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RESEARCH

"We Have the Power to Stop the Violence"

A Process Evaluation of Cuyahoga County's Defending Childhood Initiative

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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. Cuyahoga County, Ohio was chosen as one of these sites, and, since 2010, has received over $3 million in federal funding for this initiative.

Led by the Witness/Victim Service Center at Cuyahoga County's Department of Public Safety & Justice Services, the Cuyahoga County Defending Childhood Initiative (CCDCI) created a streamlined screening, assessment, and service system implemented county-wide for children ages 0-18 who have been exposed to violence and are experiencing trauma symptoms. Smaller initiative components included two targeted evidence-based/promising prevention programs (Adults and Children Together; Families and Schools Together) in high-risk neighborhoods; community awareness and education campaigns; and professional training activities.

The county-wide system for treating children who have been exposed to violence represented a system-level reform that was unique to the Cuyahoga County Defending Childhood Initiative. The first step in the system focuses on identification and screening. A short, one-page screener was created for children seven years of age and younger (completed by the caregiver) and for children eight years of age and older (completed by the child). The Juvenile Court and the Department of Children and Family Services are the primary screening agencies. If a child screens as having been exposed to violence or trauma, it leads to a referral to a newly created Central Intake and Assessment office for a full assessment, the second step in the system. If the child screens positive on the full assessment, the child is then referred to the final step in the system: appropriate evidence-based treatment services such as Trauma-Focused Cognitive Behavioral Therapy or Parent Child Interaction Therapy, administered by a CCDCI contracted agency.

Although there were barriers and challenges to implementation for each program component, the CCDCI can be potentially viewed as a model for a countywide streamlined screening, assessment, and service system to systematically address children's exposure to violence. The high level of detail and sophistication in many of the strategies in Cuyahoga County could provide other cities with a clear roadmap and guidance for replication. However, it is unknown whether or not Cuyahoga County's strong preexisting service infrastructure, interdisciplinary collaboration, and local research capacity may be found in comparable cities.

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). I am 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 grateful to Elise Jensen, Lama Hassoun Ayoub, and Michael Rempel from the Center for Court Innovation for their help with data collection and report editing, and to Julia Kohn, Peter Jaffe, David Wolfe, and Marcie Campbell for their assistance in the early stages of this project. Special thanks to Jill Smialek, Jakolya Gordon, Jeff Kretschmar, Dan Flannery, and Elsie Day for always welcoming our team with good food and good conversation.

This report is dedicated to Janet Kronenberg, an extraordinary advocate for women and children whose memory lives on in the work of the Defending Childhood Initiative in Cuyahoga County.

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Chapter 1
Introduction

About the Defending Childhood Initiative

A recent national survey found that 60% of American children have been exposed to violence, crime, or abuse in their homes, schools, or communities—and that 40% 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) providing funding to eight sites around the country to address children's exposure to violence through intervention and prevention programming, community awareness and education, and professional training. 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. This process evaluation report of the Cuyahoga County 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] In addition, a cross-site outcome evaluation of these same six demonstration project sites will be forthcoming in 2015.

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]

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

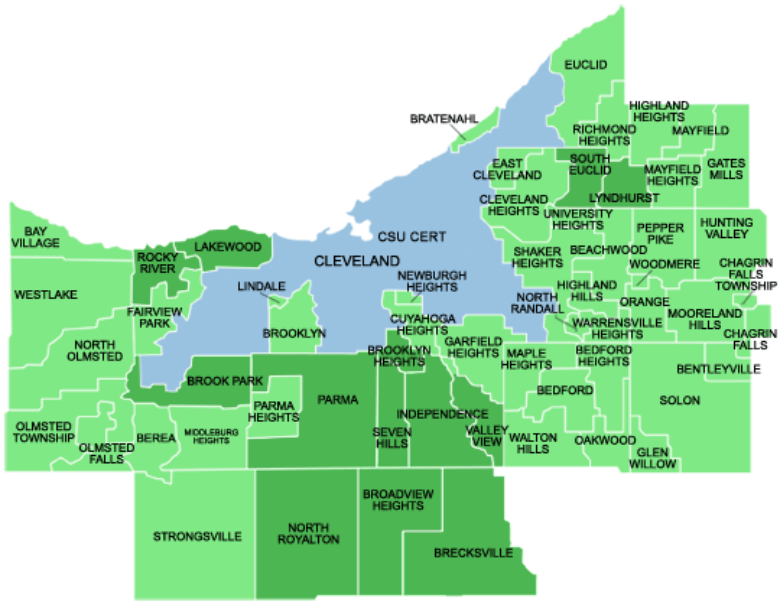
[1] Office of Juvenile Justice and Delinquency Prevention. (2009) Children's Exposure to Violence: A Comprehensive National Survey. Available at https://www.ncjrs.gov/pdffiles1/ojjdp/227744.pdf. Last retrieved 12/1/14.
[2] Swaner R, Hassoun Ayoub L, Jensen E, and Rempel M. (2015) *Protect, Heal, Thrive: Lessons Learned from the Defending Childhood Demonstration Program*. New York, NY: Center for Court Innovation.
[3] Swaner R. and Kohn J. (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.

