product.aspx?ProductID=PSI-4
[21] Available at: http://www.irct.org/Admin/Public/Download.aspx?file=Files%2FFiler%2Fglobal%2FTraining%2FIstanbul+2009%2FUCLA_Child_PTSD_Index.pdf
[22] ARC is considered promising. See Arvidson, J., Kinniburgh, K., Howard, K., Spinazzola, J., Strothers, H., Evans, M., Andres, B., Cohen, C., & Blaustein, M. (2011). Treatment of complex trauma in young children: Developmental and cultural considerations in application of the ARC intervention model. Journal of Child & Adolescent Trauma, 4(1), 34-51.

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Since June 2013, both health centers have consistently had a caseload of about 20-30 children and families and have served a total of 185 families. Besides managing their caseload, the two centers have also participated in monthly meetings with the Boston DCI Training Manager and will call him directly if they need assistance. They also participate in the Attachment, Self-Regulation, and Competency (ARC) Learning Community organized by Boston DCI (see Professional Training section below).

Challenges to Treatment and Healing

Challenges exist when providing direct services in a community context. Both health centers suffered from staff turnover and were unable to keep a clinician on staff for the duration of the grant. One health center has had two clinicians and one family partner leave; the other had one clinician and two family partner leave. There were several months with no clinician available at each site (when one clinician had left and the center had not yet hired a replacement). On average, the staff who left had been employed for about a year, although a few were employed for less than three months. Boston DCI staff believed this was in part due to the nature of the individuals who were hired: recent college graduates aiming to obtain some experience before moving on to better paying positions. Because of this staff turnover, there were times when services to clients were inconsistent and where the client caseload decreased.

Another challenge to providing direct services has been cultural competency. Most of the families served at Bowdoin are of Cape Verdean descent and many speak Cape Verdean Creole (which has a Portuguese foundation). This can create linguistic and cultural barriers for the staff. Additional challenges exist when working with children. As their schedules change year round (summer versus school year), clinicians sometimes have to work long hours to accommodate after school activities or camp in the summer time. The two centers have had varying degrees of success with keeping children and their parents engaged throughout the term of the treatment, especially due to these scheduling issues.

Finally, clinicians and family partners both have to recognize that their work is collaborative. The success of this treatment model depends on teamwork and effective communication. This approach is often challenging for the clinician, who may not be traditionally trained to work in this way. For the first time, the clinicians are collaborating with the family partner, a non-clinician, whose lived experience provides a different and unique set of skills to work with families. The Boston DCI Training Manager has worked with the clinicians and family partners to encourage team building and collaboration and ensuring they understand the delivery model. The training manager holds bi-weekly meetings with staff to ensure that they are working together closely and sharing information about clients. The training manager is also available by phone to address issues as they arise.

Prevention

The Boston Defending Childhood Initiative is utilizing multiple strategies to prevent children's initial or subsequent exposure to violence.

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Coaching Boys into Men

In partnership with the Boston Centers for Youth and Families (BCYF), the Boston DCI launched the Coaching Boys into Men (CBIM) prevention program in 2012 as a citywide initiative. The curriculum was developed by Futures Without Violence, the Defending Childhood Technical Assistance provider, and was adapted for Boston DCI specifically.

The facilities that were initially targeted for the roll-out of Coaching Boys into Men engaged youth ages 11-15 through formal teams, primarily basketball and volleyball teams. Although some of these teams use facilities in schools, they are not school teams and regular attendance by students is not mandatory. An athletic director or assistant director was trained at each site, with about 35-40 athletic staff members across 29 community centers receiving the trainings in total. The first training was in 2012 and a booster training was in 2013.

Coaching Boys into Men (CBIM) is a promising leadership program, created by Futures Without Violence, that provides athletic coaches with the strategies and resources needed to educate young males in relationship abuse, harassment, and sexual assault.[23] As the largest human service agency in the city, BCYF was an appropriate partner, since it runs over 50 community centers throughout Boston, the vast majority of which have recreation space, including basketball courts, swimming pools, and gyms. Some of the BCYF facilities are located in schools and others are freestanding.

In implementing Coaching Boys into Men, the curriculum had to be adapted greatly for the Boston DCI. Specifically, the curriculum was adapted in three major ways:

1) <u>To be more developmentally appropriate:</u> The original target audience of CBIM is high-school age youth (14-18), but the target audience in Boston was 11-15 years old.

2) <u>To be co-educational:</u> CBIM is designed for implementation with boys, however many BCYF teams included girls, and BCYF did not want to exclude them. The Core Management Team along with BCYF staff also discussed whether to change the name of the program to one that is more gender neutral; they ultimately decided to call it the Healthy Relationships Curriculum;

3) To provide additional focus on healthy relationships, by merging in other curricula.

Ultimately, the final program was titled the Boston Healthy Relationships Curriculum, and was a hybrid of three programs: Futures Without Violence's *Coaching Boys into Men (CBIM)*, Boys to Men's *Reducing Sexism & Violence Program (RSVP)*, and the Walnut Avenue Women's Center's *Healthy Relationships Workshop*.[24] RSVP is a promising violence prevention program, with

[23] See Miller E, Tancredi D, McCauley H, Decker M, Virata M, Anderson H, Stetkevich N, Brown E, Moideen F, and Silverman J. 2012. "Coaching Boys into Men": A cluster-randomized controlled trial of a dating violence prevention program." *Journal of Adolescent Health, 51,* 431-438.

[24] More information about these programs can be found at: CBIM (http://www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men/); RSVP (http://engagingmen.futureswithoutviolence.org/?program=reducing-sexism-violence-program-r-s-v-p); and Walnut Avenue Women's Center (http://wawc.org/).

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bystander intervention at its core.[25] The "Healthy Relationships Workshop" is a creative and interactive workshop which promotes healthy relationships and dialogue around issues of dating and domestic violence. Workshop topics include teen dating violence, power and control, gender, and healthy relationships. Coaching Boys into Men is a promising program and the Boston DCI staff replaced lessons and adopted language from the other programs into the Boston Healthy Relationships Curriculum. The program had been adapted so extensively that concerns about how receptive girls would be to it were no longer applicable; no references to boys or men remained in the final version.

The final Boston curriculum consists of nine lessons that are given by trained coaches or athletic staff once a week to youth for about 30 minutes prior to their participation in their team activities. The nine lessons in the final Boston Healthy Relationships curriculum are:

- Lesson 1: Introduction
- Lesson 2: What is a healthy relationship?
- Lesson 3: Personal Responsibility
- Lesson 4: Insulting Language
- Lesson 5: Digital Disrespect
- Lesson 6: Understanding Consent
- Lesson 7: When Aggression Crosses the Line
- Lesson 8: There's No Excuse for Relationship Abuse
- Lesson 9: Signing the Pledge

The curriculum provides the coaches with talking points and questions for discussion, as well as supplemental resources and activities. For example, Lesson 4 on insulting language asks the coach to say:

> *Today I want to talk with you about the impact of demeaning language. Sometimes we don't realize how harmful the words we use can be. Or sometimes we purposely use words that are disrespectful without understanding their true impact.*

This introduction initiates a discussion. Then the coach can ask the students questions like, "What do you think about saying to a guy "You're playing like a girl"? Why might this also be insulting to girls?" or "How would you feel if someone talked negatively about something you have no control over, like how you look?" The coach is also provided with statements to use when wrapping up.

At the end of the final lesson, participating youth sign a pledge that is posted in a public space, such as the BCYF hallway. It states:

> *I am ready to take a stand against relationship abuse and I believe that violence is neither a solution nor a sign of strength. I understand that by committing to treat everyone with respect, I am a role model to others. By taking this pledge, I publicly denounce all violence, including sexual assault, sexual harassment and dating violence. A world of respect starts today and starts with me.*

[25] RSVP is considered promising. See Spence RA and Furtado M. 2009. Reducing Sexism and Violence Program: A Report on the Evaluation. Augusta, ME: Maine Center for Public Health; and Richter, A. 2014. An Evaluation of Boys to Men's Reducing Sexism and Violence Program. ME: University of Southern Maine.

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When evidence-based or promising program models are selected for implementation, one key consideration is program fidelity. Program fidelity refers to the degree to which the delivery of the program adheres to the model as intended by the program developers.

In many situations, programs may deviate from the model because of context, target population, staff, or other important reasons. Program adaptations are often deemed necessary by practitioners in order to make the program more suitable for a particular population. In fact, recognizing the importance of adapting evidence-based programs for local context, the U.S. Department of Health and Human Services' Office of Adolescent Health and the Centers for Disease Control and Prevention's Division of Reproductive Health have developed guidelines to help local organizations adapt adolescent reproductive and sexual health evidence-based programs.[26]

Program fidelity is most accurately measured across five areas: program adherence, quality of delivery, program exposure, participant responsiveness, and program differentiation.[27] Only an appropriate evaluation of the fidelity of the program or intervention can produce an assessment of the impact of the adaptations on outcomes. Absent such formal fidelity assessments, it cannot be determined whether any observed impact, or lack thereof, is attributable to the adaptations, implementation factors, program design, or other issues.

Family Nurturing Programs

In partnership with the Family Nurturing Center of Massachusetts, Boston DCI funded local organizations to expand family nurturing programs. The Family Nurturing Program (FNP), an evidence-based program, promotes nurturing relationships among all family members while building community connections to support positive parenting.[28]

Boston DCI issued a request for funding proposals (RFP) in the spring of 2012 and received 28 applications. The applications were reviewed by Collaborative Body members who volunteered for a temporary review board. Six grants of $20,000 each were awarded for the establishment and support of FNPs during Round 1 and again in Round 2 (Table 3.1). All of the organizations from Round 1 had to reapply through the same competitive process for Round 2. Only two organizations from Round 1 were refunded for Round 2. The full RFP from Round 1, including more detailed information about the FNP model, can be found in Appendix D. Boston DCI staff provided a lot

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[26] More information about these adaptations specifically can be found at: https://preventyouthhiv.org/content/promoting-evidence-based-approaches-adaptation-guidelines

[27] For more information on evaluating fidelity, please see: A) Mowbray C.T., M.C. Holter, G.B. Teague, and D. Bydee. 2003. "Fidelity Criteria: Development, Measurement, and Validation." *American Journal of Evaluation* 24: 315-340; B) Durlak, J.A. and E.P. DuPre. 2008. "Implementation Matters: A Review of Research on the Influence of Implementation on Program Outcomes and the Factors Affecting Implementation." *American Journal of Community Psychology* 41: 327-350; and C) Fagan, A.A., K. Hanson, J.D. Hawkins, and M.W. Arthur. 2008. "Bridging Science to Practice: Achieving Prevention Program Implementation Fidelity in the Community Youth Development Study." *American Journal of Community Psychology* 41: 235-249.

[28] Family Nurturing Programs are considered evidence-based. Studies demonstrating their effectiveness, see Hodnett, R. H., Faulk, K., Dellinger, A., & Maher, E. 2009. Evaluation of the statewide implementation of a parent education program in Louisiana's child welfare agency: The Nurturing Parent Program for infants, toddlers, and preschool children. Final evaluation report submitted to Casey Family Foundations; and Bavolek, S. J., Comstock, C. M., & McLaughlin J. W. 1983. The Nurturing Program: A validated approach for reducing dysfunctional family interactions. Final report submitted to the National Institute of Mental Health.

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of support to organizations throughout the RFP process; as local community-based organizations, many were unfamiliar with a grant application process, and Boston DCI provided training sessions and support to ensure that applications were completed.

Table 3.1. Family Nurturing Program Summary

Grantee	Target Audience/Location	Approach
Round 1 (May 2012 – May 2013)		
St. Peter's Teen Center/ Catholic Charities	Cape Verdean community	• Focus on bringing parents and teenagers together • Working with Nurturing curriculum and bilingual groups of parents and youth
Asian Task Force against Domestic Violence (ATASK)	East Asian, South, and Southeast Asian communities	• Focus on domestic violence and children of DV survivors • Also operate a shelter
Roxbury Tenants of Harvard	Mission Hill	• Focus on community violence and bullying • Connecting youth with support services in the area • Conducted family groups in English
Martha Eliot Community Health Center	Latino community	• Focus on family violence • Provide preventative programming in addition to existing health services
Associated Care & Education	Roxbury	• Focus on children's exposure to violence • Early education and after school program
GRASP Inc.	Dorchester	• Focus on community violence and bullying • After school program
Round 2 (May 2013 – May 2014)		
St. Peter's Teen Center/ Catholic Charities	Cape Verdean community	• Refunded from Round 1
Roxbury Tenants of Harvard	Mission Hill	• Refunded from Round 1 • Added groups in Spanish and Chinese
Mujeres Unidas Avanzando (MUA)	Latina community in Dorchester	• Focus on women and family nurturing • Provides comprehensive set of services including education, social services, child care
Greater Love Triangle	Fathers in Hyde Park and Dorchester	• Focus on nurturing fathers (only ones doing this) • Connected with a local church
Upham Corner Health Center	Dorchester	• Focus on family nurturing programs in a medical environment • Crianza con Carino (FNP in Spanish)
Roxbury Multiservice Center	Roxbury	• Focus on whole family approach • No limits on participants: willing to take all age groups and demographics

The proposed programs varied widely in terms of target audience and approach, but all were aimed at preventing and reducing children's exposure to violence. Some of the organizations targeted their surrounding neighborhoods, such as Roxbury Tenants of Harvard, while other targeted specific communities, such as the Latino community in Dorchester or the Cape Verdean community. Selected organizations received training and ongoing technical assistance from the Family Nurturing Center of Massachusetts. A series of trainings were conducted in 2012 and another series was conducted in 2013. Training details can be found in Appendix H.

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The Family Nurturing Model is designed for parents and children together to build their nurturing skills and understanding of healthy development, appropriate expectations, and discipline with dignity. Generally, parents meet weekly in a Parent Group, and children meet in their own age-specific groups, with everyone gathering for a meal and Family Nurturing Time, including games, songs, and other fun activities. The Model includes different curricula depending on the age group, ranging from 12-22 weeks with most being 15 weeks long. The children's curriculum parallels the adult's curriculum.

All of the grantees worked with the Family Nurturing Center to further adapt the Nurturing Programs Model for linguistic or cultural reasons. Grantees also worked with Family Nurturing Center on their areas of focus. For example, St. Peter's Teen Center was implementing a FNP specifically for teenagers and their parents and so used an adapted version of the curriculum that addresses the unique challenges in those relationships. Similarly, in Round 2, Greater Love Triangle implemented a FNP version that was targeted and fathers and their children. The developers of the FNP model have developed adaptations for diverse cultural groups as well as children of different ages and developmental stages. As mentioned previously, evidence-based programs like FNP may be adapted when deemed necessary by practitioners in order to make the program more suitable for a particular population. Only an appropriate evaluation of the fidelity of the program or intervention can produce an assessment of the impact of the adaptations on outcomes. Since some of the organizations described here did adapt the FNP model, absent a formal evaluation, it cannot be determined whether any observed impact, or lack thereof, is attributable to the adaptations, implementation factors, program design, or other issues.

Each grantee aimed to recruit 15 to 18 families for the program, with the goal of graduating at least twelve. There was no eligibility criteria and the organizations recruited families from their existing programming, by word of mouth in the neighborhood or community, or through existing relationships with local partners. Across both rounds, family nurturing programs funded by Boston DCI have served 156 families. One organization described the success of their program through the story of one family:

> *One of the families…. described how meaningful it was to see their sons grow up and change socially over the course of the group. At the beginning of the group, the family was hesitant to stay for dinner because they felt they were unable to control their children during the busy and sometimes chaotic mealtime. Facilitators encouraged them to stay and offered to help by sitting with them at meals and offering praise.*
>
> *One of their sons had connected with a volunteer who assisted in the facilitation of the FNP… and [we] talked about how they could work with the volunteer to promote and practice social skills that their kids learned in the group, especially during meal time.*
>
> *By the end of the group, the family was staying for all meal and it was evident by their smiles and relaxed manner that they had come to enjoy this nurturing time with their children.*

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Another caregiver stated, "This group helped my family to stay intact. I felt like I was losing my grip as a parent and that things were out of control. This Nurturing Program helped a lot."

