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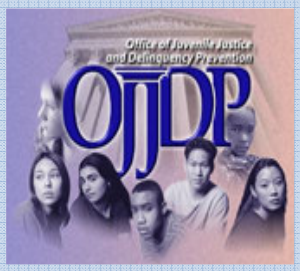
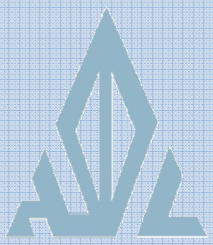
Safe Start Initiative: Demonstration Project

Promising Practices III (2006)

Report # 2007 - 3

November 2007





Association for the Study and Development of Community
438 N. Frederick Avenue, Suite 315
Gaithersburg, MD 20877
(301)519-0722 • (301)519-0724 fax
www.capablecommunity.com

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Preface

This report on the promising practices of seven Safe Start Demonstration Project sites was developed by the Association for the Study and Development of Community (ASDC) for the Office of Juvenile Justice and Delinquency Prevention (OJJDP) for the Safe Start Initiative.

We would like to recognize Katherine Darke Schmitt, deputy associate administrator, Child Protection Division; and Kristen Kracke, Safe Start Initiative coordinator and manager, for their leadership and support. ASDC staff contributing to this report include: David Chavis (project director), Yvette Lamb (senior managing associate), Mary Hyde (senior managing associate), Kien Lee (senior managing associate), Joie Acosta (managing associate), Sonia Arteaga (managing associate), Deanna Breslin (associate), and Sylvia Mahon (office coordinator). ASDC would like to thank the project directors and local evaluators of the seven demonstration sites for providing data on which this report is based. This report would not have been possible without the excellent work of the Safe Start Demonstration Project grantees.

Bridgeport Safe Start Initiative
Bridgeport, Connecticut

Chatham County Safe Start Initiative
Chatham County, North Carolina

Chicago Safe Start Initiative
Chicago, Illinois

Pinellas Safe Start Initiative
Pinellas County, Florida

Rochester Safe Start Initiative
Rochester, New York

San Francisco SafeStart Initiative
San Francisco, California

Spokane Safe Start Initiative
Spokane, Washington

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Index of Promising Practices

In this report, Safe Start promising practices are categorized and listed according to key issues identified by project stakeholders during site visits conducted by members of the National Evaluation Team in 2006. Each of the promising practices listed in this index is grouped under the issue area to which it applies.

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1. Introduction

The National Safe Start Demonstration Project, funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), was implemented in 2000 to create a "holistic approach to prevent and reduce the harmful effects of exposure to violence on young children by improving access to, delivery of, and quality of services to children and their families at any point of entry into relevant services" (Department of Justice Office of Juvenile Justice and Delinquency Prevention, 1999). Eleven communities were competitively selected as Safe Start Demonstration Project Sites: Baltimore, Maryland; Bridgeport, Connecticut; Chatham County, North Carolina; Chicago, Illinois; Pinellas, Florida; Pueblo of Zuni, New Mexico; Rochester, New York; San Francisco, California; Sitka, Alaska; Spokane, Washington; and Washington County, Maine. Each demonstration site was expected to create a comprehensive service delivery system with improved service access, delivery, and quality for young children exposed to violence or at high risk of exposure, along with their families and their caregivers. All activities were to be designed based on the available scientific and practice literature about serving children exposed to violence, resulting in evidence-based programming.

The Safe Start Demonstration Project was conducted over 5½ years in three phases: assessment and planning (Phase I), initial implementation (Phase II), and full implementation (Phase III). The 2005 report *Promising Practices of Safe Start Demonstration Sites: A First Look*[1] addresses grantee practices during Phases I and Phase II of the project. The 2006 report *Promising Practices of Safe Start Demonstration Project Sites: 2005* addresses practices that contributed to the overall success of the Safe Start Demonstration Project during Phase III of the project.

This report focuses on Safe Start grantees' site-specific Phase III practices that contributed to successful collection of data from or about children exposed to violence and their families. A practice is defined as a data-collection activity or strategy, not a particular tool, type of analysis, or data standard. For example, collecting Parenting Stress Index (PSI) data would be classified as using a particular tool; using parent liaisons to collect PSI data would be considered a practice that supported data collection with that tool.

When the Safe Start Demonstration Project began, relatively little literature addressed promising practices for data collection in programs designed to help young children exposed to violence. In the five years of the demonstration project, the Safe Start grantees developed multiple innovative practices in support of data collection. The Association for the Study and Development of Community (ASDC), serving as the National Evaluation Team for the Safe Start Demonstration Project, conducted a systematic review of all sites' data-collection practices and developed a list of those with promise. This report is intended to document

[1] Promising practices reports can be found at http://capacitybuilding.net/promising%20practices.html.

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those successful practices that others may want to explore and implement when collecting data from or about children exposed to violence and their families.

The National Evaluation Team first examined the literature to determine the criteria for a "promising" practice. When these criteria are applied to the Safe Start Demonstration Project, a promising practice is most appropriately defined as a practice that has been implemented and has demonstrated:

- Preliminary evidence of effectiveness in local data-collection practices (not necessarily across the initiative);
- Successful use by at least one of the 11 Safe Start Demonstration Project grantees;
- Potential for replication; and
- Improvement over previous data-collection practices.

"Evidence of effectiveness" was defined as data supporting increased participation by children and families in data collection (e.g., collecting outcome data from 100% of all families in a program); the implementation of new procedures to collect data (e.g., dispersing data collection across the service continuum); management and sharing of data across systems (e.g., using a centralized intake for data collection); or the development of strategies to engage service providers in data collection (e.g., sharing data with service providers).

The following standards of evidence were used; these standards are the same as those used in the National Evaluation Team's overall research methodology:

- A minimum of two independent sources (i.e., project stakeholders or project documentation), preferably three, must provide the same information (i.e., no information will be reported based on a single source);
- The more frequently a piece of data is encountered, the more "promising" or relevant it is; and
- All assumptions must be confirmed by the sites before being considered valid.

Seven of the Safe Start Demonstration Project sites developed and implemented practices that meet the above criteria. These seven sites had the organizational capacity (e.g., prior experience with data collection, resources such as staff time) to implement promising data-collection practices. Four Safe Start Demonstration Project grantees (Baltimore, Maryland; Pueblo of Zuni, New Mexico; Sitka, Alaska; and Washington County, Maine) were not able to fully implement data-collection strategies and were, therefore, not included in this report.