Children's Exposure to Violence[4] and the Task Force on American Indian and Alaskan Native Children Exposed to Violence.[5]

Cuyahoga County's Defending Childhood Initiative

In October 2010, OJJDP awarded Cuyahoga County $157,873 to embark on a collaborative process that would culminate in a needs assessment and strategic plan for addressing children's exposure to violence in the county. This was considered Phase I of the *Defending Childhood Demonstration Program*. In October 2011, Cuyahoga County was awarded $2,000,000 to implement their strategic plan between October 2011 and September 2013, considered Phase II of the initiative. The County was awarded an additional $610,000 to continue their work in Phase III between September 2013 and September 2014. Finally, on October 1, 2014, OJJDP awarded the County a two-and-three quarters year $612,260 grant to support sustainability. These monies were given as part of the U.S. Attorney's *Defending Childhood Demonstration Program*.

Led by the Witness/Victim Service Center at Cuyahoga County's Department of Public Safety & Justice Services, the Cuyahoga County Defending Childhood Initiative (CCDCI) is an effort to prevent children's exposure to violence (CEV), reduce its negative impact, and increase public awareness throughout the county. As shown in the county map below,[6] Cleveland, the 45th largest city by population in the country according to the 2010 Census, sits wholly within the county.



[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/Alaska Native Task Force can be found here: http://www.justice.gov/sites/default/files/defendingchildhood/pages/attachments/2014/11/18/finalaianreport.pdf.
[6] Map provided by Cuyahoga County Public Safety and Justice Services.

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, multiple conference calls, and 26 interviews with 33 people involved with implementing key components of the CCDCI.

Social and Historical Context

According to the 2009[7] American Community Survey, Cuyahoga County had an estimated population of 1,296,287, of which 439,013 (34%) is located in the City of Cleveland. Twenty-four percent of the county's population consists of children and youth under the age of 18. The majority (66%) are white, while 29% are black, and 5% are other or multi-racial. In addition, 4% of the population is Latino, and about one-sixth (16%) lives below the poverty line. Cleveland is the second poorest major city in the United States (30% of people living below the poverty line).

Children's Exposure to Violence and 2011 Baseline Community Survey Results

According to 2009 FBI Uniform Crime Report data, Cleveland has one of the highest violent crime rates in the country (13.95 cases per 1,000 people). The 2008-2009 Youth Risk Behavior Survey data revealed that 49% of high schoolers[8] and 63% of middle schoolers in the Cleveland Metropolitan School District had been in a physical fight in the past 12 months[9].

As part of the outcome evaluation of the *Defending Childhood* demonstration projects, the Center for Court Innovation conducted a 2011 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 Cuyahoga County site is included here to provide context for strategies related to children's exposure to violence in the county.

The Cuyahoga County baseline survey yielded a total sample of 1,201 completed phone interviews (with an oversample of adults in the Cleveland area). The sample included adults aged 18 to 95, with a mean age of 48.6 years. Fifty-four percent were female, and most (89%) had lived in Cuyahoga County for more than 10 years.

Respondents were asked about how much of a problem various types of violence were in Cuyahoga County. The types of violence that were most often identified as a "big problem" were: violent crime such as assaults, shootings, or sexual assaults (59%); gang violence (42%); and child abuse or neglect (41%). Fifty-two percent of respondents said they had been exposed

[7] Numbers in 2009 are provided, as that was the year prior to the original grant award and may better represent the context in which Cuyahoga County was deemed to be in need of an initiative to address children's exposure to violence.

[8] See full results from 2009 Cleveland Metropolitan School District High School YRBS here: http://www.prchn.org/Downloads/2009%20Steps%20to%20a%20Healthier%20Cleveland%20YRBS%20Report.pdf . Last retrieved 3/31/15.

[9] See full results from the 2008 Cleveland Metropolitan School District YRBS here: http://www.prchn.org/Downloads/2008%20Cleveland%20Metropolitan%20School%20District%20Grades%207-8%20YRBS%20Report.pdf. Last retrieved 3/31/15.

to violence in the past year, with half (50%) having witnessed violence and one-fifth (20%) having been a direct victim. Most often this exposure happened in the neighborhood. Of those respondents who had a child under 18 living in the home (N=344), 62% 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 being from peers and siblings.