One organization was never able to get their program up and running due to challenges with staff turnover, space logistics, and community engagement. In total, 38 families, 56 children, and 40 parents/caregivers graduated from the FNP programs in Round 1.

Youth Leadership Healthy Relationship Promotion Projects

The Youth Leadership Healthy Relationship Promotion Projects was a youth-focused prevention and community awareness effort, put into action in 2012. This project was implemented in partnership with Start Strong, which is also a program of the Boston Public Health Commission.[29] After an RFP release and a competitive process, two agencies that serve youth were selected in the spring of 2012, based on their preexisting peer leadership, youth organizing, and/or peer education model. As articulated in the RFP, eligible organizations needed to have had a focus that was compatible with the goals of the Defending Childhood Initiative, including experience in areas such as sexual health promotion, conflict resolution, and violence prevention. Eligible organizations also needed to have had the capacity to support and work with a consistent group of youth leaders during both the summer and the academic year. The two winning organizations were selected through a temporary review panel, half of which were composed of adult Collaborative Body members and the other half of youth from Start Strong. Start Strong youth leaders, along with Boston DCI, continued to be engaged throughout the projects by providing technical assistance to the two organizations and their respective youth leaders.

The two organizations selected were Sociedad Latina for girls and the Bird Street Community Center for boys. Sociedad Latina had worked in partnership with Latino youth and families since 1968 to end cycles of poverty and health inequities and address the lack of education and professional opportunities in the Boston Latino community with a focus on Roxbury. Sociedad Latina has two youth initiatives: Youth Community Organizing and Health Educators in Action, both serving youth ages 14 to 21 years.

The Bird Street Community Center (Bird Street) offers a community gathering place in Dorchester where children and youth are able to thrive and obtain the support they need to grow into healthy productive adults. Bird Street provides academic support, leadership training, workforce development and employment opportunities, arts activities, life skills training, community service opportunities, violence prevention programming, case management, and recreational and organized sports. Bird Street serves youth aged 10 to 22 years in its Youth Development Program, who primarily reside in Dorchester, Roxbury, Mattapan, Hyde Park and Jamaica Plain.

Each of the two organizations identified one staff member to oversee the project and manage the youth leaders. About 7-10 youth leaders were identified by the staff member from the existing programs at each organization, because of their interest in healthy relationships and violence prevention and their willingness to commit to a year-long effort, including summer trainings. Youth leaders were compensated for their time at a rate of at least $8.25 per hour.

[29] Start Strong is a Robert Wood Johnson Foundation-funded program focusing on the primary prevention of teen dating violence, and healthy relationships among middle schoolers ages 11 to 14. For more information: http://www.bphc.org/whatwedo/violence-prevention/start-strong/Pages/Start-Strong.aspx

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During the summer of 2012, the youth leaders attended a Summer Peer Leadership Institute, where they were trained by Start Strong Peer Leaders on healthy relationship promotion, teen dating violence prevention, sexual violence, domestic violence, bullying prevention, social determinants of health, social marketing and other related topics. At the conclusion of the Institute, each team completed a project planning workshop and developed a plan for their work for the year. Then, the youth leaders actively led the planning and implementation of an education or organizing project to promote healthy teen relationships in their neighborhood that between September 2012 and April 2013.

Activities of the Sociedad Latina Youth Leaders. Sociedad Latina youth leaders were recruited primarily from their Health Educators in Action group. During the year, 10 youth participated as health educators/youth leaders and their efforts included:

- Bi-weekly Gender Dialogues: Youth leaders facilitated 16 gender dialogues engaging 140 participants between September 2012 and April 2013. They had originally planned for 14 gender dialogues. The dialogues involved high school aged peers, specifically Latino youth and youth of color in Roxbury and were conducted at Sociedad Latina by ten youth leaders who are also peer health educators. Youth reached out to their schools and local youth programs to recruit their peers for participation in the dialogues. Some examples of dialogue topics are: 1) does violence in the community affect boys and girls in the same way? 2) How do we support LGBTQ peers in our organization, schools and community? 3) How would you handle being in a biracial relationship? How would your friends and families react? 4) How do you define being an honest person in the context of a relationship? Does not telling information count as being honest? 5) Should you date your friend? 6) Does the way a girl dresses indicate how she respects herself? 7) Are youth influenced by lyrics in music? 8) What is the underlying cause/factor of someone becoming abusive? 9) Why do people stay in abusive relationships?

- Healthy Relationships Workshops: Youth leaders held 16 one or two hour workshops on a variety of topics related to healthy relationships. Topics included: romantic relationships; healthy friendships; social media and relationships; HIV/AIDS 101. Attendance was usually about 30 youth per workshop, meaning that this effort may have reached close to 500 youth in total.

- Youth Blog on Healthy Relationships: Youth leaders at Sociedad Latina maintained a blog and online resource center with information on interesting topics and community resources. Through the blog, they shared dating tips and advice for youth. During the year, there were over 30 blog posts (about two per month) and they also covered relevant media topics such as the Steubenville rape case[30] and relationships portrayed on the show, "Family Guy."

- Self-expression through Performance, Visual Arts and Writing: Youth leaders developed several events that used the power of performance and art to send messages about healthy relationships and violence prevention. One example was a Valentine's Day Spoken Word

[30] The Steubenville High School rape occurred in Steubenville, Ohio, on August 11, 2012, when a high school girl, incapacitated by alcohol, was repeatedly sexually assaulted by her peers, several of whom documented the acts in social media.

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event with over 150 youth in attendance (event flyer in Appendix E). Another example was an art installation, which was their final project, where the youth leaders collaborated with the Youth Arts team at Sociedad Latina to create art that reflected the power of communication. The artist statement and two images of the art can be found in Appendix F. They also facilitated performances for youth by outside organizations at Sociedad Latina, such as a performance on LGBTQ attended by 55 youth and a performance on Teen Empowerment attended by 50 youth.

- Publications: Sociedad Latina youth leaders also developed several publications targeted at youth. They published a Relationships Resource Guide that lists local and national information for youth, as well as online resources.

In total, the Sociedad Latina Youth Leaders believe they reached over 500 youth through their various efforts. Their work has touched youth in the Latino community in ways that many of them did not expect. For example, one youth encouraged by their work on LGBTQ issues, which can be taboo in Latino communities, went on to start at LGBTQ and Straight Allies group at his high school. The Youth Leaders themselves have had many opportunities to build skills and grow. The adult staff member at Sociedad Latina provided them with many workshops that informed their efforts, such as workshops on public speaking or role playing and ensured that their projects were youth-led and youth-driven. Many of them saw huge improvements in their public speaking skills or had a renewed interest in art or performance.

Activities of the Bird Street Youth Leaders. At Bird Street, there were 7-10 youth involved who were all male. Early on, it seemed that the adult staff member had less experience allowing youth to completely lead projects and took the initiative to plan events and activities without youth leadership or involvement. This reportedly led to different outcomes and less opportunities for the youth to develop and implement their own ideas. For example, the staff member teamed up with the (adult) Girls' Coordinator and the (adult) Education Coordinator at Bird Street to plan workshops for single sex groups. While this meant that youth at Bird Street were exposed to workshops on relevant topics, those workshops were not youth-initiated or youth-led. In most cases, only a few youth leaders were involved with each event.

The Bird Street Youth Leaders suffered a huge loss when two of their members were involved in a shooting and one of them was directly shot and became paralyzed. This created a different dynamic amongst the youth, and much of their work was reflective rather than celebratory. Their final product, a PSA described below, was released with a somber, rather than positive, tone. Despite these challenges, many activities and events did occur:

- Battles of the Sexes: This activity involved a math competition between young women and young men followed by a discussion about how the young people viewed each other. Two youth leaders were involved and there were about 22 attendees. The competitors met three separate times.

- Prep Workshop for Job Rally: The youth leaders partnered with GOTCHA Youth Leadership[31] to discuss issues that plague Boston teens and how jobs would help teens

[31] GOTCHA (Get off the corner hanging around) is a collaboration of over 20 nonprofits working with youth.

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mature and stay out of trouble. About seven youth leaders were involved and there were about 75 attendees. The session lasted two hours.

- Youth Summit Workshop: The Bird Street Community Center has an annual Youth Summit, and at the summit in April 2013, the youth leaders presented six workshops on topics such as Domestic Violence and Healthy vs. Unhealthy Relationships, which focused on males and females respecting one another. There were 8-10 youth leaders involved and about 150 attendees.

- Public Service Announcement (PSA) Video: The youth leaders created a script that discussed healthy relationships. They filmed the PSA at Bird Street and all of the leaders were involved with either acting or directing. The PSA was not presented at the Youth Summit but was shown at Bird Street's 35th Anniversary Fundraising Dinner in 2013.

Challenges Related to Prevention

Since Boston DCI utilized three major approaches to prevention programming, each came with specific challenges. In implementing Coaching Boys into Men, challenges existed around ensuring adapting the model in a new context. Because of the incorporation of the other curricula, the final Healthy Relationships Curriculum was very different from the original and is yet to be evaluated. However, they maintained the approach, utilizing athletic centers and staff. Staff highlighted that although the program is targeted at the athletic community, athletic directors and coaches are not normally expected to serve as facilitators of discussions, particularly on issues related to violence and healthy relationships. The clear advantage of a sports-based approach is that coaches play an important role in the lives of youth and have access to them in a less formal environment (when compared to school). However, Boston DCI staff anticipated that the coaches and athletic directors would need continuous monitoring and support to ensure appropriate program implementation. Additionally, since the format of sports teams at the BCYF is less structured than school-based sports teams, there was an expectation that some youth would not be exposed to all of the sessions. Indeed, youth were reported occasionally to skip out on BCYF practices and sports commitments. Athletic staff were instructed to maintain a roster so that they could be aware of which youth missed sessions and therefore missed exposure to the program.

In terms of the Family Nurturing Programs, the first challenge emerged during the RFP process when it became clear that some of the community-based organizations applying did not have the grant writing expertise to develop strong applications. Boston DCI staff addressed this by providing assistance and training on the grant application process and grant writing. Once the grantees were selected, Boston DCI continued to work with them and experienced many of the same challenges that grant funders experience: delays in adequate reporting of progress, providing continuous support and problem-solving, and ensuring that grant requirements are met. One of the grantees in particular did not apply for funding during Round 2 because it was never able to get its program up and running in Round 1. This grantee faced challenges with staff turnover as well as community engagement. The grantee was not able to get community members to participate consistently and occasionally could not find appropriate locations and space. These challenges proved detrimental to their efforts.

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Working with youth on the Healthy Relationships Promotion project had its own unique set of challenges. Staff turnover and youth engagement were challenges when working with Sociedad Latina and Bird Street. Some staff members at these organizations did not always fully understand that the efforts were to be youth-led. While having youth lead initiatives was an important part of Boston DCI's efforts, ensuring that adults supported youth and gave them space to lead is vital. These efforts built off of Start Strong's ongoing work in engaging youth and implementing youth-led efforts may have been more difficult to accomplish without the partnership with Start Strong.

Community Awareness and Education

The Defending Childhood Initiative invested in one major community awareness campaign, however, some of their other work may fall under the realm of community awareness. For example, the Youth Leadership Healthy Relationship Promotion Projects discussed in the previous section as a prevention effort also engaged youth in raising awareness in their neighborhoods (Roxbury, Dorchester, and Mattapan) about children's exposure to violence.

Start Strong Boston was a key partner in community awareness and education. Start Strong: Building Healthy Teen Relationships is a program of the Boston Public Health Commission's Division of Violence Prevention aimed at working with young people as the solution to ending teen dating violence. Start Strong received funding from the Office of Violence against Women Engaging Men and Boys grant and youth leaders were at the forefront of this community awareness effort.

The Halls

In 2013, Boston DCI and Start Strong developed a large citywide (and arguably national and international) web series designed to engage young men in a conversation to end violence, particularly gender-based violence against women and girls. Titled "The Halls," the web series consisted of professional television-style episodes that tell the stories of three young men in Boston and their struggles through relationships, trauma, masculinity, and identity. The story also involved rumors at their school about an accused rape.

The Halls was an entirely youth-led initiative. Start Strong youth leaders worked closely with Boston DCI and Start Strong adult staff to plan and implement every aspect of the web series. Initially, the youth leaders decided to conduct focus groups to learn more about the type of campaign might be most effective with youth in their neighborhoods. They co-facilitated a series of focus groups, including a young fathers and a young mothers group. The youth leaders then wrote up the themes and decided on developing a web series. They worked with Boston DCI to develop the RFP for production companies. They also led the review committee, interviewed applicants, and selected the production company. Then the youth leaders worked on the storyboards and character development with the production company, which allowed the company to develop a draft script. The script was reviewed multiple times by both the youth and Start Strong/Boston DCI staff. The youth then participated in the production of the web series as actors and assistants and recruited additional youth to be actors. A companion discussion guide was developed to be used in workshops by youth or adults (teachers, parents, youth workers) that focuses on themes within the web series. Since its release, they have continued to be engaged by

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leading workshops with screenings of the series at local schools and community organizations and by doing interviews for local media.

As depicted in Figure 2, the web series and its advertisements were intentionally developed to feel different from a public service announcement. Instead, they appear like standard television show advertising and do not include any Boston DCI or Start Strong logos. Information and contact information for local organizations can be found on the Resources page of The Halls website.

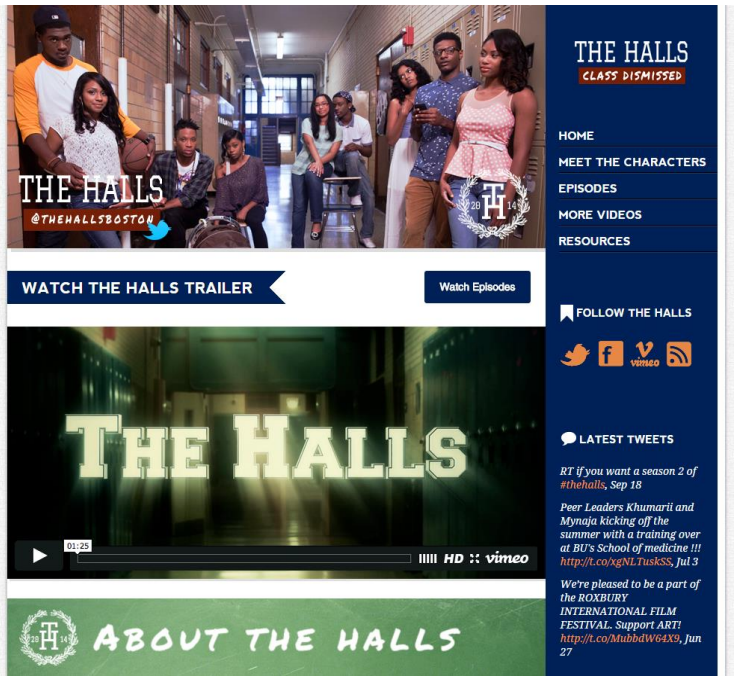

Figure 2. The Halls main webpage

The Halls series premiere was on February 25, 2014 and all episodes were initially released one week at a time, but the entire season can now be viewed online. The episodes can be viewed on the program's website (www.thehallsboston.com), on YouTube, or on Vimeo.[32] Boston DCI and Start Strong also developed a discussion guide for use by teachers and community organizations that choose to screen the series. The Halls was accompanied by a massive marketing campaign, including advertisements throughout the city of Boston, in newspapers, and on buses. A series of advertisements in Metro Boston, a free daily newspaper that reaches about 267,000 individuals in Boston, primarily subway riders.[33] There was also a social media campaign focused on Twitter. As of October 2014, the program's Twitter handle, @TheHallsBoston, had sent out 927 tweets and had nearly 500 Twitter followers. Start Strong staff and a youth peer leader were also interviewed by local television station BNN,[34] providing additional promotion and television coverage for the online web series.[35]

As of October 2014, the website has had 68,845 views with an average of 325 hits per day. Click counts are a summary measure across all three methods of viewing: the website, YouTube and Vimeo. Viewership declined over time, as is typical with most television shows, and only 1,139 clicks were recorded for viewers who watched the entire series. However, most individual episodes had much greater numbers of clicks, especially Episode 1, which had 12,578 clicks. The trailer had over 6,000 clicks. Appendix G provides detailed statistics on the viewership and the online presence of the series.