Thus, this report summarizes promising practices for data collection created and implemented by seven of the Safe Start Demonstration Project grantees. The report is organized according to the following key issues related to data collection identified by project stakeholders during site visits conducted by the National Evaluation Team:

- Engaging and retaining families in data collection;
- Engaging service providers in data collection;
- Maximizing data collection;
- Managing data collection; and
- Data-based decision making.

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2. Method

The National Evaluation Team analyzed documentation for each of the eleven demonstration sites to identify and collect information about promising practices. For any needed clarification about potentially promising practices, the National Evaluation Team contacted project directors via email and/or telephone. The data collection and analysis occurred in five phases:

1. Review of documents generated by the National Evaluation Team, including site visit reports from site visits;
2. Review of site documents submitted to the Office of Juvenile Justice and Delinquency Prevention, including local evaluation report forms, site visit reports, January-June 2006 progress reports, and other reports generated or provided by each site;
3. Extraction of pertinent information, including source of evidence qualifying each practice as promising, based on the criteria for a promising practice;
4. Entry of information into the Promising Practices Data Matrix (see Appendix); and
5. Selection of promising practices by the National Evaluation Team.

2.1 Review of documents

Each grantee's most recent site visit report, 2005 case study report, and 2005 local evaluation report form were reviewed. 2006 site visit reports and 2006 local evaluation report forms were not available for four Safe Start Demonstration Project grantees (Baltimore, Maryland; Chatham County, North Carolina; Spokane, Washington; and Washington County, Maine), because these sites were no longer under contract with OJJDP in 2006; site visit reports and local evaluation report forms from 2006 were reviewed for the remaining seven Safe Start Demonstration Project grantees.

2.2 Extraction of information

For each promising practice identified through document review, data were extracted regarding the reason for its promise and evidence of its success. The practices identified were categorized according to the key data-collection issues listed above. Appendix A contains the promising practices for each site.

3. Promising Practices

Practices deemed promising based on established criteria are included in this section. A description of each practice is provided, and the results of the practice are discussed.

3.1 Engaging and retaining families in data collection

Collecting data from families in crisis or families victimized by violence allows service providers and partners to begin to understand the unique characteristics of these families and assess the appropriateness and effectiveness of the services they receive. Safe Start sites, however, faced challenges engaging and retaining this population in data-collection efforts. Four Safe Start sites developed promising practices to collect data from children exposed to violence and their parents/caregivers: Bridgeport, Connecticut; Pinellas, Florida;

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Rochester, New York; and Spokane, Washington.

Collecting data from families through parent liaisons: Bridgeport, Connecticut

Bridgeport Safe Start and the Partnership for Kids (PARK) Project, which provides school-based mental health services, conducted a family-driven assessment of family engagement when they observed underutilization of the limited services available for young children's mental health. The Safe Start local evaluator trained parents who had received services to conduct focus groups with other local parents to identify barriers to services. To accommodate the large Spanish-speaking population in Bridgeport, one focus group was conducted in Spanish.

Parents cited a lack of responsiveness when making inquires about services, difficulty in connecting with the appropriate agency or person, and a lack of respect and trust in their interactions with agency staff. Using the findings from the family engagement study, the Safe Start grantee and PARK Project staff created a series of cultural competency trainings targeting front-line staff. To promote broader dialogue on ways to improve responsiveness and respectful engagement in the system, Bridgeport Safe Start presented the parental focus group findings more than 15 times to a variety of audiences in Bridgeport and around the state. At the time of this report, no data on the impact of these practices were available.

Using practices that engage families in services to promote their participation in data collection: Pinellas, Florida

Pinellas Safe Start conducted careful screening, focused on building trust between service providers and families, concentrated on being responsive to family needs as defined by each family, and shared information gathered through family assessment. These strategies, which kept families engaged in services, also retained their participation in data collection.

Families participated in initial and continuing data-collection efforts. Pinellas Safe Start used the Parenting Stress Index and the Temperament and Atypical Behavior Scale (TABS) to collect information from families. From January 2004 to December 2006, 226 families participated in the evaluation research by completing at least one PSI, and 136 families completed all three administrations of the PSI. From October 2004 to December 2006, 103 families completed three administrations of the TABS. This repeated participation of families in data-collection efforts demonstrates that Pinellas Safe Start was able to retain families in the data-collection process.

Connecting with families to accommodate individual needs: Bridgeport, Connecticut and Rochester, New York

Both Bridgeport and Rochester Safe Start grantees used staff to connect personally with families when collecting data and offered incentives to reward families for participating in data collection. To reduce the burden on families created by lengthy evaluation

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measures, Bridgeport Safe Start offered families a choice of multiple formats for data collection, while Rochester Safe Start staggered measures over several visits. These specific practices and the evidence of their promise are discussed in detail below.

Bridgeport Safe Start encouraged all families, regardless of level of literacy, to participate in data collection by reading all instruments aloud to caregivers and by using an interview format, rather than a written survey, to administer outcome instruments at discharge. They also provided gift cards as an incentive for some families to complete the discharge instruments.

From August 2004 to April 2006, these strategies led to collecting pre- and post-test outcome data on 54 of the approximately 200 children referred to services. This data collection occurred despite the perception among families and clinicians that evaluation requirements were too burdensome. On the other hand, successful collection of data was limited to one of three Bridgeport Safe Start agencies, suggesting that these data-collection strategies may be dependent on the capacity of the organization implementing them.

Rochester Safe Start was successful in collecting data through Fast Track Supervised Visitation[2] staff, because staff members were clear and non-threatening when discussing participation in data collection with families and provided incentives to families (e.g., gift cards) to encourage their participation. In addition, administration of measures was staggered over several visits. For example, the Parent Child Rating Scale could be completed by families at any of the first three visits. Safe Start and Fast Track staff perceived these procedures as successful for obtaining information about children exposed to violence and their families. Evaluation of the Fast Track program is just beginning, however, and data-collection procedures may change or be refined as the program is further implemented.

Implementing a multi-faceted process to initiate and monitor data collection from children and families at the scene of a crisis: Spokane, Washington

Because many families do not seek professional services despite persistent trauma, Spokane Safe Start staff considered it critical to document children and families in crisis and therefore developed a process to assess the quality and benefits of crisis services for families and children.