[32] Youtube and Vimeo are both video streaming websites.
[33] Metro Boston 2013 Media Kit. Available at: http://www.slideshare.net/wilfmaunoir/metro-bos-r12013genpres
[34] Boston Neighborhood Network; available on Comcast Channel 23 and RCN Channel 83 in the Boston area
[35] Watch the interview online at http://vimeo.com/87617705.

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Challenges Encountered in Community Awareness

Community awareness efforts can be challenging for a city the size of Boston. When developing and implementing the Halls, Boston DCI experienced many of the typical challenges one might expect to be associated with developing a web series: experiencing delays in the timeline, and accommodating youth and their schedules and priorities. In particular, Boston DCI wanted all efforts to be youth-led and were willing to work with youth to overcome challenges throughout the process.

Professional Training

The Boston DCI established the Defending Childhood Training Institute (DCTI) to function as a training, technical assistance, and knowledge dissemination hub for the Initiative. The DCTI focused on three broad areas of training, with a variety of goals and target audiences for each area, as depicted in Table 3.2. Much of the training was developed and implemented with the assistance of Child Witness to Violence, a Boston Medical Center project focusing on mental health service provision for children exposed to violence.[36]

Overview of the Learning Communities Training Model

Early on, the Boston DCI Leadership Team determined that it was important that trainings that occurred through the DCTI were set up as *learning communities*.[37] A learning community is a long term learning model, which brings together clinicians from different organizations and requires them to make a one to two year commitment.[38] The model focuses on institutional adoption of best practices through clinician and supervisor training, typically involving one supervisor and multiple clinicians per organization. The model includes interactive training methods and skill-focused learning, and has the following main components: (1) Two to three in-person training sessions; and (2) Follow up phone consultations over the extended time period, including sharing progress, providing resources to support continuous learning, and practicing new skills.[39]

The learning communities approach was considered to be ideal for building evidence-based service capacity in the target neighborhoods, ensuring some sustainability of service provision. Boston DCI staff felt that using learning communities and engaging local organizations in professional training over a longer period of time (as compared to one-time training efforts) also contributed to their goals of achieving health equity and reducing disparities.

Throughout, the Collaborative Body played a central role in developing and implementing the training institute. The evidence-based practices for training were selected through a collaborative process that engaged members of the collaborative.

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[36] See http://www.childwitnesstoviolence.org/ for more information.
[37] Markiewicz, J., Ebert, L., Ling, D., Amaya-Jackson, L., & Kisiel, C. 2006. Learning Collaborative Toolkit. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.
[38] A learning collaborative can be distinguished from a learning community because learning collaboratives are sanctioned by the developers of the treatment and occasionally involve them.
[39] FAQ: Learning Collaboratives and Learning Communities. The National Child Traumatic Stress Network. Accessed on October 10, 2014. Available at: http://www.nctsn.org/resources/training-and-education/nctsn-learning-collaboratives.

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Table 3.2 Defending Childhood Training Institute Programming

Type of Training	Goals	Implementation
Basic training and information dissemination	1) To increase knowledge of the impact of violence on children 2) To increase skills to identify and respond supportively to children, skills to prevent and reduce violence, and skills to promote resilience and protective factors in children	Enhancing Resiliency & Trauma Awareness Training Institute for Youth Workers
Learning Communities	1) To disseminate evidence-based trauma-focused mental health interventions for children and adolescents. 2) To improve upon the shortage of mental health services in several of Boston's neighborhoods where children are disproportionally exposed to violence.	• ARC Learning Community • TF-CBT Learning Community • CPP Learning Community
A Learning Community on Trauma Sensitive Environments	1) To change organizational culture by building trauma-sensitive environments for children and adolescents	Trauma Informed Early Education and Care Systems Breakthrough Series Collaborative

Three Mental Health Learning Communities

The Boston Defending Childhood Training Institute implemented a Child-Parent Psychotherapy (CPP) Learning Community, an Attachment, Self-Regulation, and Competency (ARC) Learning Community and a Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Learning Community. The trainers for the CPP learning community came from Child Witness to Violence; those for the TF-CBT learning community came from the University of Massachusetts Medical School; and those for the ARC learning community came from the Justice Resource Institute Trauma Center.[40]

For each, the Boston DCI Director and/or Training Manager distributed a 15-page application to local agencies and had a kickoff meeting to provide information about the training opportunities. All trainings and follow-up consultations were led by the trainers of the evidence-based practice. The learning communities were all 12 to 18 months long and included two to four in-person training sessions and 10 to 24 case conference and supervision calls.

Eligible clinicians had to have at least a Master's degree with some experience preferred. A senior leader track was developed with the goal of organizational sustainability. Participation in the learning community required that supervisors carried at least two cases. Eligible organizations had to have at least two staff members, have child clients (age requirements varied depending on the learning community), and had to have the ability to commit to long-term treatment of 12-42 weeks.

Child-Parent Psychotherapy (CPP) Learning Community. CPP is an evidence-based intervention for children from birth through age 5 who have experienced at least one traumatic event and, as a result, are experiencing behavior, attachment, and/or mental health problems, including

[40] To learn more about these trainers, please visit their respective websites: 1) Child Witness to Violence (http://www.childwitnesstoviolence.org/); University of Massachusetts Medical School (http://works.bepress.com/jessica_griffin/); and JRI Trauma Center (http://www.traumacenter.org/)

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posttraumatic stress disorder.[41] The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning.

The first CPP learning community was held between October 2012 and September 2013. There were 29 mental health clinicians and supervisors/senior leaders at the trainings, across seven organizations. Of the seven organizations, four are located in the Boston DCI target neighborhoods, and the other three are citywide with multiple locations. The learning community began with a two-day basic in-person learning session that involved both clinicians and supervisors. Immediately after this initial training, the trained clinicians and supervisors started seeing clients and using the CPP model. All clinicians and senior leaders participated in the monthly consultations by phone with the CPP trainers from Child Witness to Violence for 18 months. On a rotating basis, each agency developed a case presentation for the monthly call. The calls provided an opportunity to discuss challenges, ask questions, and develop solutions. The last 30 minutes of the call was specific for senior leaders, giving them the opportunity to discuss issues that might arise in their supervision or management duties. Nine supervisors completed an additional Reflective Supervision training in December 2012. A one-day advanced CPP learning session was held in May 2013, with the participation of 22 clinicians and supervisors/senior leaders across the seven organizations.

In March 2014, an 'advanced track' of supplemental training and consultation was initiated for teams from two large community mental health agencies, who had previously completed the October 2012 CPP learning community and were positioned to obtain CPP roster-level training. Training requirements for clinicians to be on a national roster were released by the CPP developers in the fall of 2012, after the learning community had already begun. The advanced track was developed to address the new training guidelines. Of note, the roster-level training requirements reflect changes in the intensity of length in training need for clinicians to attain full implementation of the model based on the developers' experience with CPP dissemination across the country. Other organizations who had participated in the first CPP learning community elected not to participate in the advanced track because they had lost key staff or were already committed to other learning communities. The advanced track involves two in-person learning sessions (6 hours per day for two days) along with bimonthly consultation calls. The first learning session was held in April 2014 and included a topics such as CPP core principles review, fidelity tools, and case-based learning.

Attachment, Self-Regulation, and Competency (ARC) Learning Community. Attachment, self-Regulation, and Competency (ARC) is a comprehensive framework for intervention with youth exposed to complex trauma.[42] The approach is based on attachment theory and early childhood

[41] CPP is considered evidence-based. Studies that demonstrate its effectiveness include Lieberman, A.F., Van Horn, P.J., & Ghosh Ippen, C. 2005. Toward evidence-based treatment: Child-Parent Psychotherapy with preschoolers exposed to marital violence. Journal of the American Academy of Child and Adolescent Psychiatry, 44, 1241-1248; and Cicchetti, D., Rogosch, F.A., & Toth, S.L. (2006). Fostering secure attachment in infant in maltreating families through preventive interventions. Development and Psychopathology, 18, 623-650.

[42] ARC is considered promising. See Arvidson, J., Kinniburgh, K., Howard, K., Spinazzola, J., Strothers, H., Evans, M., Andres, B., Cohen, C., & Blaustein, M. (2011). Treatment of complex trauma in young children: Developmental and cultural considerations in application of the ARC intervention model. Journal of Child & Adolescent Trauma, 4(1), 34-51.

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development and addresses how a child's entire system of care can become trauma informed to better support trauma focused therapy. ARC centers on three core principles of understanding trauma and intervening in cases of complex trauma: (1) trauma derails healthy development; (2) trauma does not occur in a vacuum; and (3) good intervention goes beyond individual therapy. Thus, three core domains are addressed:

1) Attachment: Creation of a trauma-informed environment and safe relationships that are able to support children and adolescents in meeting developmental, emotional, and relational needs;

2) Self-Regulation: Work with children to build ability to safely and effectively manage experience on many levels (emotional, physiological, cognitive, and behavioral), including the ability to identify, access, modify, and share various aspects of experience;

3) Competency: Build the foundational skills needed for healthy ongoing development, particularly support in the mastery of an array of tasks crucial to resiliency.[43]

The ARC-based intervention is intended to be tailored to each client's needs and may include individual and group therapy for children, education for caregivers, parent-child sessions, and parent workshops. The first ARC learning community started in November 2013 with 45 mental health clinicians across nine organizations. The learning community was initiated with a two-day training in late 2013, monthly consultation calls began in December. In 2014, 26 clinicians attended a one-day advanced training in ARC.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Learning Community. TF-CBT, an evidence-based treatment, is designed to help children, adolescents, and their parents to overcome the negative effects of trauma.[44] The model blends fundamentals of CBT with traditional child abuse therapies, thereby enabling clients to regain trust and a personal sense of integrity. It targets the symptoms, such as intrusive thoughts of the traumatic event, avoidance, and trouble sleeping or concentrating that are characteristic of post-traumatic stress disorder. The therapy is typically for children ages 3-18 who have either one more multiple traumas in their lives. The program lasts from 12 to 16 weeks, depending on the severity of the trauma.

The TF-CBT learning community was started in late 2013 with a two-day basic in person training for 39 mental health clinicians across six organizations. The clinicians began implementing TF-CBT in their practices, and participated in monthly consultation calls for 18 months. One organization/team dropped out because of staff turnover and concerns about the fit of the model

[43] National Child Trauma Stress Network. 2012. ARC General Information Sheet. National Child Trauma Stress Network. Available at: http://www.nctsn.org/sites/default/files/assets/pdfs/arc_general.pdf

[44] TF-CBT is considered evidence-based. Studies that demonstrate its effectiveness include: Deblinger, E, Lippman,J, and Steer, R. 1996. Sexually Abused Children Suffering From Posttraumatic Stress Symptoms: Initial Treatment Outcome Findings. Child Maltreatment, 1, 3, 10–21; and Cohen, J, Deblinger, E, Mannarino, A, and Steer, R. 2004. A Multisite Randomized Trial for Children With Sexual Abuse–Related PTSD Symptoms. Journal of the American Academy of Child and Adolescent Psychiatry, 43, 393–402. For research on TF-CBT and children under the age of 5, see Scheeringa M.S. et al. 2011. Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three through six year-old children: A randomized clinical trial. J Child Psychol Psychiatry; 52(8): 853–860.

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for their site. An advanced training was held in May 2014 with 24 mental health clinicians across 5 organizational teams.

Summary: Scope and Reach of the Mental Health Learning Communities. In total, at least 135 professionals attended the CPP learning community, the TF-CBT learning community, or the ARC learning community. In total, 15 senior leaders (executive staff), 15 clinical supervisors and 105 clinicians were trained. Of those, 59 also participated in the CPP advanced track. Near perfect attendance was reported for all trainings and consultation calls, a reflection of the dedication of the clinicians and their organizations to learning and applying evidence-based and promising treatment models.

Trauma Informed Early Education and Care Systems Breakthrough Series Collaborative

In 2013, the DCTI also began implementation of the Trauma Informed Early Education and Care Systems Breakthrough Series Collaborative (BSC). During the planning stage for Boston DCI, partners identified the need for assisting whole programs and organizations to become trauma-informed. Accordingly, the Breakthrough Series Collaborative was envisioned as a way of helping early education and care centers throughout Boston to make sustainable changes in their trauma treatment-related policies and practices. It is an evidence-based methodology developed by the Institute for Healthcare improvement.[45] The aim of the Breakthrough Series was to support early education and care systems in preventing and reducing the impact of the children's exposure to violence by becoming trauma-informed settings.[46] Early education and childcare systems were selected as a target for the first BSC because of their ability to focus on primary prevention, stopping violence before it starts.

Planning and Staffing. To plan the Breakthrough Series, Boston DCI identified and hired an Improvement Advisor, who served as a consultant and was an expert in the implementation of new practices, particularly creating change in organizational cultures for child welfare and child trauma-focused agencies. The Improvement Advisor had worked with the National Child Trauma Stress Network on methodology for organizations to focus on child trauma. In 2001, she had been an organizational director for the first ever BSC conducted in a child-trauma setting and helped to adapt the method from the healthcare arena to child welfare. Since that initial BSC, she had been involved in 17 Breakthrough Series Collaborative and was the ideal individual to consult on the relatively novel approach of implementing a BSC on trauma-informed early childhood centers.

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[45] The Breakthrough Series Collaborative, along with other learning collaboratives, are considered evidence-based approaches to training. Much of the evidence on these approaches is in the medical field; Boston's application of the BSC to early childhood centers is a relatively novel application. Studies that demonstrative the effectiveness of this type of training include Benedetti R, Flock B, Pedersen S, Ahern M. 2004. Improved clinical outcomes for fee-for-service physician practices participating in a diabetes care collaborative. The Joint Commission Journal on Quality and Patient Safety. 30(4):187-194; and Pierce-Bulger M, Nightswander T, Nutaqsiivik. 2001. An approach to reducing infant mortality using quality improvement principles. Quality Management in Health Care. 9(3):40-6.

[46] Trauma-informed settings and systems are spaces that are safe and predictable to reduce traumatic stressors and triggers, as well as to help children learn, grow, and heal. Trauma-informed environments ensure that children can build nurturing relationships with their caregivers, as well as build resiliency and protective factors. For more information about trauma-informed systems, see http://www.nctsn.org/resources/topics/creating-trauma-informed-systems.

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Framework for the Breakthrough Series. A Collaborative Change Framework was developed from the existing evidence and stakeholder perspective to serve as a guide of the BSC. Fifty people participated in an Expert Meeting to create the change framework. Participants included parents of young children, early childhood education teachers, directors, and administrators, mental health and trauma clinicians, primary care providers, social workers, and others who interact with children and families. The final outline of the Collaborative Change Framework is in Appendix I.

This BSC was designed to support trauma-informed early care and education (ECE) programs to:

- Prevent: Promote healthy social and emotional development, and nurturing, safe and stable relationships and environments for all children, families and communities;
- Protect: Identify children and families exposed to violence and ensure physical and emotional safety;
- Heal: Respond to children and families exposed to violence with trauma-informed practices in day-to-day interactions, and trauma-informed interventions that are accessible and appropriate; and
- Thrive: Strengthen resilience, protective factors, and social and emotional wellness in children, families and communities.

Faculty Recruitment. BSC faculty members were recruited through a separate application process. Because the BSC methodology is built on helping teams bridge the gap between "what we know" and "what we do," faculty members serve as practice experts. They share their expertise, perspectives, and experiences in various aspects of the Collaborative Change Framework. Faculty members also play a critical role in supporting and mentoring teams, helping teams learn the Collaborative Change Framework, understand the BSC methodology, and brainstorm changes teams test throughout the BSC. As part of supporting and mentoring teams, faculty facilitate communication within and between teams—building a culture of cross-team learning within the Breakthrough Series Collaborative. Faculty members also serve as consultants to the BSC project staff and planning team. Their consulting role may involve identification of team-specific issues that need to be addressed, providing insight into how teams are approaching the change process, pointing out common themes, learnings, and challenges occurring across teams, and serving as a "think tank" to resolve problems that may arise throughout the BSC. Faculty also lead specific BSC events such as a topic-specific all-Collaborative call, facilitation of breakout sessions during a Learning Session, or provide individual team consultation. In total, there were seven faculty members, including experts in infant mental health and young children and trauma, early education teachers, a pediatrician, an early childhood center director, and an expert in early childhood training and curricula.

Implementation. The Breakthrough Series Collaborative began in October 2013, ended in January 2015 and involved six local organizations and over 50 individuals. The six organizations were: Associated, Bridge Boston Charter School, Ellis Memorial & Eldredge House, Nazareth Child Care Center, Children's Services of Roxbury, and Wesley Childcare Center. Boston DCI released an RFP to recruit organizations for the BSC and went through a selection process that involved a temporary review committee consisting of faculty members. In its recruitment, Boston DCI focused on its target neighborhoods and early childcare organizations, with the hopes that creating change in these organizations could create systems change in low-resource settings, address health and racial inequalities when it comes to early childcare, and have a long term impact on youth in Boston's toughest neighborhoods.

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Each organization had at least four individuals as part of their team: a teacher, an administrator, a mental health clinician and a parent. These participants were referred to as Leaders; for example the parents were referred to as Parent Leaders and the clinicians were referred to as Mental Health Leaders. These collaborative teams, representing the full community of the early education system, worked with the BSC faculty and staff coaches to gain skills, set specific goals, and test improvements. Early on, organizations were required to complete a full self-assessment that covered the following areas: 1) capacity building and knowledge; 2) partnering with parents and caregivers; 3) health equity and racial justice; 4) early education and care agency structures and processes; 5) daily interactions with children and caregivers that promote resilience; and 6) systems that support strong families and communities. The organizations varied in their assessment outcomes but showed that, on average, the organizations felt that they had some strengths but significant challenges and had only limited trauma-informed approaches, services and structure. Self-assessment results (de-identified) can be found in Appendix J.

Teams attended four learning sessions and participated in numerous monthly calls. The first learning session was in October 2013, attended by 65 people, including teams, faculty, and observers. The second learning session was six months later in February 2014 with 53 participants; and the final learning session was in June 2014, with 50 total participants. Learning sessions were followed by monthly consultation calls with the sites, site visits and in-person meeting, and an expectation that the team from each organization would meet together weekly.

The primary method for implementing small changes was the PDSA, which stands for Plan-Do-Study-Act. Each team developed PDSAs for their organization, which were in turn tested, changed, and/or implemented during the timeframe of the BSC. Teams also received technical support to encourage continuous learning and support across teams. The first learning session helped introduce the organizations to the concept of a PDSA and allowed them the time to work together and develop their own. Each organization's teams worked on two to five PDSAs and, after completing the first learning session, kept the BSC faculty and staff coaches aware of their efforts through an online system. They also met twice a month at their organization to monitor their progress and track metrics. The use of PDSAs provided a means by which organizations were not overwhelmed about making large changes to become trauma-informed. Rather by making small

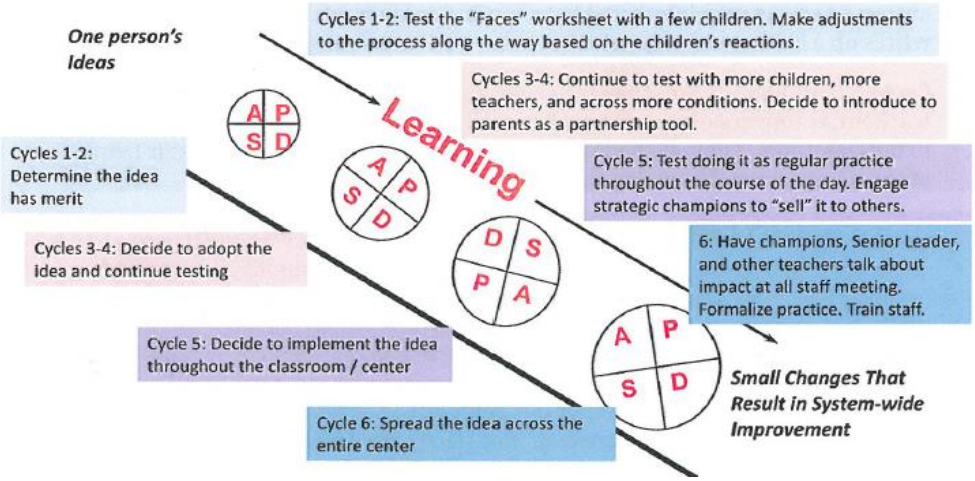

Figure 3. Repeated use of the PDSA cycle

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changes, testing them before adoption, and eventually making them regular practice, organizations could ensure greater success and sustainability in their efforts. An example of a PDSA moving from small change to full organizational implementation is found in Appendix K. A PDSA is intended to go through multiple cycles, as depicted in Figure 4. Only after multiple rounds of planning, doing, studying, and acting can the change become system-wide.

The BSC faculty and mental health partners (participants who were clinicians or social workers) developed a three-part workshop series for centers to train staff on the impact of trauma, importance of relationships and trauma informed practices. All of the centers have started or completed this training for their staff.

Incorporation of a Racial Justice Focus. In line with the Boston DCI focus on social justice and health inequalities, a BSC racial justice subcommittee was convened in January 2014. This committee met periodically and was charged with incorporating themes of racial justice throughout the collaborative, from learning sessions to resources to faculty coaching support. This committee also adapted the National Child Traumatic Stress Networks "12 Core Concepts of Childhood Trauma," to highlight the areas in which race and racism intersect with trauma.

The parent representatives from the early education centers created and led, with the support of DCI staff, a parent plenary that promoted positive relationships, power sharing and consumer control. In addition, the Parent Leaders co-created a Parent Partnership Guide highlighting the principles of 1) Open Communication, 2) Parent Leadership Promotion, 3)Parent/Teacher Relationships, and 4)Staff Capacity to Partner with Families.

Our research team observed one day of Learning Session 2, where organizational teams were trained on race, assumptions, privilege, and implicit bias, and their impact on decisions and climate. The teams also worked with faculty and staff to problem-solve around their ongoing PDSAs and to develop new ones. One component of the training was also breaking out into affinity groups, that is, groups based on role rather than organization. So, the teachers from across all six organizations broke out into one group, as did the parents, mental health clinicians, and administrators. This allowed for information-sharing across the organizations between individuals who had more similar roles and experiences.

Evaluation of the Breakthrough Series Collaborative (BSC). The BSC was being evaluated by Dr. Anne Douglas, an Assistant Professor in Early Education and Care Program at the University of Massachusetts Boston. She is also Director of Bachelor's and Post Master's Certificate Programs in Early Education and Care. Generally, her research focuses on early childhood policy implementation, professional and leadership development, the quality improvement and change process, and the role of early education and care in supporting and strengthening families and preventing abuse and neglect. This ongoing local evaluation will examine the implementation and outcomes of the BSC. The purpose of this study is twofold: 1) To examine how child care programs and systems improve quality and trauma-informed practices as a result of participation in the Breakthrough Series Collaborative, and 2) To investigate the implementation of an evidence-based quality improvement method originating from the health services field in the child care context. The study uses a structured multiple case study methodology, and data will be collected (direct observation, interviews, document review, and survey methods) to explore how improvements developed, spread, and were sustained, and with what outcomes. In addition, data collected as part

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of the BSC (monthly metrics, applications from participants, program self-assessments, and other BSC data) will be accessed and used in this study. Data from interviews, focus groups, and document review will be analyzed using qualitative methods, including coding for predicted and emergent themes. Results are expected in the spring of 2015. Although a rigorous impact study would be difficult to achieve, considering the sensitivity of data around children and trauma, this rich multi-method implementation study will have great value for understanding and improving the BSC methodology in a child welfare setting.

Youth Worker Training

Boston DCI stakeholders identified youth workers as a particularly important resource. Youth workers were defined broadly as any professional who works with young people who might have been exposed to violence and trauma. They typically support young people through relationship building, informal counseling and linking young people to resources. This includes street workers, youth/victim advocates, youth programming staff, and school or college counselors. Because youth workers use a relationship-based approach to working with young people, they are often trusted in ways that other services providers are not. Boston DCI believes that youth workers can be lifelines for young people and children exposed to violence.

Planning and recruitment for the youth worker training started about one year before its implementation. Through a request for proposals process, the Boston Area Rape Crisis Center was selected as the primary training partner to collaborate with Boston DCI to design and implement a youth worker training curriculum. The Boston DCI training manager reached out to community partners, both citywide organizations and partners in the target neighborhoods, to conduct interviews and set up focus groups with youth workers and youth. People were also recruited through youth worker networks. Twenty interviews were conducted with community partners and three focus groups were set up: two with youth workers, totaling 30 individuals, and one group with 15 youth. The interviews and focus groups provided insight on the best way to approach training youth workers, the needs of children who are exposed to violence, and the areas where training is lacking. In terms of needs, the results of the interviews and focus groups indicated that more knowledge is needed on the basic science behind brain development and how trauma affects the brain. More knowledge is also needed on the long-term effects of trauma, on self-care strategies, and strategies for improving resiliency among young people.

This effort led to the establishment of an advisory committee consisting of community partners who would work on the planning of the youth worker trainings. The advisory committee held three half-day meetings to determine the definitions and framework and create learning objectives and a training outline. Local and national curricula were also reviewed and an emphasis was placed on including racial and social justice themes. The results and training outline are provided in Table 3.3.

The first training was held in February 2012 and youth worker trainings have been implemented regularly since 2012 with over 700 attendees. Youth workers have come from a variety of Boston organizations, including: the Boys & Girls Club; YMCA; Catholic Charities, whose St. Peter's Teen Center received family nurturing grants in both rounds from Boston DCI, discussed previously; Whittier Community Health Center, which also provides direct services under the Boston DCI grant, discussed previously; Bottom Line, an organization focused on getting

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disadvantaged youth into college and graduating; Mass Mentoring Partnerships; Boston Center for Youth and Families, who partnered with Boston DCI to provide the Coaching Boys into Men program; Suffolk County DA's office, and Boston City Hall. A twelve part training series in the summer of 2014 had nearly 300 participants. Appendix H provides details on all professional trainings.

Table 3.3 Youth Worker Training Details

Learning Objectives	**Training Curriculum**
1. Increase youth workers knowledge of youth development, traumatic stress, and resiliency	***Day 1***: Adolescent Development and Trauma 101 • Identity • Impact of Trauma on Youth and on us ***Day 2:*** Building Resilient Youth • Crisis response skills • Boundaries ***Day 3:*** Trauma Informed Programs and Interactions • Stages of Change (motivational interviewing) • Restorative Justice • Action Plans
2. Increase youth worker's self-awareness of their personal beliefs, strengths, and biases around working with youth, trauma, and self-care	
3. Increase youth worker's ability to identify and use strategies for enhancing resiliency	
4. Increase youth worker's knowledge of how race, gender, ethnicity, sexual orientation, and other various identities can impact their own and youth's responses to trauma	

Challenges Related to Professional Training

Early on, partners and staff identified training as important to improve systems-wide knowledge and expertise, and to ensure sustainability. However, it took quite some time for Boston DCI to get training efforts off the ground and no trainings occurred in Year One, although Boston DCI had originally planned to do 30 trainings that year. One of the reasons for delay was the lack of staff dedicated to training. Originally, Boston DCI planned to hire two training managers, one for professional trainings and the other for community trainings. It took much longer than anticipated to hire, and they ultimately hired for only one position, due to the hiring restrictions of the Boston Public Health Commission and the City of Boston, as discussed in further detail in Chapter 4. This proved to be a significant barrier to developing and implementing professional training, especially early on. Once a training manager was in place in 2013, additional time was necessary for efforts to implement trainings; thus, a larger number of trainings occurred in the latter years of the project.

The use of the learning communities and breakthrough series models ensured that training participants would receive intensive, long-term support in their implementation of the evidence-based or promising treatments (as opposed to short-term trainings with little to no follow through). However, this training model limits the number of professionals who are reached, and thus limits the reach of the interventions.

Other challenges exist with professional training that are similar to those discussed under Treatment and Healing, since both have to do with working with mental health providers. Staff turnover and self-care can be challenges, and training staff who may soon leave an organization results in a need for ongoing changing and inconsistency in providing care to children and families.

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System Infrastructure and Coordination/System Capacity Building

Policy change was an important component of the Boston DCI's strategic plan. The primary goals were to promote trauma-informed systems in the multiple sectors serving children; to improve relevant data collection; and to put in place protocols that would help sustain the focus on trauma and CEV in Boston after the Defending Childhood grant funding ended.

Outreach to State Officials

To promote better policies, The Boston DCI Collaborative Body, coordinating with the Boston Public Health Commission Office of Inter-Governmental Relations, developed a briefing and supporting materials to make the case to the Massachusetts Department of Public Health (MDPH) to include exposure to violence as a preventable and prevalent health condition and recommend evidence based practices for addressing violence, trauma and related health conditions in the new Prevention Trust Fund. Forty-three organizations from across Massachusetts signed on in support of the briefing. The briefing was sent to the Commissioner of the Massachusetts Department of Public Health and the members of the Prevention Trust Fund advisory board.

Training as Form of Capacity Building

The aim of the Trauma Informed Early Education and Care Systems Breakthrough Series Collaborative (BSC), described previously under Professional Training, was also to build capacity and create large-scale change. By using the collaborative format, Boston DCI hoped to create systems change in the organizations that were involved in serving the CEV population.

Improved Data Collection by the Boston Police Department

The Boston Police Department currently requires its officers to complete an incident report form when responding to a call, including violence-related calls. To improve data collection, Boston DCI worked with the Boston Police Department to update incident reports to include a check box to indicate if a child has witnessed domestic or community violence. The hard copy forms now have a check box but the change on the online system is pending. As part of their growing partnership, and with the assistance of the Department of Justice, Boston DCI and the Boston PD had also been working on developing a training on trauma-informed practices for new recruits at the Police Academy.

Challenges Related to System Infrastructure and Capacity Building

Making changes system-wide is by far the most challenging component of any effort to address children's exposure to violence. The Boston Police Department has always been a member of the Collaborative Body and governmental representatives have shown support for Boston DCI; however large-scale changes are not easily accomplished. During the planning stages, the Collaborative Body made a clear decision to focus their effort on targeting the neighborhoods where health and violence disparities were evidence, and subsequently developed their strategic plan to focus on those communities and to fund local organizations to ensure that Boston DCI reached those who were most impacted by violence, rather than attempting to make change in the entire city.

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Chapter 4
Implementation Barriers, Facilitators, and Sustainability

The preceding chapter discussed the various strategies employed by Boston DCI and the challenges associated with each strategy. This chapter highlights the general barriers and challenges of the Initiative as a whole, as well as facilitators and other contextual factors. The chapter also includes a discussion of the technical assistance provided by Futures Without Violence and the Initiative's plans for sustainability.

General Barriers and Challenges

Implementing a large, multi-goaled initiative over multiple years is not without challenges. As discussed in the previous chapter, there have been specific barriers to providing direct services, implementing professional trainings, improving community awareness, and creating system-wide changes. Several additional important challenges cut across multiple aspects of the initiative.