After conducting an extensive literature review, an analysis of lessons learned from Spokane Safe Start staff, and a review of 110 clinical records, the Spokane grantee developed tools for clinicians to assess and monitor families in crisis. For example, a database was developed for clinicians to input consistent clinical information at the scene of a crisis. Practitioners working with families in crisis can use the database and other tools to develop service program goals for each family and identify and track objective indicators of progress toward goals.

[2] Rochester Safe Start funded Fast Track Supervised Visitation, a program designed for families affected by domestic violence, to reduce the amount of time families had to wait for visitations between parents and children.

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Spokane Safe Start staff also developed a process to monitor and assess the effectiveness and comprehensiveness of their assessment tools.

3.2 Engaging service providers in data collection

Safe Start grantees realized that service providers are a primary source of data about children exposed to violence and their families, as service providers have regular contact with families in need. Grantees increased their ability to collect data from and about children and families exposed to violence by working with service providers. In 2006, data were verified for promising practices related to working with service providers to collect data at six Safe Start sites: Chicago, Illinois; Chatham County, North Carolina; Rochester, New York; Pinellas, Florida; San Francisco, California; and Bridgeport, Connecticut.

Including service providers in the design of data-collection tools and processes: Chicago, Illinois; Chatham County, North Carolina; and Rochester, New York

To engage service providers in data collection, three Safe Start sites asked providers to help select or design instruments and processes that would be effective in collecting information from their clients. Service providers in Chatham were continually asked to review and revise data-collection tools and processes, while Chicago and Rochester Safe Start service providers were asked for feedback before the data-collection process began. The practices of each site are discussed in more detail below.

Chicago Safe Start's local evaluator, staff, and local service providers collaborated to select common screening tools for children exposed to violence. The data-collection tools (e.g., the Trauma Symptom Checklist for Young Children) were selected because they were considered brief and not burdensome for families or service providers. Service providers reliably reported data to Chicago Safe Start because their involvement in the measurement-selection process created buy-in for data collection.

Chatham County Safe Start engaged service providers to review, modify, and expand their screening tool for children's exposure to violence, as well as conducting focus groups with direct service providers to assess the effectiveness of Safe Start services coordination. Based on input from direct service providers, revisions were made on a yearly basis to protocols; tools (e.g., Traumatic Events Screening Inventory); and the local Safe Start services handbook, a guide for service providers and community members that defines the processes to identify, refer, and respond to children exposed to violence. By engaging service providers in the improvement of data-collection tools, Chatham County Safe Start was able to identify family concerns about privacy and confidentiality, and therefore revised existing data-collection protocols, forms, and service handbook to include policies and procedures for handling client records. These revisions improved the consistency of client data collected by Chatham County Safe Start.

Because of their investment of time in the Fast Track program, Rochester Safe Start staff suggested that measurement

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development and data collection begin as early as possible. To create the instruments for data collection, Rochester Safe Start involved the Fast Track provider (Society for the Protection and Care of Children) at every point. The local evaluator worked with the social workers responsible for collecting data, along with their supervisors, in designing the program evaluation and selecting the measures for data collection. Engaging the Fast Track supervisors helped to create accountability and facilitate data collection; if the local evaluator encountered problems in collecting data from a particular social worker, the evaluator was able to enlist the support of the supervisor to gather the data.

Using measures that inform both clinical and research needs: Rochester, New York and Pinellas, Florida

The Rochester and Pinellas Safe Start grantees used their evaluation tools to inform both clinical and research needs. To do so, Rochester Safe Start adapted existing measures, while Pinellas Safe Start used standardized measures (e.g., Parenting Stress Index).

Service providers and Rochester Safe Start evaluation staff jointly produced instruments that served both program and evaluation needs. For example, Rochester Safe Start used Mount Hope Family Center's[3] simple internal tools to track outcomes of the Safe Start-funded intervention provided through Mount Hope. For SAFE Kids,[4] the data form was modeled after Child Development-Community Policing forms provided by the National Center for Children Exposed to Violence, but was adapted to suit service providers' internal needs. Data were successfully collected from 100% of the participants in the SAFE Kids (n=305) and Mount Hope (n=101) interventions.

To collect information for both clinical and research needs, family advocates providing Pinellas Safe Start intensive family services used the following tools: Ages and Stages, Family Psychosocial Assessment, Parenting Stress Index, Temperament Atypical Behavior Scale, and Traumatic Events Screening Inventory. The family advocates reported that they found the information collected through these tools useful and as a result were more willing to collect the information. Service providers at Help-a-Child[5] and Coordinated Child Care (CCC)[6] are continuing to use these measures, even though federal funding for Pinellas Safe Start has ended.

[3] Mount Hope Family Center is a nationally recognized research institute that has pioneered a community-supported, complete family approach to the treatment and prevention of child abuse and family violence, as well as the promotion of positive child development, the improvement of parenting skills, and the prevention of child maltreatment.

[4] SAFE Kids, a variant of Child Development-Community Policing, forged a partnership between police and social workers on behalf of young children exposed to violence in the community or home.

[5] Help-A-Child provides the following intensive family services in Pinellas County: crisis counseling, comprehensive family assessment, parent-child observations, weekly home visits, support services for parents, family plan assistance, and resource referral and service coordination.

[6] Coordinated Child Care is the central agency for child care resource and referral in Pinellas County.

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Using a capacity-building and streamlined data-collection process: San Francisco, California

San Francisco SafeStart developed service provider capacity through training and technical assistance, including guidance on how to balance collection of assessment data with crisis intervention services (both conducted on a family's first visit). SafeStart also put service providers in face-to-face contact with the local evaluation team to create a relationship and facilitate quality data collection. To ensure that data collection was not burdensome for families or service providers, SafeStart selected tools that were brief and easily completed; in addition, data-collection tools were refined based on recommendations from service providers. For example, a reduction was made in the number of items to be gathered through data collection from 200 items to 20. Finally, to create some incentive for service providers to collect data, SafeStart provided financial support for data collection and continuous technical assistance to clinical staff within service provider agencies.

Through these strategies, SafeStart service providers positioned as consultants within their home agencies assessed 699 children from October 2002 to October 2005.

Sharing data with service providers to increase their buy-in and garner assistance with interpreting data: Pinellas, Florida

Pinellas Safe Start's local evaluator shared evaluation data with service providers through regularly scheduled meetings. During the meetings, the local evaluator reviewed how data were being used and the impact that service providers were having on families. In addition, the local evaluator used the meetings to gather feedback from service providers on the interpretation of evaluation data.