Administrative and Budget Issues

The original Strategic Plan for the Boston DCI did not include the implementation of direct intervention services for children who have been exposed to violence, although the training communities were designed to improve the availability and quality of such services. In 2011, Boston DCI, along with the other Defending Childhood sites, were required to add on a direct intervention component because of additional funding from the Office on Violence Against Women (OVW). The new intervention component also had to have a domestic violence component, and subsequent reporting required sites to provide information on their services to DV victims and children. The Boston DCI Core Management and Leadership Teams worked quickly and efficiently to come up with the direct service model through subcontracts to local health centers. However, this additional component initially proved to be time-consuming and burdensome, especially since the original strategic plan, developing by the Collaborative Body, did not include it for intentional reasons of purpose and philosophy.

Early on, the grant was reduced from a three-year to a two-year initiative, forcing cutbacks on the timeline and proposed efforts. Boston DCI essentially cut all of their year three activities, and attempted to merge additional efforts into Year Two, while simultaneously experiencing delays and hiring challenges that postponed the initiation of some components of the project, such as the professional training. Ultimately, OJJDP was able to fund the sites for a longer period of time, initially through the third year (and eventually through 2017). The extended timeline compelled the site to rethink their efforts once again. Boston DCI was grateful to have the additional years of funding, but, like many of the other Defending Childhood sites, felt, justifiably, that they would have planned their Initiative differently if they had advance knowledge of full length of funding. That is, planning for a two-year grant is very different from the planning and decision-making for a five or six year grant.

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Hiring and Staff Turnover

The Boston Public Health Commission had two major challenges related to hiring that proved to be an impediment in ensuring that that the Defending Childhood implementation ran smoothly.

Like many other grant-funded programs, employment with the Defending Childhood Initiative was subject to funding restrictions, including only a one- or two-year time commitment. In this situation, Boston DCI found it difficult to attract competitive candidates, particularly for the Training Manager positions, as they were only for one year. The Boston DCI was unsuccessful in finding an ideal candidate in the first year of implementation, and this limitation delayed a strong investment in training, which was at the core of Boston DCI's original strategic plan.

In addition, the BPHC is also restricted in hiring due to a city-imposed residency requirement. Specifically, all jobs posted by the BPHC require Boston residency; thus, residents of Boston's suburbs and other areas were not eligible or had to move into the City of Boston by the time they began employment. Since Boston is a major city that can be quite expensive to live in, this coupled with the short-term duration of the jobs offered made employment as core DCI staff not as desirable as it might otherwise have been.

Staff turnover problems emerged with the subcontracting organizations as well, especially the Family Nurturing Programs and the direct service community health centers. As mentioned previously, staff working on the front lines, especially clinicians and social workers, tended to be younger, less experienced, and looking eagerly to move on to better job opportunities. Both services by the FNPs and the Whittier and Bowdoin Health Centers suffered when they had staff turnover, leading to delays in service provision or prevention programming. Additionally, when staff members turned over, additional time and money had to be expended to replace old staff members and retrain new ones.

Collaborative Fatigue

There are many ways that organizations are feeling over-committed in Boston. First, the city is quite resource-rich, but organizations are increasingly becoming involved in multiple teams, efforts, and collaboratives related to different funding streams. Specifically, many collaborative members are also involved in the National Forum on Youth Violence, Promise Neighborhoods, Choice, Start Strong, and STRYVE. Organization leaders work together in many different ways because of these many efforts and grant-funded initiatives; however, there is a feeling of being over-committed and spending too much time in meetings and working on collaborative groups.

In addition, the project faced a challenge with community partners who did not receive funding as part of the Boston DCI. It was especially difficult to keep these partners engaged, since they are often community-based, under-funded, and less likely to participate in efforts where they may not receive any direct financial benefit. City agencies were more likely to remain engaged throughout the duration of the initiative, but the inclusion of other organizations and their voices was equally important to the work of Boston DCI, yet more difficult to sustain.

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Moving beyond Silos

A major challenge of engaging numerous partners and working across a variety of agencies and local organizations was moving beyond silos. Similar to the rest of the country, many organizations in Boston often work in one specific area and address issues in that realm (e.g. domestic violence advocates do not necessarily work on community violence issues). This silo effect may stem in part from disparate funding streams that different types of agencies receive, differential community involvement and prioritization, or other reasons. The Core Management and Leadership teams of Boston Defending Childhood worked deliberately to encourage Collaborative Body members to look beyond their silos and to recognize children's exposure to violence as multi-faceted. This step required looking at community violence, domestic violence, school violence, relationship violence, and other forms as connected—a view that can be challenging for career professionals who have generally worked in one field.

Additionally, because of the late addition of the OVW funding stream and its requirement to focus on domestic violence, some of the collaborative players felt that this change counteracted the Phase I planning work they had done to break down the silos separating service providers that address different types of violence (i.e., forcing them back into their silos). By requiring Boston DCI to report specifically on service provision to domestic violence victims and their children, the site had to tease out exposure to one form of violence over the other (domestic violence) and seemingly give it preference. This appeared to be contrary to their efforts thus far; that is, working to push Collaborative partners and trained clinicians to think holistically about multiple exposures to violence and to ensure appropriate service provision and training to address all forms of exposure and multiple exposures.

There were other ways in which silos had an impact on the Boston DCI work. Addressing community violence often requires a multi-disciplinary approach, with criminal justice agencies as important partners. Yet, because the only local criminal justice agency participating in the Boston DCI was the Boston Police Department, addressing community violence comprehensively was impossible to do. The youth worker trainings and other efforts were aimed at increasing awareness and capacity to address children's exposure to violence, including community violence, yet evaluation research indicated that project scope was limited without additional criminal justice partners.

Time-Consuming and Seemingly Bureaucratic Reports

Because of the way the initiative was funded, with funding streams and requirements coming from a number of different divisions of the federal Department of Justice as well as from other federally-funded partners, program staff had to complete multiple progress reports. Every six months, staff had to submit one report to the Office of Juvenile Justice and Delinquency Prevention, which included separate reporting requirements for OJJDP and OVW. Additionally, every three months staff had to submit a quantitative implementation report to the Center for Court Innovation as part of the evaluation. Staff from the federally-funded technical assistance agency, Futures Without Violence, often asked for qualitative stories from the sites for their own reporting purposes. Each of these reports had different formats and took a great deal of time to complete. Additionally,

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program staff remained unclear as to how the routine federal funder reports were utilized, since they never received any feedback on them.

Other Contextual Factors

Operating in a major city, Boston DCI found high levels of violence in the community (as opposed to the home) to be particularly difficult to address given complicating factors such as concentrated poverty, unemployment, and disadvantage. There were many contextual factors that impacted the work of Boston Defending Childhood and its Collaborative Body partners.

The Affordable Care Act of 2010

The state of Massachusetts enacted comprehensive health care reform in 2006. However, despite the similarities between Massachusetts health care laws and the federal Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148, as modified by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010), changes to Massachusetts state law were expected. In 2012, state lawmakers passed legislation that tied health spending to the state's overall economic growth. The law also required greater transparency around hospital, health system and insurance company financials.[47] Although these changes did not directly affect the Boston DCI, organizations on the Collaborative Body were concerned about the impact that the new laws would have on health care billing, particularly in the area of mental health service provision.

In brief, these laws led to the following changes in Massachusetts, among others:

- State-funded healthcare programs moved from fee-for-service to payment models that emphasize coordination and cost-effectiveness;
- The state allocated $135M over four years to support infrastructure for new payment methods and care delivery models;
- 150,000 individuals insured through the state's subsidized Commonwealth Care program had to begin re-enrolling in updated subsidized health care plans;
- 100,000 individuals were shifted from Commonwealth Care into the state's Medicaid program, known as MassHealth;
- 45,000 uninsured people became eligible for MassHealth;[48]
- Benefits equivalent to MassHealth standard coverage became available to 19- and 20-year-olds as well as long-term unemployed Department of Mental Health clients.[49]

In terms of mental health and substance abuse treatment coverage, the ACA expands the scope of the applicability of federal mental health parity requirements and creates a mandated benefit for the coverage of specific mental health and substance abuse services.[50] Additionally, the ACA funds new and existing school based health centers with mental health and substance abuse treatment

[47] PricewaterhouseCoopers Health Research Institute. 2013. The Massachusetts Experience: New wave of consolidation for health sector post reform. New York, NY: PricewaterhouseCoopers LLP.
[48] The Associated Press. 2013. "How the Affordable Care Act Will Affect Massachusetts." *WBUR*, Sep 30, 2013. Retrieved October 15, 2014 (http://www.wbur.org/2013/09/30/obamacare-massachusetts-changes)
[49] See http://www.massresources.org/health-care-2014.html for more information.
[50] Sarata AK. 2011. *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010.* Washington, DC: U.S. Congressional Research Service.

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options, giving priority to underserved communities. School-based health centers must provide an array of mental health services, including assessments, crisis intervention counseling, treatment, and referral.[51]

While it remains unclear how these changes have directly impacted children's exposure to violence in Boston, it is likely that since 2010 and 2012, larger numbers of children and families have obtained medical insurance and greater exposure to behavioral and mental health treatment services. Along with the many other medical institutions in Boston, Whittier Street and Bowdoin Street Community Health Centers were actively engaged in determining how best to take advantage of increased coverage and funding through the Affordable Care Act. The ACA was an important ongoing contextual factor and Boston DCI staff were kept abreast of the developments due to their implications for available services and payment options related to children's exposure to violence.

Boston Marathon Bombing

In April 2014, two bombs went off at the finish line of the annual Boston Marathon. Three people were killed and over 260 were injured. This was quickly followed by a car hijacking, police chase, firefight with police, and the death of a university police officer. One suspect was killed and the other was captured shortly after. The entire experience was a traumatic one for the residents and city of Boston. One of the Collaborative Body members described it as a collective traumatic experience that needed to be addressed. The slogan "Boston Strong" was created as a part of the reaction to the attacks; it was soon adopted by celebrities and the local sports team in a widely publicized effort to move past the traumatic experience. About six months following the attack, research shows that 11 percent of children who had attended the Boston Marathon were reporting symptoms of post-traumatic stress disorder. This proportion was six times higher than those children who did not attend the event.[52] The study also found that exposure to the manhunt was more strongly associated with children's overall mental health problems than exposure to the attack itself. Boston Public Schools geared up to address children's exposure to violence in the aftermath and worked closely with local mental health clinics to increase the provision of services to students who needed them. Boston DCI and its Collaborative Body partners were also concerned about the traumatic experience, but believed that local community health centers and organizations were prepared to address any mental health and trauma needs.

Mayoral Change

Thomas Menino served as the Mayor of Boston from 1993 to 2014, when he retired after being the longest serving Boston Mayor. Martin Walsh was elected Mayor and began his term on January 2014. Regardless of the politics of the new mayor, the end of Mayor Menino's term was marked by great upheaval due to the fact that he had been in office for over 20 years. Throughout the last year, there has been extensive efforts and time undertaken to reintroduce the Defending Childhood

[51] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).
[52] Comer, JS. A Dantowitz, T Chou, AL Edson, RM Elkins, C Kerns, B Brown, and JG Green. 2014. Adjustment Among Area Youth After the Boston Marathon Bombing and Subsequent Manhunt. *Pediatrics* 134(1): 7-14.

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Initiative to key personnel and to work on creating the same buy-in and support that the initiative had under Mayor Menino. Mayor Walsh and his staff have made addressing violence and trauma a priority. In July 2014, Mayor Walsh provided the Boston Public Health Commission with $700,000 to expand Defending Childhood's direct services model in community health centers to 6 additional centers.

Facilitators

While there were challenges, there were some mechanisms in place that helped facilitate the successful implementation of the Boston DCI.

One of the primary facilitators in Boston was the richness of the city's resources. A multitude of city agencies, grassroots and community-based organizations, health centers, universities, and non-profits has led to an atmosphere that is conducive to partnership and implementation. The rich variety of professionals, advocates, and leaders in the city who are interested and engaged in addressing children's exposure to violence is most visible in the broad involvement in the Collaborative: over 65 organizations representing a wide range of fields. Through the leadership of Boston DCI, and as conveyed in research interviews, these organizations excelled at working together, building trust, and improving engagement with local communities.

As reported to the research team, an important component of this resource-rich city was the sheer number of high quality community-based organizations operating in the neediest neighborhoods. Because of the availability of these organizations, Boston DCI was able to, through its competitive grants and subcontracts, bring money and programming into the neighborhoods where such support was most needed. Strong partnerships were developed with relatively small organizations, including St. Peter's Teen Center and Mothers for Justice and Equality.

The political will of the leadership of the City of Boston also played an important role in facilitating project implementation. This element included a commitment by former Mayor Menino to the Defending Childhood Initiative and engagement of community leaders and other political representatives. The renewed commitment by the new Mayor will continue to be a facilitator for Boston Defending Childhood.

An important aspect of the efforts implemented by Boston DCI is the engagement and involvement of youth, including several youth-led projects such as The Halls and the Youth Leadership Healthy Relationship Promotion Projects. Youth were also involved in the development of the youth worker trainings and the collaborative body. This purposeful involvement of youth was an asset to Boston DCI and was greatly facilitated by the strong partnership with Start Strong. Other jurisdictions who may not have this type of partnership or organizations that have a strong legacy of youth engagement and leadership may find youth involvement more challenging.

Technical Assistance

The Boston Defending Childhood Initiative worked well with the technical assistance (TA) provider, Futures Without Violence. During the first year of implementation, Boston DCI staff worked together with staff at Futures Without Violence to adapt and implement the Coaching Boys

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into Men program at the Boston Area Centers for Youth and Families. Futures Without Violence also assisted with the dissemination of The Halls, the community awareness online episodes discussed earlier.

Throughout the course of the grant, Boston consulted with the TA provider on a variety of topics: the development of the public education campaign and feedback on the content; troubleshooting issues related to direct service provision, especially community outreach and staff turnover; youth worker training curriculum; overall grant management issues; and sustainability.

Futures Without Violence staff conducted a site visit to Boston in May 2012. Topics covered included health care reform and financing to fund therapeutic interventions for children and youth, home visitation curriculum to better address CEV, policy issues, strategies for engaging the collaborative body, information for parent advocates, grant related administration questions, breakthrough series process feedback and document review. The TA providers also attended Boston DCI training sessions for youth workers.

Boston DCI also participated in the bi-weekly TA calls and attended all-sites and project director meetings annually. However, staff indicated that the relevance and importance of the bi-weekly calls declined with time; as projects moved farther into implementation, hearing about new program options or strategies was just no longer relevant to the work they were already doing.

Sustainability

As the Boston Defending Childhood Initiative moved into implementation, the Core Management Team and Leadership Team began discussions about long-term sustainability. The Boston Public Health Commission itself is an organization that is mostly grant funded meaning that agency staff are engaged in an ongoing and active effort to look for grants at all times. The BPHC has received additional funding from the Office of Violence Against Women and recently started strong funding partnerships with local hospitals, including Children's Hospital of Boston. In 2014, Children's Hospital funded Boston DCI ($350,000 over two years) to support training and capacity building strategies. This funding stream will continue into the foreseeable future. The Core Management team is reportedly optimistic that the Collaborative Body will continue to work together and meet beyond the timeline of the Defending Childhood Demonstration Program grant.

The emphasis on training and learning communities ensured that the City of Boston has the capacity to continue to address children's exposure to violence beyond this grant. Professionals, youth workers, and organizations that were trained during this grant period will continue to work in this field at their organizations well beyond the grant. Additionally, the learning community and breakthrough series models will help to ensure that trainees implement their training appropriately and continuously. In developing RFPs and subcontracts, Boston DCI required sustainability plans from their grantees and encouraged them to learn about existing and new funding mechanisms such as MassHealth and the Affordable Care Act. For the community health centers providing direct services, the plan is to move to a billable hours model, where they will bill insurance carriers for their work. This change will help ensure that the Clinician and Family Partner roles will continue into the future.

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Conclusion

Although it took some time to get all of the programming up and running, the Defending Childhood Initiative in Boston had significant accomplishments in an effort to prevent and reduce the impact of children's exposure to violence.

One of the most significant accomplishments was simply the establishment and continuation of the Collaborative Body, where the project harnessed the resources of the city and brought together a large group of stakeholders and organizations from a variety of fields. The Collaborative Body and Core Management Team addressed obstacles to working across fields and encouraged greater collaboration and cooperation amongst organizations that had not interacted before—or that had interacted before but not on an initiative of the current magnitude.

Working predominantly with communities of color, Boston DCI developed a model for centralizing the importance of racial/social justice and health equity during both planning and implementation in nearly every approach for addressing children's exposure to violence. Examining implicit bias (race, gender, sexual orientation) was a theme across most of the work.

Additionally, Boston DCI successfully implemented evidence-based training programs in the form of Learning Communities and Breakthrough Series, which create an environment of learning and continued engagement for professional and system wide change. Rather than relying on one-shot training sessions or workshops, Boston DCI embraced a long-term commitment to educating professionals and improving organizations through extensive and continuous training. This strategy is not only a potential trigger for higher quality work among those who were trained but also represents a commitment to sustainability—since the effects of professional training have potential to outlast a one-time funding stream.

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Appendix A. Full List of Collaborative Body Members

Sector	Organization
Domestic Violence	• Asian Task Force Against Domestic Violence • Casa Myrna Vasquez • The Network/La Red (LGBT domestic violence services) • Massachusetts Alliance of Portuguese Speakers
Sexual Assault	• Boston Area Rape Crisis Center
Intimate Partner Violence Prevention	• Close to Home
Sexual Exploitation	• The My Life My Choice Project
Law Enforcement	• Boston Police Department • Suffolk County District Attorney's Office • Youth Advocacy Department
Head Start, afterschool, education and childcare	• Action for Boston Community Development (ABCD) Head Start/Early Head Start • Associated Early Care and Education • Boston Centers for Youth and Families • Boston Public Schools • Boys and Girls Clubs of Boston • YMCA of Greater Boston • Thrive in 5
Health and mental health	• Boston Medical Center • Boston Conference of Community Health Centers • Bowdoin Street Health Center • Brigham and Women's Hospital • The Child Witness to Violence Project/Boston Medical Center • Children's Hospital • Codman Square Health Center • JRI Health/ The Trauma Center • School Based Health Centers, Boston Public Health Commission • Roxbury Youth Works
Family Strengthening	• Families First • Family Nurturing Center of Massachusetts
Child maltreatment	• Child Advocacy Center • Children's Trust Fund • Family Service of Greater Boston • Massachusetts Society for the Prevention of Cruelty to Children

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Sector	Organization
Community and school violence	• Citizens for Safety • Project Right Inc (Grove Hall VIP Coalition) • Inquilinos Boricuas en Acción (IBA) • Jamaica Plain VIP Collaborative • Madison Park Development Corporation (Orchard Gardens VIP Coalition) • Mattapan Community Health Center (Mattapan VIP Coalition) • Uphams Corner Health Center (Uphams Corner VIP Coalition) • Youth Connect • The Louis D. Brown Peace Institute • Mothers for Justice and Equality
Faith-based	• Boston Ministerial Alliance • Catholic Charities (Haitian and Cape Verdean services) • Boston Ten Point Coalition
Other culturally-specific or vulnerable population	• Boston Alliance of Gay, Lesbian, Bisexual, Transgender Youth (BAGLY) • Federation for Children with Special Needs • Somali Development Center, Inc.
State Agencies	• Department of Children and Families • Department of Public Health • Department of Transitional Assistance • Department of Youth Services • Governor's Council to Address Sexual and Domestic Violence • Jane Doe Inc.: The Massachusetts Coalition Against Sexual Assault and Domestic Violence • Massachusetts Office of Victim Assistance
Funders	• Blue Cross Blue Shield Foundation • The Boston Foundation • State Street Foundation- Massachusetts Strategic Grantmaking & Youth Violence Prevention Funder Learning Collaborative • United Way of Massachusetts Bay and Merrimack Valley
Academic Institution	• Harvard Youth Violence Prevention Center
Other	• Health Resources in Action • Children's Hospital Boston Center for Media and Health

*Many partners will represent multiple categories.

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Appendix B. Collaborative Body and Workgroup Meetings

Meeting Date	Type of Meeting	Meeting Time	# of Participants
YEAR ONE			
11/30/2011	Collaborative Body Meeting	3:00pm – 5:00pm	24
1/9/2012	Leadership Team Meeting	2:00pm – 4:00pm	16
1/25/2012	Community Health Center Conference Call	9:30am – 10:30am	15
2/17/2012	Direct Services Input Meeting	3:00pm – 4:30pm	20
2/21/2012	Youth Engagement Input Meeting	9:30am – 11:00am	6
2/27/2012	Leadership Team Meeting	4:00pm – 6:00pm	20
3/12/2012	Collaborative Body Meeting	3:30pm – 5:00pm	36
3/23/2012	Parent Advisory Council	6:30pm – 8:00pm	8
3/30/2012	Family Nurturing Grants Bidders Conference	9:30am 11:00am	25
4/18/2012	DCI State Partners Meeting	11:00 am - 12:30 pm	6
4/20/2012	Parent Advisory Council	6:00 pm - 7:30 pm	7
4/23/2012	Leadership Team Meeting	4:00 pm - 5:30 pm	15
4/26/2012	Youth Leadership Healthy Relationship Promotion Projects Grant Review	4:00 pm - 6:00 pm	7
5/1/2012	Family Nurturing Center Grant Review	9:00 am - 11:00 am	5
5/1/2012	Family Nurturing Center Grant Review	1:00 pm - 3:00 pm	5
5/3/2012	Family Nurturing Center Grant Review	9:30 am - 11:30 am	5
5/3/2012	Family Nurturing Center Grant Review	12:00 pm - 2:00p m	5
5/25/2012	Parent Advisory Council	6:00 pm - 7:30 pm	5
5/30/2012	DCI State Partners Meeting	11:30 am - 12:30 pm	7
5/31/2012	Mental Health Learning Community Kick Off	10:00 am - 11:30 am	34
6/8/2012	Collaborative Body Meeting	9:30 am - 11:30 am	43
6/18/2012	Leadership Team Meeting	4:00 pm - 5:30 pm	14
6/19/2012	Direct Services Grant Review	2:00 pm - 5:00 pm	6
6/29/2012	Parent Advisory Council	6:00 pm - 7:30 pm	7
4/18/2012	DCI State Partners Meeting	11:00 am - 12:30 pm	6
4/20/2012	Parent Advisory Council	6:00 pm - 7:30 pm	7
4/23/2012	Leadership Team Meeting	4:00 pm - 5:30 pm	15
4/26/2012	Youth Leadership Healthy Relationship Promotion Projects Grant Review	4:00 pm - 6:00 pm	7
5/1/2012	Family Nurturing Center Grant Review	9:00 am - 11:00 am	5
5/1/2012	Family Nurturing Center Grant Review	1:00 pm - 3:00 pm	5
5/3/2012	Family Nurturing Center Grant Review	9:30 am - 11:30 am	5
8/3/2012	DCI State Partners Meeting	2:00pm – 3:30pm	8
YEAR TWO			
9/28/2012	Caregiver's Council	6:00pm – 8:00pm	8
10/9/2012	Leadership Team Meeting	3:30pm - 5:30 pm	10
10/23/2012	Collaborative Body Meeting	3:00pm - 5:00 pm	32
11/30/2012	Caregiver's Council	6:00pm - 8:00pm	5
12/15/2012	Caregiver's Council Empowerment Breakfast	10:00am - 1:00pm	55
12/20/2012	Leadership Team Meeting	3:30pm - 5:30 pm	13
3/22/2013	Breakthrough Series Expert Meeting	9:00am – 5:00pm	65
3/27/2013	Collaborative Body Meeting	9:00am – 11:00am	40
4/26/2013	Leadership Team Meeting	9:00am – 11:00am	13

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5/22/2013	Collaborative Body Meeting	9:00am – 11:00am	39
6/4/2013	Leadership Team Meeting	9:00am – 11:00am	13
7/24/2013	Leadership Team Meeting	9:00am – 11:00am	18
7/31/2013	Caregiver's Council	6:00pm - 7:30pm	5
8/28/2013	Caregiver's Council	6:00pm - 7:30pm	4
YEAR THREE			
10/16/2013	Leadership Team Meeting	9:00am – 11:00am	15
2/20/2014	Leadership Team Meeting	9:00am - 11:00am	17
3/6/2014	Collaborative Body Meeting	9:00am - 11:00am	29
3/17/2014	Parent Council Meeting		7
5/29/2014	Leadership Team Meeting	9:00am -11:00am	10
6/3/14-6/4/14	Trauma-Informed Early Education and Care Systems Breakthrough Series Collaborative	8:30am - 4:00pm	60
7/10/2014	Collaborative Body Meeting	9:30am -11:30am	16

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Appendix C.

Defending Childhood Service Delivery Model

Referrals

Referrals from Medical Home

Referrals from Community Partners

Engagement & Assessment Visits

- **Team- Based Engagement:** The initial visits should be done jointly by the Clinician and Family Partner, as both providers are essential to understanding the full picture of a family's strengths and needs.
- Initial visits can be conducted in health center, home visit or at community partner site.
- Discuss confidentiality and informed consent.(FP & Clinician)
- Inquire about immediate crisis concerns (ex: safety issues, basic needs) & if immediate response is necessary, formulate crisis plan (FP & Clinician)
- Introduce Child and Family to Defending Childhood services.
- Conduct CANS and site specific Defending Childhood Assessment. (Family Partner and Clinician)
- Administer trauma standardized measures for child and for parent. (Clinician)
- **Clarify Roles** of Clinician and FP moving forward: Clinician to work on behavioral health plan for child & FP to work with caregiver on resources and supports for the family

Treatment Plan

Plans are individualized to each family; the involvement of the Clinician and FP will vary for each family based on their individual needs. A site-specific, clear communication system between the FP and Clinician is critical for coordinated, team-based care. Treatment Plans include both therapeutic/clinical goals (clinician) and resource/supports goals (family partner).

Clinician takes lead on the Child's Clinical Treatment Plan

•Clinician develops clinical goals of family's participation in DCI Services and identifies clinical practices to address needs of the child and family based on the assessment.

•Clinician develops plan to link caregiver into behavioral health supports, as needed.

•Clinician provides therapy, coordinates clinical services plan with collateral contacts (medical home providers/school/DCF etc.) as specified in the clinical treatment plan

Family Partner takes lead on the Family's Resource & Support Plan

•FP leads family engagement efforts to support, encourage and empower caregiver to engage in clinical treatment plan and ensures that family voice is represented in plans.

•FP works with caregiver to identify caregiver's resource & support goals, all which relate to addressing the child's exposure to violence and trauma, based on the assessment.

•FP brainstorms possible community and medical home resources to support caregiver in meeting her resource & support goals. Specific strategies may include addressing basic needs, community resources, connect to domestic violence advocacy, parent education, family nurturing program, skill building, workshops, identifying/strengthening natural supports, mentorship, etc.

• FP provides flexible family support, & coordinates community-based services and supports

Integrate Clinical Plan with Resource & Support Goals

Includes Family, Clinician, Family Partner, Natural Supports

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Appendix D. Request for Proposals for Family Nurturing Programs (Select Pages)

Boston Public Health Commission
Division of Violence Prevention:
Defending Childhood Initiative Family Nurturing Programs
Request for Proposal Guidelines

Applications Due: May 30, 2013 by 4:00 pm

Overview

The Boston Public Health Commission (BPHC) is pleased to announce this Request for Proposals (RFP) under the *Defending Childhood Initiative*. The Boston Public Health Commission will fund 5 community based organizations to be trained in and implement the evidence-based Family Nurturing Program in their community. Current grantees are eligible to apply, based on performance and up to 3 current grantees may be awarded funds.

Funding Amount: $20,000.00 per organization

Funding Period: July 1, 2013 to June 30, 2014

Bidders' Conference: ***May 10, 2013 at 10:30 am to 12:00 pm*** at the Boston Public Health Commission (Hayes Conference room on the 2nd floor). The Bidder's conference is an opportunity to for potential bidders to hear from the Defending Childhood Initiative and Family Nurturing Center of Massachusetts and ask questions. **Please RSVP for the Bidders' Conference by May 8th at 5 pm to sdoyle@bphc.org.**

Letter of Intent: Organizations are encouraged to submit a letter of intent stating that they plan to apply for the Family Nurturing grant by **May 17th at 5 pm to sdoyle@bphc.org**. Letters of intent are strongly encouraged so that we may plan for the review process but they are not mandatory or binding.

Eligible Organizations

Organizations encouraged to apply for this funding are community based organizations in Boston that work with children and families. This may include child care centers, schools, after school programs, health centers, grassroots community groups, faith-based organizations, tenant associations, domestic violence shelters or established nonprofit organizations currently working with children and families in Boston. Organizations must have demonstrated experience working with families; must be a 501(c)(3) based in Boston or must apply via a 501(c)(3) organization that will act as the fiscal manager for the funds. **A collaboration of organizations may apply but must identify a lead agency who will act as the fiscal manager for the funds.** Current grantees are eligible to apply, based on performance and up to 3 current grantees may be awarded funds. This RFP will refer to the selected grantees as grantees.

Background and Justification

The Boston Public Health Commission, in partnership with the Child Witness to Violence Project at Boston Medical Center, received a $2 million grant from the United States Department of Justice to lead the Boston Defending Childhood Initiative. Since 2010, over 60 diverse organizations and agencies have come together to help create and implement an action plan to prevent and reduce the impact of exposure to violence in homes, schools, and communities for children aged 0 to 17 years old. Please see Attachment A for more information about the Defending Childhood Initiative's five strategies.

In a needs assessment conducted by the Defending Childhood Initiative, parents expressed a need for support from other parents and from community resources. Providers saw a need for family engagement and more opportunities for support and skill building for parents. The Defending Childhood Initiative will fund community

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organizations or collaborations to deliver the evidence-based Family Nurturing Program to the families that they serve. The Family Nurturing Program promotes nurturing relationships among all family members while building community connections to support positive parenting. It has been adapted for diverse cultural groups as well as developmental stages of children.

Background of the Family Nurturing Program

* From the Family Nurturing Center of Massachusetts http://www.familynurturing.org

Nurturing Program Core Values

- Love of life, self, and others
- Respect for self, others, and the environment
- Structure and discipline
- Fun and laughter

Goals of the Nurturing Program

- Develop positive self-concept and self-esteem in all family members
- Build empathic awareness of the needs of others
- Teach positive discipline and alternatives to hitting and yelling
- Increase awareness of self needs and strengths
- Enhance family communication
- Raise awareness about developmental needs of other family members
- Substitute nurturing values and behaviors for abusive parenting practices
- Promote healthy physical and emotional development of self and others
- Build family cohesion
- Connect families to other families for exchange and support
- Learn to have fun as a family and as a community

How do Nurturing Programs work?

The Nurturing Program is a series of classes for families to take together. Sometimes these classes are brought to one family in their home. Most often, they are held at a community meeting place where families can come together in a group to learn nurturing skills. Trained nurturing teams, made up of professionals and volunteers representative of the families they serve, deliver group-based programs at convenient locations, providing transportation when needed. Most Nurturing Programs serve 10 to 12 families at a time, with approximately 20 to 40 parents and children participating. Children are grouped by age and the number of groups you have depends on the families you are serving. The time and frequency of meetings depends on the curriculum used. In most cases, there are 15 weekly sessions, lasting 3 hours each week. Typically, programs will need 2 trained facilitators for the parent group and each of the child groups. In addition, you may need to offer child care for some children.