Sharing data with service providers in this way increased their buy-in for the evaluation. Service providers in Pinellas commented that evaluation research was useful to them because it helped provide concrete information about the impact they were having on families. Sharing data also helped the local evaluator to interpret data and ultimately improve family participation. For example, when data collection using the Parenting Stress Index declined, the local evaluator learned through meeting with service providers that parents were reluctant to complete the PSI because they feared the information gathered could be used against them in court. Pinellas Safe Start then moved child and parent data to separate case files, which increased data collection from families.

Dispersing data collection responsibility across the service continuum: San Francisco, California

To reduce the data-collection burden on any one provider, family advocates administered the first Child Behavioral Checklist (i.e., the pre-test) to San Francisco SafeStart clients, and behavioral health clinicians administered the post-test at the end of behavioral health services. Although variation remained in the volume and quality of data collected across provider agencies, this division of data-collection duties increased the volume of reporting; at the end of 2005, San Francisco SafeStart

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had collected data from over 500 families.

Performance-based contracting with service providers: Bridgeport, Connecticut

Service provider agencies for Bridgeport Safe Start received funding in response to a competitive bid to implement an integrated service delivery model as a collaborative body. Contractual responsibilities associated with Safe Start funding included contributing service data to the Safe Start evaluation and working toward a shared client information system.

To facilitate data submission by service providers, the local evaluation team developed databases through which clinicians were able to submit data electronically on a quarterly basis. These procedures were successful in collecting data from one service provider agency; between August 2004 and April 2006, outcome data were collected on 54 children. As previously mentioned, however, only one of three agencies provided these data, suggesting that success of the Bridgeport data-collection procedures may be dependent on the capacity of the organization implementing them.

3.3 Maximizing data collection

Safe Start grantees worked to maximize the quantity of data collected; sufficient data were needed at regular intervals for Safe Start grantees to assess their effectiveness and make improvements to intervention strategies. Four Safe Start grantees had promising practices for maximizing data: Chatham County, North Carolina; Spokane, Washington; Bridgeport, Connecticut; and Pinellas, Florida.

Conducting extensive training of referral sources: Chatham County, North Carolina and Spokane, Washington

To ensure sufficient recruitment of families into services, two Safe Start grantees conducted extensive training of sources that refer children exposed to violence and their families to service providers. Spokane Safe Start conducted specialized in-service trainings for law enforcement officers, while Chatham County Safe Start focused broadly on professionals and community residents.

Through its training program, the Chatham County grantee taught 729 professionals (e.g., family support service providers, therapists, human service agency personnel, child care professionals, child protective services workers, and law enforcement officers) and residents how to identify and refer children and families to Safe Start. Agency professionals were retrained periodically, to serve as a refresher for previous training participants and as an orientation for newly-hired employees. In addition, a Safe Start staff member met monthly with human resource directors, business owners, child care professionals, primary health care providers, and religious leaders to educate and provide materials on children's exposure to violence and Chatham County Safe Start.

Identification and referral trainings increased Chatham's capacity to identify children exposed to violence; 447 children exposed to violence were identified by 20 different community sources. Nine new child protective

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services workers at the Department of Social Services became aware of Chatham Safe Start and referred cases to the service coordinator because of their participation in or knowledge of trainings.

Spokane Safe Start provided eight, two-hour in-service trainings on identification and referral of children exposed to violence to every commissioned and some non-commissioned members of the Spokane Sheriff's Department. Spokane Safe Start also created a hotline number through which law enforcement officers could contact an answering service to be patched through to a member of the Safe Start crisis intervention team (i.e., the on-call child outreach specialist). Spokane Safe Start received 479 referrals from law enforcement, which comprised the majority of their referrals (71.6%).

Using existing sources of data: Bridgeport, Connecticut and Pinellas, Florida

Both Bridgeport and Pinellas Safe Start used existing electronic databases and case-level data from service providers for evaluation purposes.

To examine the impact of their 2004 social marketing campaign, Bridgeport Safe Start reviewed calls made to InfoLine 2-1-1, a statewide system that connects callers to an electronic database of resources. Calls six months prior to and six months subsequent to implementation of the social marketing campaign were reviewed, to identify any changes in overall call volume and/or volume of calls relating to specific issues. The review found no change in overall InfoLine call volume, but did document a significant increase in calls to "Help me Grow," the InfoLine referral service specifically relating to young children. In addition, there was a significant increase in the proportion of calls about family violence issues, as well as child abuse and neglect.

Bridgeport Safe Start also used family service plans developed by local service providers to collect system-wide data on the appropriateness of services received. Each service plan documents the services to which clients are referred upon entry into the program and follows up with a 90-day assessment to determine whether clients connected to those services. Collecting and tracking this information helped connect children to appropriate services (overall, 57% of recommended services were received). For the three program years for which complete data are available, the ratio of recommended-to-received services increased from 0.52 in year one, to 0.56 in year two, to 0.65 in year three. These data suggest that, over time, families experienced fewer barriers to obtaining needed services. The data tracked through family service plans also proved useful to service providers; Child FIRST, a service provider agency in Bridgeport, plans to institutionalize the use of service plans by incorporating them into its routine assessment process.

Pinellas Safe Start used the Services and Activities Management Information System (SAMIS)[7] to generate aggregated analyses for reporting and to advocate for continued funding. The Pinellas grantee used SAMIS to track the

[7] SAMIS is a web-enabled reporting program that agencies funded by the Juvenile Welfare Board of Pinellas County use for submitting both fiscal and case-participant data.

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number of families referred (n=2,320) and assessed (n=530) from May 2002 to December 2005 because of exposure to violence, and continues to use SAMIS to track service utilization and referrals for children exposed to violence. Pinellas Safe Start also was able to look at the number of non-Safe Start programs offering mental health and prevention/ intervention services for violence-involved families. Pinellas Safe Start used these data to advocate for additional resources and consequently received funding from the Juvenile Welfare Board and the Pinellas County Sheriff's Office to continue their key programs serving children exposed to violence. As they move forward, Pinellas Safe Start will use SAMIS to review measurable objectives for their Safe Start Partnership Center, Coordinated Child Care, and Child Development-Community Policing programs.

3.4 Managing data collection

Safe Start grantee data on children exposed to violence and their families came from multiple sources. Effective practices to manage data from multiple sources helped Safe Start grantees to effectively oversee and refine or streamline their data-collection efforts. Safe Start grantees with promising practices for managing data collection are: Pinellas, Florida; and Chicago, Illinois.

Partnering with an entity that has the capacity to collect and manage data and is willing to provide in-kind technical assistance: Pinellas, Florida

Pinellas Safe Start's local evaluator partnered with Coordinated Child Care, the Community Child Care Coordinating (4C) agency for Pinellas County families, to manage data collected from service providers. Data were gathered from multiple local service providers and reported to the Safe Start local evaluator under the umbrella of the Safe Start Partnership Center, a collaborative comprised of five agencies.[8] A CCC staff member dedicated to data administration helped the local evaluator convert and consolidate data files received from service providers into a single merged data set.

Help-A-Child, Inc., the lead agency for the Safe Start Partnership Center, also dedicated a staff member to consolidate local data for evaluation purposes. During the period when Help-A-Child did not have a staff member dedicated to monitoring data, data submissions decreased.

Having one individual handle family intake data: Chicago, Illinois

Beginning in 2004, Chicago Safe Start used a centralized intake process to facilitate engagement and retention of families in services and data collection; under this process, the intake coordinator collected information from families and entered it into an internal database to track families. Although only one of the two service provider sites in Chicago utilized the centralized intake process, service providers from the one site perceived that centralized intake helped improve consistency of referrals and reduced the loss of data that occurs when

[8] The lead agency for the Safe Start Partnership Center is Help-A-Child, Inc. The four other subcontracted point-of-service providers are 2-1-1 Tampa Bay Cares, The Haven, CASA, and Pinellas County Health Department.

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multiple individuals handle data. This process also improved the flow of services for families, which helped facilitate their engagement and retention in services and data collection.

3.5 Data-based decision making

Gathering and using data to make decisions enabled Safe Start sites to prioritize individual and community needs, as well as to target and customize their strategies. Four Safe Start sites showed promising practices for making decisions based on data: San Francisco, California; Spokane, Washington; Rochester, New York; and Chatham County, North Carolina.

Using data to strengthen programs: San Francisco, California; Spokane, Washington; and Rochester, New York

Three Safe Start sites used data to strengthen programs. Both San Francisco and Rochester Safe Start used data to demonstrate program effectiveness and increase understanding of children exposed to violence among service providers and community residents. In addition, Rochester and Spokane Safe Start used data to show evidence of the need for attention and resources to address issues related to family violence.

San Francisco SafeStart made decisions about policies, procedures, and practices based on data and findings provided by the Safe Start local evaluator. SafeStart's Committee on Evaluation set an evaluation agenda, to ensure that data would be relevant and useful. This committee, which met monthly, was comprised of national experts in research methods as well as issues of children exposed to violence, and functioned as a broker between the program director and the local evaluator. The evaluator collected, analyzed, and reported data. The committee interpreted the report and instructed the director in implementing program changes and the evaluator in conducting the evaluation. The effectiveness of this data-driven decision-making practice in San Francisco hinged on using a credible research firm to collect and analyze data.

Using the data collected, the evaluator generated reports on a regular basis to facilitate questions and decision making about improving programs. A monthly bulletin was used to monitor caseload, utilization, penetration, and compliance with data-collection protocols. For example, a capitated bonus for caseload was established. If contractors opened more than a certain number of cases in the first six months of their contract, they received a $10,000 increment in funding the next fiscal year; if they opened less than a certain number of cases during that time period, they received a $10,000 decrement in funding. A client-data summary report was used to analyze the population of children exposed to violence, the nature of violence to which children were exposed, the characteristics of families with children exposed to violence, and progress in achieving case plan goals. A client satisfaction report was used to understand and measure what families liked and did not like about the services they received, as well as to assess service performance. Annual evaluation reports were used to measure and report on strategic goal and objective attainment, and to determine what program changes to make.

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Data enabled San Francisco SafeStart to demonstrate its value and the importance of its programs. Data also enabled SafeStart to target its strategies and better engage partners, by using reports to target specific activities to specific partners. Data allowed SafeStart to move beyond assumptions and identify critical issues to address.

In Spokane, through the development of a large Safe Start clinical database and other non-Safe Start data developed by Washington State University, the issue of substance abuse as the number one correlate to family violence became part of the regular dialogue within the domestic violence and substance abuse provider communities. This dialogue was made possible by Washington State University's longstanding relationship with the Spokane County Domestic Violence Consortium, as well as through the close connections of a partnering agency, Native Project, with leadership at the YMCA that administers the Spokane domestic violence shelter and other support services to domestic violence victims. Support for data-driven decision making came in part from the university, a leading partner in Spokane Safe Start, with a history of deep interest in community issues and credibility within the community prior to Safe Start.

Rochester Safe Start used data and research in several ways to strengthen programs. Data were used as evidence for program need and as evidence of effectiveness when prioritizing program funding, and research was used to better understand the issues of children exposed to violence. A screening tool developed by Rochester Safe Start through its early childhood intervention provides an example of using research to better understand children's exposure to violence; this tool will be completed by parents of incoming kindergartners throughout the city of Rochester. The lead agency at Rochester Safe Start is a research institute, which facilitates a culture of making data-driven decisions.

Real-time feedback on effectiveness through single-subject research design: Chatham County, North Carolina

In Chatham County, the Safe Start grantee used a single-subject research design to inform therapists in real time of the effectiveness of treatment approaches.

Single-subject research, which targets service providers, produces data that can be used to 1) inform clinical or case decision making, and 2) modify therapeutic practices to produce better outcomes. Use of single-subject research enables providers to track the progress of individuals, respond to the needs of individuals if goals are not being met, and change the trajectory of treatment. Although Chatham County Safe Start experienced challenges in implementing the single-subject research design, all nine providers modified their practices to accommodate the inclusion of single-subject data collection. Six providers eventually used the results of single-subject analyses to inform clinical or case decision making. Two permanently incorporated single-subject research into their practices, and one developed a new and to-be-published measure of child anxiety specifically designed to quantify the effects of partner violence on children.

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4. Conclusion

Data collection from children and families exposed to violence is a complex process; Safe Start Demonstration Project sites have provided valuable insight into practices that may be promising.