Parents and children usually attend the Nurturing Program together and learn the same skills. This structure helps families get along better and establish a nurturing way of life. By bringing groups of families together, it also build more nurturing communities that support parents and reinforce nurturing values.

The program helps participants explore the meaning of nurturing and how each of us has learned to nurture others and ourselves. Through self awareness and skill-building activities participants: increase empathy and positive use of personal power; develop realistic expectations of children and more appropriate family roles; and decrease reliance on hitting, yelling, and other harsh forms of discipline. The program also builds connection, support, and a sense of community by providing opportunity for sharing and exchange among participants.

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Scope of work:

Grantees will be awarded up to $20,000.00 each to plan and implement a Family Nurturing Program with families in their community. Grantees will:

- Identify the type of Family Nurturing Program that the grantee will implement:
  - Prenatal Nurturing Program
  - Nurturing Program for Parents and Children (English and Spanish)
  - Parents and Adolescents
  - Nurturing Fathers Program

  Please visit The Family Nurturing Center of Boston (http://www.familynurturing.org/programs-nurturing.htm#types) and the national Nurturing Parenting website (http://nurturingparenting.com/) to learn more details about each type of program. Programs have been adapted for different languages and cultural groups. Please explore.
- Participate in a three hour grantee orientation meeting the week of July 22, 2013.
- Participate in a 3-day Developing Nurturing Families and Communities Facilitator Training. All staff or volunteers who will be facilitating the curriculum and one supervisor must attend the training. The trainings will take place late September, October and early November 2013.
- Work with the Defending Childhood Initiative and Family Nurturing Center of Massachusetts to develop a technical assistance plan for the planning and implementation of the program.
- Identify one staff person to be the coordinator of the program. This person will be responsible for coordinating recruitment, the intake process for families, logistics (transportation, food, materials and space) for the program and completing evaluation materials. It is estimated that Coordinator will devote 5 to 7 hours per week during the planning/recruitment phase and during the implementation of the curriculum.
- Recruit at least 15 to 18 families to participate in the Family Nurturing Program.
  - Complete intake forms, and pre/post AAPI assessments with each family.
  - Conduct consistent outreach and follow up with families to support them to complete the curriculum. Connect families to other supportive resources when needed.
- Implement a Family Nurturing Program with fidelity to the model and training.
  - Plan for all logistics related to the program, including space, transportation, materials, and food. The space for the program must have separate rooms or sections for small groups. The Defending Childhood Initiative can assist in identifying space when needed.
  - Identify and support staff and volunteers to be facilitators of the program. Each parent and child group will need 2 facilitators. Staff and volunteers will need to devote 5 hours per week during the program to facilitate; this includes planning the session, delivering the session and debriefing.
  - Ensure that 12 to 15 families graduate from the program.
- Complete fidelity checklists, quarterly progress reports and a final report for the Defending Childhood Nurturing Program.
- Ensure sustainability of the project and present a plan for continuing activities after the conclusion of funding.

The Boston Public Health Commission will:

- Provide up to $20,000.00 to each grantee to plan and implement one Family Nurturing Program.
- Provide training and support to grantees in partnership with the Family Nurturing Center of Massachusetts.
- Assist grantees in identifying space.
- Ensure active, accurate, and consistent communication between the Boston Public Health Commission and the grantees.

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Evaluation Criteria and Notification Process

The application will be reviewed and evaluated on the basis of:

- Commitment to the Family Nurturing Program and core principles. (10 points)
- Identification of need for the program in the grantee's community. (10 points)
- Capacity to recruit and support families to successfully complete the program. (15 points)
- Commitment and capacity to successfully plan and implement a Family Nurturing Program with fidelity. (20 points)
- Ability to conduct intakes and collect and report evaluation data. (15 points)
- Commitment to sustain the program and bring it into the organization's culture. (10 points)
- Realistic and thorough timeline. (10 points)
- Relevance of budget to support planning and implementation of the program. (10 points)

The Boston Public Health Commission will convene a review board comprised of residents, partners, and Boston Public Health Commission staff. The committee will review all proposals and recommend the best candidates for selection by a designated official of BPHC.

As part of the review process, Boston Public Health Commission staff may conduct a site visit in which Boston Public Health Commission staff and Family Nurturing Center representatives may meet with organization staff. The visit will be an opportunity to learn more about the organization and their commitment to the Family Nurturing Program.

Notwithstanding the review board's recommendation, BPHC reserves the right to make the final decision regarding the selection of a proposal under this Request for Proposals (RFP). BPHC will notify applicants on or about June 17, 2013. Organizations that receive grants will be required to sign a Boston Public Health Commission standard contract.

Inquiry and Submission Process

- Questions about this RFP can be referred in writing to Stephanie Doyle at sdoyle@bphc.org and must be submitted by May 28th, 2013 at 5:00 pm.
- Questions and answers will be shared with all applicants at the BPHC website under ***RFPs & Bids***. A PDF document will be updated regularly with questions that are received and their answers.
- **Letter of Intent:** Organizations are encouraged to submit a letter of intent stating that you plan to apply for the Family Nurturing grant by **May 17th at 5 pm to sdoyle@bphc.org**. Letters of intent are strongly encouraged so that we may plan for the review process but they are not mandatory or binding.
- **Submission: All proposals must be received at the Boston Public Health Commission by May 30, 2013 by 4:00 pm. There will be no exceptions to this deadline.**
    - **Email:** Stephanie Doyle at sdoyle@bphc.org with subject *Defending Childhood Initiative Family Nurturing Programs* Review
    - **Hand Deliver:** Original proposal and seven copies must be submitted to the receptionist on the 2nd floor at 1010 Massachusetts Avenue, who will provide a signed receipt.
    - **Mail:** Original proposal and seven copies mailed to:

      ***Defending Childhood Initiative Family Nurturing Programs* Review**
      Stephanie Doyle, Div. of Violence Prevention
      Boston Public Health Commission
      1010 Massachusetts Avenue, 2nd Floor
      Boston, MA 02118

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Funding

Applications should include a budget for July 1, 2013 to June 30, 2014. A grant of up to $20,000.00 each will be available for five (5) sponsored organizations. Funds may be used:

- To pay part of a salary of a staff person to work as a coordinator.
- To pay a stipend to facilitators.
- To pay for space.
- Purchase the relevant Family Nurturing Program curriculum.
- To pay for food, transportation, and materials necessary for the program.

Funds will be paid on a cost reimbursement basis. Funds cannot be used for costs incurred before the contract is issued in July 2013 or after June 2014. Final payments will be made after the receipt of all data and evaluation reports.

Summary of *Defending Childhood Initiative Family Nurturing Programs* Timeline	
RFP Release	April 25, 2013
Bidder's Conference	May 10, 2013
Letter of Intent due	May 17, 2013
Application Due	May 30,2013
Award Notice	On or about June 17, 2013
Contracts Issued	July 1, 2013
Contract Year 1 end	June 30, 2014

Grant Application Checklist

- ✓ Answer all of the grant application questions below.
- ✓ Proposals shall not exceed 10 double-spaced pages, NOT including coversheet, budget, budget narrative and timeline. Please no binders or folders.
- ✓ The application must be typewritten in 12 point font with one inch margins.
- ✓ Prepare an itemized budget and budget narrative that supports the proposed activities.
- ✓ Timeline that outlines activities and benchmarks to plan and implement the proposed program.
- ✓ Complete and sign the attached coversheet. *An authorized signatory of the 501(C)(3) organization must sign the coversheet.*
- ✓ The original proposal plus seven copies must be received by May 30, 2013 at 4:00 pm on the 2nd floor at 1010 Massachusetts Ave. at the Boston Public Health Commission OR emailed to Stephanie Doyle at sdoyle@bphc.org. *There will be no exception to this deadline.*

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Attachment B:

Family Nurturing Center of Massachusetts
200 Bowdoin Street, Dorchester, MA 02122
(617) 474-1143 or Fax (617) 474-1261

Family Nurturing Program Budget

(based upon a 15 week Family Nurturing Program + an Open House)

Training (funded by the Defending Childhood Initiative)	0
(the factors below will vary by program)	
Coordinator Time (planning and implementation)	4,000
Facilitators	9,000
Curriculum	800
Transportation (100-300/pm @ 16 nights)	1,600
Food (130/night @ 16 nights)	2,080
Space ($50 rental for 16 nights)	800
Consumable Supplies & Graduation	800
TOTAL	**19,080**

NOTES:

* Staffing costs for NPs vary a lot. We estimate the coordinator will spend 5 hours a week for 6 months.
* Some programs/groups provide stipends to the members of the Nurturing Team. That is an individual program decision often based on resources and whether or not people are doing the program as part of their existing job or doing it above and beyond their job. FNC of MA provides stipends when available and the range is $500 - $2000 based upon role (lead or co-faciltator) and experienced NP facilitator or 1st time NP facilitator.
* Food, space, travel and supplies are all variable costs based upon what exists already and what resources you may be able to get community partners to donate. Above figures are guidelines for planning/proposal development.

Additional Note: The above costs are based upon doing the Nurturing Program for Families birth - teen age curriculum.

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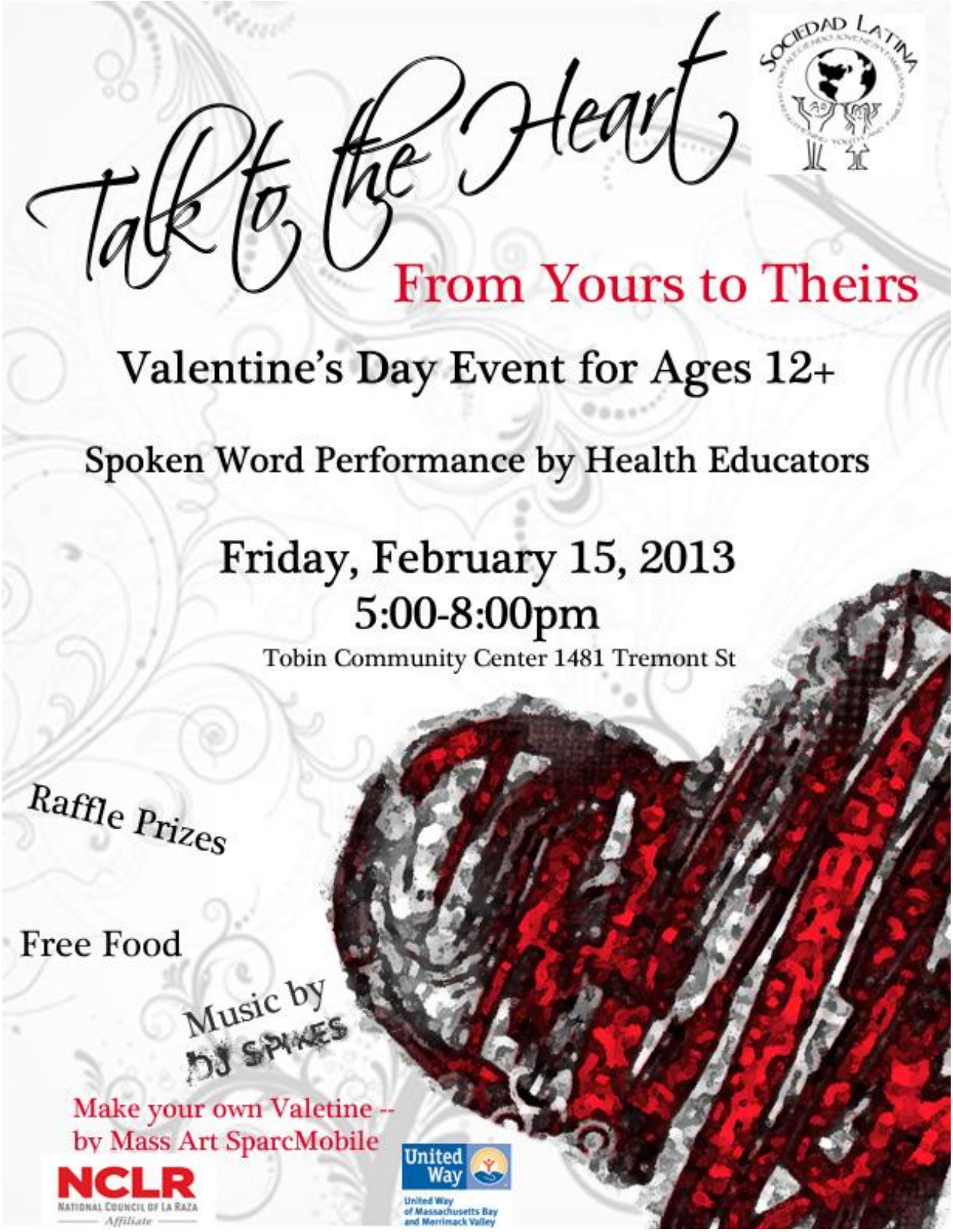
Appendix E. Sociedad Latina Event Flyer



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Appendix F. Sociedad Latina Art Installation

Two Rooms, Two Feelings: Artist Statement

Our installation is a work of art that is interactive and generates emotion. It plays into the senses of sight, smell, touch and hearing. Two Rooms, Two feelings is a temporary exhibit at Sociedad Latina.

Blocked Communication

This is a room of white with a mass of white chairs in the center. The color white and the chairs symbolize emptiness and when someone feels lonely, disrespected, unloved or unimportant in a relationship. A recording plays remarks on failed interaction in the room. In the room you see two windows, one clear and one black in the center. Black was used on the windows to represent a block in communication. Windows are usually clear and are an entry point. However, when one does not realize how they are communicating with others, it is blocked.

Communication Discovered

This is a colorful room with a bouquet of flowers and a recording that pays compliments to people in a healthy relationship. The different colors and flowers symbolize happiness and how somebody feels when they are being respected, loved and cared for in a relationship. For this room, one of the main colors is white and blue. Blue signifies loyalty, strength and wisdom, and we used this in the room to show that we should be loyal to our peers and that we are strong and wise when we are together. Orange is a combination of red and yellow. It is also a bright and warm color. It represents fire, the sun, fun, warmth and tropical images. It is considered a fun light color with appetizing qualities. This is the warmth you feel when you are in a good relationship.

We invite you to reflect and think about how you interact with others based on the words, body language and tone with which you convey your message.