Service providers are well positioned to collect information from children and families. For service providers to buy in to the data-collection process, it is helpful to involve them during the design and selection of instruments to ensure that instruments are feasible, valid, and inform both clinical and research needs. It is also helpful to build their capacity to implement and interpret data-collection instruments. To encourage both service providers and families to participate in data collection, the collection process must be streamlined and manageable, with incentives for participation by both service providers and families (e.g., sharing data with service providers, gift cards for families). Because data collection from children exposed to violence is challenging, it is important to maximize and effectively manage the data collected. Data collection can be maximized by training referral sources and using existing sources of data. Centralizing data collection and partnering with an entity with the capacity to collect and manage data are two ways to more efficiently manage data collection.

Because many families in crisis do not seek services, future data-collection practices should consider additional sources of data and methods of collecting data through other community sectors that have contact with children and families, for example, crisis responders.

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Appendix: Matrix of Promising Practices

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Site	Topic	Name/Description of practice	What makes it promising? And what is the evidence of success?
Bridgeport	Engaging and retaining families in data collection	**Collecting data from families through parent liaisons.** Bridgeport Safe Start and the PARK Project, which provides school-based mental health services, conducted a family-driven assessment of family engagement when they observed that services they funded had gone underutilized. The local evaluator trained parents that had received services to conduct focus groups with other local parents to identify barriers to services for families. To accommodate the large Spanish-speaking population in Bridgeport, one parent focus group was conducted in Spanish.	The findings from the family engagement study were used to create a series of cultural competency trainings targeting front-line staff. To promote a broader dialogue on ways to improve responsiveness and respectful engagement in the system, the Bridgeport Safe Start Initiative presented the parental focus group findings more than 15 times to a variety of audiences in Bridgeport and around the state. (**Sources:** 2005 Case Study; 2005 LERF; 2006 Site Visit Report)
Bridgeport	Engaging and retaining families in data collection	**Connecting with families to accommodate individual needs.** Bridgeport Safe Start encouraged all families to participate in data collection by reading all instruments aloud to caregivers, using an interview format to administer outcome instruments at discharge, and providing gift cards as an incentive for some families to complete the discharge instruments.	Between August 2004 and April 2006, these procedures were successful in collecting data from 54 children. (**Sources:** 2005 LERF; Evaluation of the Child FIRST Program Services for Children Exposed to Family Violence)
Bridgeport	Maximizing data collection	**Using existing sources of data.** To examine the impact of their 2004 social marketing campaign, Bridgeport Safe Start reviewed calls made to InfoLine 2-1-1, a statewide system that connects callers to an electronic database of resources. Calls six months prior to and six months subsequent to implementation of the social marketing campaign were reviewed.	By tracking overall InfoLine call volume and calls about family violence issues, child abuse and neglect, and other child-related issues, Bridgeport was able to link changes in the volume of calls about issues targeted in the social marketing campaign to implementation of the campaign in the community. Bridgeport Safe Start's analysis found significant increases in calls to a referral service specifically relating to young children, as well as calls about family violence issues and child abuse and neglect. (**Sources:** 2005 LERF; 2005 Bridgeport Case Study)

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Site	Topic	Name/Description of practice	What makes it promising? And what is the evidence of success?
Bridgeport	Maximizing data collection	**Using existing sources of data.** Bridgeport Safe Start used family service plans developed by local service providers to collect and assess system-wide data on the appropriateness of services received. Each service plan documents the services to which clients are referred upon entry into the program, and follows up with a 90-day assessment to determine whether clients connected to the services to which they were referred.	Collecting and tracking this information helped to connect children to appropriate services. Findings indicate that 3,009 services were recommended by service providers, and 57% of recommended services were received. Service plan data suggest that, over time, families experienced fewer service system barriers that prevented them from obtaining needed services. This data collection was also beneficial to service providers. Child FIRST, a service provider agency in Bridgeport, plans to institutionalize the use of the service plans by incorporating them into its routine assessment process. (**Sources:** 2005 LERF; 2005 Bridgeport Case Study)
Bridgeport	Engaging service providers in data collection	**Performance-based contracting with service providers.** Service provider agencies for Bridgeport Safe Start received funding in response to a competitive bid to implement an integrated service delivery model as a collaborative body. Contractual responsibilities associated with Safe Start funding included contributing service data to the evaluation and working toward a shared client information system. To facilitate data submission by service providers, the local evaluation team developed databases for clinicians to electronically submit data on a quarterly basis.	These procedures were successful in collecting data from one service provider agency, and between August 2004 and April 2006 outcome data were collected on 54 children. As previously mentioned, however, only one of three agencies provided these data, suggesting that success of the Bridgeport data collection procedures may be dependent on the capacity of the organization implementing them. (**Sources:** 2005 LERF; 2005 Bridgeport Case Study)
Chatham County	Data-based decision-making	**Real time feedback on effectiveness through single-subject research design.** A single-subject research design (SSRD) was used to inform Chatham County Safe Start therapists in real time of the effectiveness of treatment approaches. The SSRD practice, which targets service providers, produces data that can be used to track the progress of individuals, respond to the needs of individuals if goals are not being met, and change the trajectory of treatment.	All nine service providers modified their practices to accommodate the inclusion of single-subject data collection. Six providers eventually used the results of single-subject analyses to inform clinical or case decision-making. Two providers permanently incorporated single-subject research into their practices, and one developed a new and to-be-published measure of child anxiety specifically designed to quantify the effects of partner violence on children. (**Sources:** 2005 LERF; 2005 Site Visit Report)

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Site	Topic	Name/Description of practice	What makes it promising? And what is the evidence of success?
Chatham County	Maximizing data collection	**Conducting extensive training of referral sources.** Chatham County Safe Start trained 729 professionals (e.g., family support service providers, therapists, human service agency personnel, child care professionals, child protective services workers, and law enforcement officers) and residents in how to identify and refer children and families to Safe Start. Agency professionals were retrained periodically to provide a refresher for previous training participants and an orientation for newly-hired employees. In addition, a Safe Start staff member met monthly with human resource directors, business owners, child care professionals, primary health care providers, and religious leaders to educate and provide materials on children's exposure to violence and the services available through Chatham County Safe Start.	Identification and referral trainings increased community capacity to identify children exposed to violence; 447 children exposed to violence were identified by 20 different community sources. As a result of participating in identification and referral trainings, nine new child protective services workers at the Department of Social Services became aware of Chatham Safe Start and referred cases to the service coordinator. (**Sources:** 2005 LERF; 2005 Site Visit Report)
Chatham County	Engaging service providers in data collection	**Including service providers in the design of data collection tools and processes.** Chatham Safe Start engaged service providers to review, modify, and expand their screening tool for children's exposure to violence.	By engaging service providers in the improvement of data collection tools, Chatham County Safe Start was able to identify family concerns about privacy and confidentiality. Consequent revisions in policies and protocols improved the consistency of client data collected by Chatham County Safe Start. (**Sources:** Chatham County Case Study; January-June 2004 Progress Report; 2005 Site Visit Report; 2005 LERF 2005)
Chicago	Engaging service providers in data collection	**Including service providers in the design of data collection tools and processes.** Safe Start's local evaluator, staff, and local service providers collaborated to develop a common screening tool for children exposed to violence. The data collection tools (e.g., the Trauma Symptom Checklist for Young Children) were selected because they were considered brief and not burdensome for families or service providers.	Service providers reported more data to Chicago Safe Start because of buy-in for data collection created through their involvement in the measurement selection process. (**Sources:** 2006 Site Visit Report; 2005 LERF)

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Site	Topic	Name/Description of practice	What makes it promising? And what is the evidence of success?
Chicago	Managing data collection	**Having one individual handle the intake data collection from incoming families.** Beginning in 2004, Chicago Safe Start used a centralized intake process to facilitate engagement and retention of families in services and data collection. The intake coordinator collected information from families and entered it into an internal database to track families.	Although only one of the two service provider sites in Chicago utilized the centralized intake process, service providers from the one site perceived that centralized intake helped improve the consistency of referrals and reduce the loss of data that occurs when multiple individuals handle data. (**Sources:** 2006 Site Visit Report; 2005 Case Study)
Pinellas	Managing data collection	**Partnering with an entity that has the capacity to collect and manage data and is willing to provide in-kind technical assistance.** Pinellas Safe Start's local evaluator partnered with Coordinated Child Care (CCC), the Community Child Care Coordinating (4C) agency for Pinellas County families, to manage data collected from service providers through a dedicated CCC staff member.	Pinellas Safe Start was able to collect and manage data collected by multiple service providers in Pinellas County and reported to the Safe Start local evaluator under the umbrella of the Safe Start Partnership Center. (**Sources:** 2006 Site Visit Report)
Pinellas	Engaging service providers in data collection	**Using measures that inform both clinical and research needs.** To collect information for both clinical and research needs, family advocates providing Pinellas Safe Start intensive family services used the following tools: Ages and Stages, Family Psychosocial Assessment, Parenting Stress Index, Temperament Atypical Behavior Scale, and Traumatic Events Screening Inventory.	Family advocates found the information collected through the tools listed useful and as a result were more willing to collect the information. Service providers at Help-a-Child and Coordinated Child Care are continuing to use these measures, even though federal funding for Pinellas Safe Start has ended. (**Sources:** 2006 Site Visit Report)

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Site	Topic	Name/Description of practice	What makes it promising? And what is the evidence of success?
Pinellas	Maximizing data collection	**Using existing sources of data.** Pinellas Safe Start used the Services and Activities Management Information System (SAMIS) to generate aggregated analyses for reporting and to advocate for continued funding. SAMIS is a web-enabled reporting program that agencies funded by the Juvenile Welfare Board of Pinellas County use for submitting both fiscal and case participant data.	Pinellas Safe Start used SAMIS to track the number of families they referred (n=2,320) and assessed (n=530) between May 2002 and December 2005, and continue to use SAMIS to track service utilization and referrals for children exposed to violence. Pinellas used the data tracked in SAMIS to advocate for their programs, and consequently received funding from the Juvenile Welfare Board and the Pinellas County Sheriff's Office to continue their key programs serving children exposed to violence. (**Sources:** 2006 Site Visit Report; 2006 LERF; 2005 LERF)
Pinellas	Engaging service providers in data collection	**Sharing data with service providers to increase their buy-in and assist with interpreting data.** Pinellas Safe Start's local evaluator shared evaluation data with service providers through regularly scheduled meetings. During the meetings, the local evaluator reviewed how data were being used and the impact that service providers were having on families. The local evaluator also used the meetings to gather service provider feedback on the interpretation of evaluation data.	Sharing data with service providers increased their buy-in for the evaluation and helped provide information that improved data collection from families. For example, when data collection using the Parenting Stress Index declined, the local evaluator learned through meeting with service providers that parents were afraid to complete the PSI because they perceived that it could be used against them in court. Safe Start moved child and parent data storage to different case files, which increased data collection from families. (**Sources:** 2006 Site Visit Report)
Pinellas	Engaging and retaining families in data collection	**Using practices that engage families in services to promote their participation in data collection.** Pinellas Safe Start conducted careful screening, focused on building trust between service providers and families, concentrated on being responsive to family needs as defined by each family, and shared information gathered through assessment with families. These strategies, which kept families engaged in services, also kept them participating in data collection.	Families participated in initial and continuing data collection efforts by Pinellas Safe Start, which collected data from over 226 families. Safe Start retained family participation in data collection, as demonstrated by the fact that 136 families (60%) participated in data collection three separate times. (**Sources:** 2006 Site Visit Report; 2006 LERF)

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Site	Topic	Name/Description of practice	What makes it promising? And what is the evidence of success?
Rochester	Engaging service providers in data collection	**Using measures that inform both clinical and research needs.** Rochester service providers and evaluation staff jointly produced instruments that served both program and evaluation needs. For example, Rochester Safe Start tracked outcomes of the intervention they funded at Mount Hope through simple internal tools already used by the organization. In SAFE Kids, the data form was modeled after Child Development-Community Policing forms provided by the National Center for Children Exposed to Violence, but was adapted to suit the service providers' internal needs.	Data were successfully collected from 100% of the participants in the SAFE Kids (n=305) and Mt. Hope (n=101) interventions. (**Sources:** 2005 LERF)
Rochester	Data-based decision-making	**Using data to strengthen programs.** Rochester Safe Start used data to strengthen programs by 1) incorporating evaluation tools into daily program operations, 2) using data as evidence for program need and as evidence of effectiveness to prioritize program funding, and 3) using research to better understand issues of children exposed to violence. The Rochester Safe Start lead agency is a research institute, which facilitates a culture of making data-driven decisions.	Staff perceived that the use of data strengthened Rochester's Safe Start initiative. (**Sources:** 2005 LERF; 2005 Site Visit Report)
Rochester	Engaging and retaining families in data collection	**Connecting with families to accommodate individual needs.** The staff of Fast Track, a streamlined supervised visitation program, were clear and non-threatening when discussing participation in data collection with families, and provided incentives to families (e.g., gift cards) to encourage their participation. In addition, administration of measures was staggered over several visits.	These procedures were successful for obtaining information about children exposed to violence and their families in the Fast Track program. (**Sources:** 2006 Site Visit Report)
Rochester	Engaging service providers in data collection	**Including service providers in the design of data collection tools and processes.** To create the instruments for data collection from Fast Track participants, Rochester Safe Start involved the provider (Society for the Protection and Care of Children) in every aspect of development. Rochester Safe Start's local evaluator worked with the social workers responsible for collecting the data and their supervisors in designing the evaluation and selecting the measures for data collection.	Engaging the Fast Track supervisors helped to create accountability and made it easier for the local evaluator to collect data from the social workers. If the local evaluator encountered a problem in colleting data from a social worker, the local evaluator was able to enlist the support of the supervisor to gather the data. (**Sources:** 2006 Site Visit Report)