The Healthy Relationships Group at Sociedad Latina

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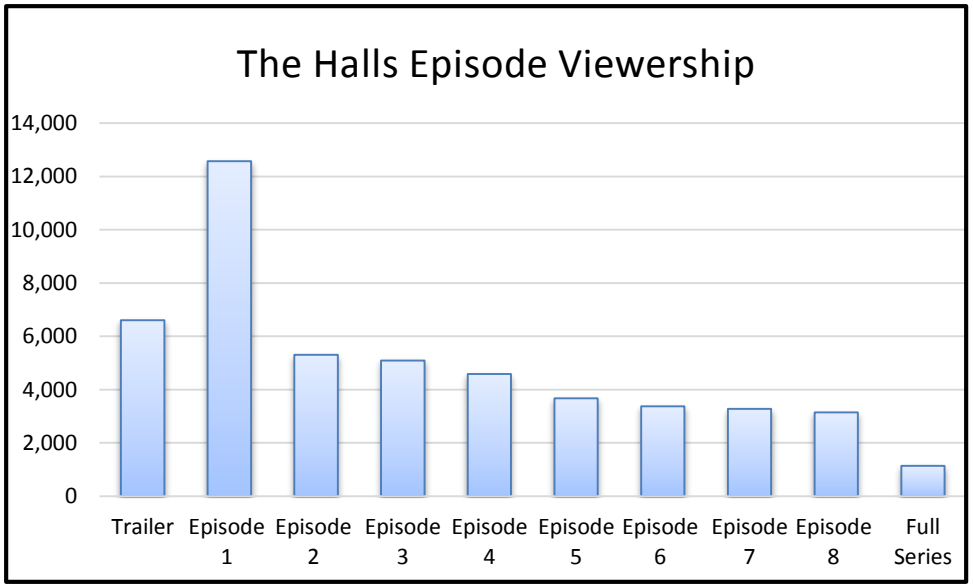
Appendix G. The Halls Viewership and Web Statistics

Episode Statistics	Website	Vimeo	YouTube	Total
Trailer	0	5,946	660	6,606
Episode 1	6,791	5,463	324	12,578
Episode 2	2,812	2,326	175	5,313
Episode 3	2,746	2,152	188	5,086
Episode 4	2,527	1,874	186	4,587
Episode 5	2,104	1,536	38	3,678
Episode 6	1,899	1,440	37	3,376
Episode 7	1,868	1,372	42	3,282
Episode 8	1,806	1,311	31	3,148
Full Series	591	548	0	1,139

Website	Clicks
Website Views	68,845
Average Hits/Day	325
Homepage	19,963
Justin	540
Tyler	430
Quincy	292
Resources	1,380
Website Referrals	
Facebook	121,311
Google	6,420
Twitter	423

Twitter	Clicks
Followers	489
#thehalls	66,252
Timelines	143,061
ReTweets	80
Direct Messages	10
Original Tweets	93
Total Tweets	927



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Appendix H. Professional Trainings

Training Name	Event Dates	Participants	Audience
Trauma and Resiliency Training for Summer Youth Workers	6/22/2012	71	Summer youth workers
Trauma and Resiliency Booster Training for Summer Youth Workers	7/10/2012	15	Summer youth workers
Trauma and Resiliency Booster Training for Summer Youth Workers	7/23/2012	14	Summer youth workers
Child Parent Psychotherapy Learning Community Basic Training	10/10/2012 - 10/11/2012	29	Mental Health Clinicians
Child Parent Psychotherapy Learning Community Clinical Supervisor Training	12/7/2012	9	Clinical Supervisors
Child Parent Psychotherapy Learning Community Monthly Consultation Call	12/20/2012	23	Mental Health Clinicians
Building Nurturing Families and Communities Trainings	10/2/2012 - 10/4/2012	12	Multi-disciplinary staff from FNP grantees
Building Nurturing Families and Communities Trainings	12/10/2012 -12/12/2012	13	Multi-disciplinary staff from FNP grantees
Coaching Boys into Men Training	10/23/2012	35	Boston Centers for Youth and Families Athletic Directors
Building Nurturing Families and Communities Trainings	1/16/2013	12-14	Multi-disciplinary staff from FNP grantees
Building Nurturing Families and Communities Trainings	1/23/2013 - 1/24/2013	12-15	Multi-disciplinary staff from FNP grantees
Building Nurturing Families and Communities Trainings	1/30/2013	12-16	Multi-disciplinary staff from FNP grantees
Building Nurturing Families and Communities Trainings	2/7/2013	12-17	Multi-disciplinary staff from FNP grantees
Building Nurturing Families and Communities Trainings	2/14/2013	12-18	Multi-disciplinary staff from FNP grantees
Trauma Informed Approaches to Working with Families	04/2013	20	Boston Public Schools Family and Community Outreach Coordinators
Child Parent Psychotherapy Learning Community Basic Training	5/9/2013	22	Mental Health Clinicians
Positive Youth Development and the Neurology of Trauma	05/2013	25	PACT Staff
Strategies for Self-Care	07/2013	50	High Risk Youth Network Staff
Coaching Boys into Men Training Booster Training	6/11/2013	40	Boston Centers for Youth and Families Athletic Directors
Enhancing Resilience	10/2013	10	MJE
TF-CBT Basic Training	11/21/2013 - 11/22/2013	39	Mental Health Clinicians
Attachment, Self-Regulation and Competency Basic Training	11/7/2013 - 11/8/2013	45	Mental Health Clinicians
Building Nurturing Families and Communities Training	11/19/2013 - 11/21/2013	6	Family Nurturing grantees
Building Nurturing Families and Communities Training	12/3/2013 - 12/5/2013	21	Family Nurturing grantees

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Building Nurturing Families and Communities Training	12/12/2013 - 12/14/2013	18	Family Nurturing grantees
Trauma Awareness & Resilience Youth Worker Training- Pilot 1	1/31/2014, 2/14/2014, 2/21/2014	22	Youth workers
Positive Youth Development and the Neurology of Trauma	02/2014	40	Boys and Girls Club Staff
Trauma Awareness & Resilience Youth Worker Training- Pilot 2	3/21/2014, 3/28/2014, 4/4/2014	24	Youth workers
Trauma Informed Systems and Approaches	3/2014	30	Out of School Nutrition & Physical Activity Staff
Trauma Awareness & Resilience Youth Worker Training- Pilot 3	5/2/2014, 5/9/2014, 5/16/2014	24	Youth Workers
Trauma Informed Approaches to Working with Young People	05/2014	30	Youth Workers
TF-CBT Advanced Training	5/13/2014	24	Mental Health Providers
ARC Advanced Training	5/16/2014	26	Mental Health Providers
Trauma Informed Approaches to working with Young People	5/12/2014	25	Youth Workers
Trauma Informed Approaches and Practices for Supervising Young People	06/04/2014 - 07/09/2014 (12 Trainings)	300	Root Cause Youth Workers
Trauma Awareness and Self-Care Strategies	07/2014, 08/2014	13	Mothers for Justice and Equality
Trauma Awareness and Self-Care Strategies	07/30/2014	40	District Attorney's Office
Trauma Awareness & Resilience	07/29/2014	20	City Councilors
Condensed Training Institute	08/25/2014	45	Mission Hill
Trauma 101 Workshop	08/29/2014	10	Wesley Education
Healing Trauma Circle	09/18/2014	6	Mattapan Community Health Center
Blue = youth worker trainings; purple = prevention program trainings; white = mental health trainings			

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Appendix I. BSC Collaborative Change Framework Outline

Core Area 1: Foundational Approaches

I. Capacity Building: What we need to know

A) Impact of Violence and Trauma
B) Social Emotional Learning as a Primary Prevention Strategy
C) Strong and Equitable Communities
D) Identification and Referrals
E) Trauma-informed Interactions with Children and Families
F) Mental Health Interventions
G) Healthy Staff

II. Partnering with Parents and Caregivers

A) Respect, Honor, and Accommodate
B) Strength-Based
C) Partners in Prevention and Promotion
D) Clear Communication
E) Involvement in Assessment
F) Preparation for and Involvement in Interventions
G) Validation and Celebration

III. Health Equity and Racial Justice

A) Agency Staffing
B) Perceptions of and Reactions to Families
C) Understanding Cultural Norms
D) Implicit Bias and Decision-Making
E) Honoring Language
F) Data
G) Agency Practice and Policy

Core Area 2: Early Education and Care Center Approaches

IV. Early Education and Care Agency Structure and Processes

A) Safe Early Education and Care Communities
B) Strong Families
C) Information Gathering and Use
D) Trauma-informed Mental Health Assessment
E) Trauma-informed Interventions
F) Tailored Approaches
G) Safety and Well-Being
H) Supervision, Support and Guidance
I) Strong Staff and Supportive Agencies

V. Daily Interactions with Children and Caregivers that Promote Resilience

A) Organization of Early Education and Care Space
B) Flow of the Day
C) Parent and Caregiver Engagement
D) Behavior Management and Language
E) Learning and Play
F) Consistent Adult Relationships

Core Area 3: Sustainability Approaches

VI. Systems that Support Families and Communities

A) Strong Families
B) Strong Communities
C) Effective Collaboration
D) Access to Evidence-Supported Preventative and Mental Health Interventions
E) Policies, Procedures, and Practices
F) Financing and Access

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Appendix J. Breakthrough Series Collaborative Self-Assessment

Trauma-Informed Early Education and Care Systems BSC							
	OBJECTIVES Headlines from Change Framework	Self-Assessment (Status Color and Date)					
I. Capacity Building: What We Need to Know							
		LS2	LS2	LS2	LS1	LS1	LS2
A.	Impact of Violence and Trauma	1	3	2	3	1.5	2
B.	Social Emotional Learning as a Primary Prevention Strategy	1	3	3	3	3	2
C.	Strong and Equitable Communities	1	2	2	1	2	2
D.	Identification and Referrals	2	4	3+	3	3	2
E.	Trauma-Informed Interactions with Children and Families	1	3	3	2	2	3
F.	Mental Health Interventions	2.5	4	3	2.5	3	3
G.	Healthy Staff	1	2.5	3	1	2	2
II. Partnering with Parents and Caregivers							
A.	Respect, Honor, and Accommodate	3	3	4	4	4	3
B.	Strength-Based	2	3	4	3	3	3
C.	Partners in Prevention and Promotion	2	2.5	3	2	2	2
D.	Clear Communication	2	3	3	3	2.5	3
E.	Involvement in Assessment	2.5	2	4	3	1	3
F.	Preparation for and Involvement in Interventions	1.5	3	2	1	3	2
G.	Validation and Celebration	2	4	3	3	3	2
III. Health Equity and Racial Justice							
A.	Agency Staffing	3.5	2	3	4	3	3
B.	Perceptions of and Reactions to Families	2.5	4	3	4	2	3
C.	Understanding Cultural "Norms"	2.5	3	3	4	3	2
D.	Implicit Bias and Decision-Making	3	3	3	3	4	3
E.	Honoring Language	3.5	3	4	4	4	3
F.	Data	1	2	3	2	4	2
G.	Agency Practice and Policy	1	2	3	1	2	3
IV. Early Education and Care Agency Structures and Processes							
A.	Safe Early Education and Care Communities	3.5	4	4	3	3	3
B.	Strong Families	2.5	4	3	4	3	3
C.	Information Gathering and Use	2	3	3	3	3	2
D.	Trauma-Informed Mental Health Assessment	3	4	3	2	1	2
E.	Trauma-Informed Interventions	2	2	2	2	1	2
F.	Tailored Approaches	1.5	4	4	3	1	3
G.	Safety and Well-Being	3	4	3	3	3	3
H.	Supervision, Support, and Guidance	2.5	3	3+	4	2	2
I.	Strong Staff and Supportive Agencies	2	3	2	2.5	3	3
V. Daily Interactions with Children and Caregivers that Promote Resilience							
A.	Organization of Early Education and Care Space	3	4	4	4	3.5	3
B.	Flow of the Day	4	4	4	3	2.5	3
C.	Parent and Caregiver Engagement	2.5	3	4	4	2.5	3
D.	Behavior Management and Language	2.5	3	3+	2.5	2	2
E.	Learning and Play	3	4	4	3	4	3
F.	Consistent Adult Relationships	2.5	4	3	2	2	2
VI. Systems that Support Strong Families and Communities							
A.	Strong Families	2.5	3	3	2	1	2
B.	Strong Communities	2	3	1	1	2	2
C.	Effective Collaboration	3	3	4	3	3.5	2
D.	Access to Evidence-Supported Preventive and Mental Health Interventions	2.5	3	4	1	1	2
E.	Policies, Procedures, and Practices	2.5	4	4	4	3	2
F.	Financing and Access	1.5	3	4	4	3	2

Very Strong or Exists in a Systematic/Clearly Defined Way
Shows Strengths or Exists in a Fairly Consistent Way
Some Challenges or Exists Only in a Limited Way
Serious Challenges or Does Not Yet Exist

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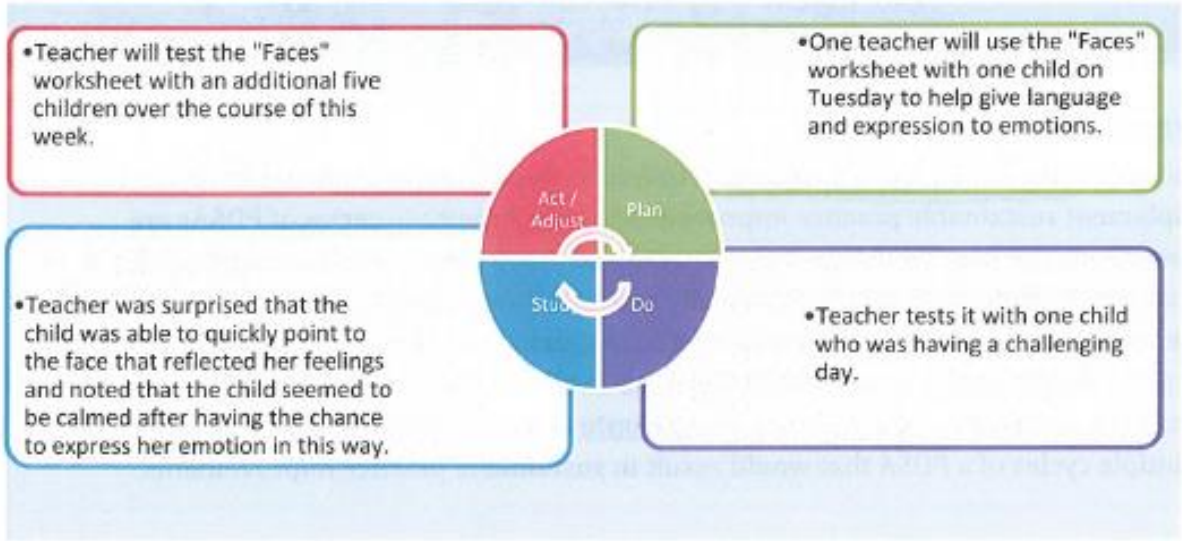
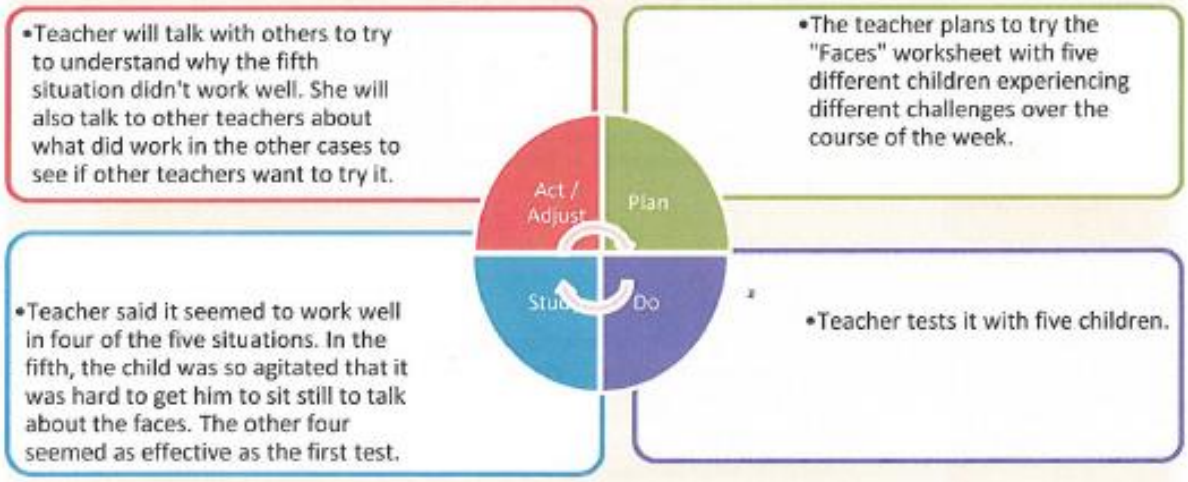
Appendix K.
Breakthrough Series Collaborative PDSA Example

THE EXAMPLE: CYCLE 1



THE EXAMPLE: CYCLE 2



THE EXAMPLE: CYCLES 3-5

- **Cycle 3**: Teacher uses the "Faces" worksheet for an entire week every time there is a highly positive or negative situation in the classroom. She uses it not only with individual children on a case-by-case basis, but incorporates it into the classroom as a check-in with the children. Two other teachers began using the tool as well in their classrooms. Together these three teachers were able to develop guidelines about how and when this worksheet is best used in the classroom, and when it might not be the right tool to use.

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