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Site	Topic	Name/Description of practice	What makes it promising? And what is the evidence of success?
San Francisco	Data-based decision-making	**Using data to strengthen programs.** San Francisco SafeStart made decisions about policies, procedures, and practices based on data and findings provided by the local evaluator. San Francisco SafeStart's Committee on Evaluation set an evaluation agenda, to ensure that data would be relevant and useful. The effectiveness of the data-driven decision-making practice in San Francisco hinged on using a credible and neutral research firm to collect and analyze data. Using the data collected, the local evaluator generated reports on a regular basis to facilitate questions and decision-making about improving programs. In addition, San Francisco SafeStart centralized a database to collect information on families as they move through the system of care. This database helped SafeStart with its transition from an entity funded by OJJDP to one funded by the Department of Children, Youth, and Family (DCYF), because SafeStart was able to tack its database onto the DCYF database. The use of this database promotes accountability to DCYF, because service provider resources are contingent upon the data entered. Service providers are also now accountable for shepherding families through the system of care, because families can be tracked through the centralized database.	Data enabled San Francisco SafeStart to demonstrate its value and the importance of its programs. Data also enabled SafeStart to target its strategies and better engage partners, by using reports to target specific activities to specific partners. Data allowed SafeStart to move beyond assumptions and identify critical issues to address. (**Sources:** 2005 Site Visit Report)
San Francisco	Engaging service providers in data collection	**Using a capacity building and streamlined data collection process.** San Francisco SafeStart developed service provider capacity through training or technical assistance, including guidance on how to balance collection of assessment data with crisis intervention services (both conducted on a family's first visit). SafeStart also put service providers in face-to-face contact with the local evaluation team to create a relationship and facilitate quality data collection. To minimize the burden of data collection for families and service providers, San Francisco SafeStart selected tools that were brief and easily completed. Finally, to create some incentive for service providers to collect data, SafeStart provided financial support for data collection within service provider agencies.	Continuous technical assistance to clinical staff helped encourage data collection compliance. SafeStart service providers positioned as consultants within their home agencies assessed 699 children between October 2002 and October 2005. Data collection tools were refined based on recommendations from service providers. For example, a reduction was made in the number of items to be gathered through data collection from 200 items to 20. (**Sources**: 2005 LERF; 2006 Site Visit Report)

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Site	Topic	Name/Description of practice	What makes it promising? And what is the evidence of success?
San Francisco	Engaging service providers in data collection	**Dispersing data collection responsibility across the service continuum.** To reduce the burden on any one provider, family advocates within San Francisco SafeStart's partner agencies administered the first Child Behavioral Checklist (CBCL pre-test), and behavioral health clinician administered the second CBCL (CBCL post-test) at the end of behavioral health services.	This process resulted in an increase in the volume of reporting, but did not eliminate variation in volume and quality of data collected across Family Resource Centers. At the end of 2005, SafeStart had collected data from over 500 families. (**Sources:** 2005 LERF; 2006 Site Visit Report)
Spokane	Data-based decision-making	**Using data to strengthen programs.** Through the development of a large Safe Start clinical database and other non-Safe Start data developed by Washington State University, the issue of substance abuse (the number one correlate to family violence) became part of the regular dialogue within the domestic violence and substance abuse provider communities. The dialogue was made possible by Washington State University's longstanding relationship with the Spokane County Domestic Violence Consortium, as well as through the close connections of a partnering agency, Native Project, with leadership at the YMCA that administers the Spokane domestic violence shelter and other support services to domestic violence victims. Support for data-driven decision-making came in part from the local university, a leading partner in Spokane Safe Start, with a history of deep interest in community issues and credibility within the community prior to Safe Start.	Dialogue around the relationship between substance abuse and family violence was enhanced by data. (**Sources:** 2005 LERF; 2005 Site Visit Report)
Spokane	Maximizing data collection	**Conducting extensive training of referral sources.** Spokane Safe Start provided eight, two-hour in-service trainings on identification and referral of children exposed to violence to every commissioned and some non-commissioned members of the Spokane Sheriff's Department. Spokane Safe Start also created a one-number system through which law enforcement officers could contact an answering service to be patched through to a member of Safe Start's crisis intervention team (i.e., the on-call child outreach specialist).	Spokane Safe Start received 479 referrals from law enforcement, which comprised the majority of their referrals (71.6%). (**Sources:** LERF 2005; 2005 Site Visit Report)

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Site	Topic	Name/Description of practice	What makes it promising? And what is the evidence of success?
Spokane	Engaging and retaining families in data collection	**Implementing a multi-faceted process to initiate and monitor data collection from children and families at the scene of a crisis.** Spokane Safe Start developed a process to assess crisis service quality and benefits for families and children, including a management information system and clinical management tools to support performance monitoring of crisis intervention services for children exposed to violence.	The tools were developed based on an extensive literature review, an analysis of lessons learned from Spokane Safe Start staff, and a case file review of 110 clinical records confirming that the tools could be used with a range of families. This extensive development process resulted in tools and an information management system that Spokane Safe Start has been able to use to collect information about services and their benefit for families and children in crisis. (**Sources:** Crisis Intervention and Outreach Services for Children Exposed to Violence, 2006; Practice Monograph: Crisis Intervention Service for Children Exposed to Violence, 2006)

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