History of Related Programs

Despite the overwhelming amounts of poverty and violence, Cuyahoga County has many community resources and programs. The countywide Children Who Witness Violence (CWWV) initiative, which was established in the 1990s, provides evidence-based crisis intervention, trauma assessment, and therapy to children and families who have been exposed to violence. The county has social workers assigned to the courts to assist with child abuse cases. Planning is underway for a Family Justice Center, where victims of domestic violence, sexual assault, and child abuse can come to one location for legal, social, and medical services; this center is scheduled to be open in 2015. In 2003, Cuyahoga County received a SAMHSA grant to develop the Cuyahoga Tapestry System of Care, which uses a wraparound, strengths-based approach to serving children involved or at-risk of being involved with multiple public systems (e.g., child welfare, juvenile justice). The U.S. Attorney's Office for the Northern District of Ohio runs the prevention program STANCE (Standing Together Against Neighborhood Crime Everyday), part of a comprehensive anti-gang and reentry initiative that seeks to encourage children and youth to pursue positive alternatives to gangs. MyCom (My Commitment, My Community) is a prevention program for school-aged children and youth where a coalition of service agencies partner with local schools to provide after-school and summer programming, mentoring, and meaningful youth employment. The Domestic Violence & Child Advocacy Center (formerly called the Domestic Violence Center of Greater Cleveland) provides dating violence prevention programming in some high schools. Much of this prevention work has a positive youth development focus, seeing young people as resources to the community.

In addition to having strong community programs, Cuyahoga County has other assets, including quality data collection and management. For example, the CWWV initiative has been collecting data on incidents and children's mental health systems since the late 1990s. As a result, the local research team has over ten years of community-level data involving victimization, violence exposure, and risk for perpetration. Standard intake protocols for juvenile delinquency cases include validated mental health and victimization screeners. A lot of joint research and data-sharing occurs among various players. As one CCDCI collaborative member stated, the strong relationship between law enforcement, social services, and researchers "is in our DNA here." This history of collaboration is a palpable strength of the Defending Childhood Initiative. As the local researchers observed, the relationship between the justice-system players (e.g., the court, law enforcement) and social service practitioners in Cuyahoga County runs deep. They see each other as essential partners and involve each other in almost all of their activities.

Despite extant strong intervention and prevention programs in the county, there remained a large gap in services because of the numbers these programs can serve vis-à-vis the even more vast scope of the problem of children's exposure to violence. This is the gap that the Cuyahoga County Defending Childhood Initiative was designed to fill.

Chapter 2
The Oversight and Structure of the Initiative

This chapter provides a brief overview of the central structures that oversee and operate the Cuyahoga County Defending Childhood Initiative (CCDCI): a dedicated *core management team* whose members are charged with implementing the everyday work of the initiative; a *collaborative body* that includes stakeholders from health, mental health, law enforcement, and criminal justice agencies whose main contribution came during the planning phase in helping to shape and guide the CCDCI strategic plan; *subcommittees* that are comprised of members of the collaborative body who are tasked with specific tasks related to topics such as training, funding and sustainability, and research and evaluation; and a *governing board* that provides general planning, oversight, and coordination. This chapter also discusses project staffing and budget allocations.

The Core Management Team

The core management team (CMT) consists of four people who are responsible for implementing and supporting all aspects of the initiative, as well as monitoring performance measures. These include two staff members from the Witness/Victim Service Center at Cuyahoga County's Department of Public & Justice Services, and two research and evaluation partners from Case Western Reserve University.[10] The CMT meets regularly and is in continuous phone and email contact about the initiative, working together to troubleshoot problems that arise regarding implementation, produce monthly reports to monitor performance, and discuss sustainability of the initiative.

The Collaborative Body

The collaborative body consists of representatives from over 60 local agencies—health, mental health, law enforcement, and criminal justice organizations whose main contribution came during the planning phase in helping to shape and guide the CCDCI strategic plan. At the start of the initiative, their feedback was constantly sought at all levels of decision-making. As a former CMT discussed in an interview, because it will be difficult to get such a large group of people to always agree on everything, the process for choosing the vision, goals and objectives, target population, and even the definition of violence was a collective one, achieved by consensus. Because everyone felt their voice was heard, participation in the subcommittees, which drove development of the strategic plan, was strong and membership in each subcommittee was open to anyone who wishes to participate.

Since Phase I, some of the original agencies have dropped off, potentially in part because they did not receive any money from the initiative. CCDCI contracted various agencies for treatment

[10] At the start of the implementation of the project, there were two additional CMT members: one from the Witness/Victim Service Center and an external consultant. However, one staff member passed away, and the consultant's contract was not renewed.

services, but the services had to be Medicaid-eligible, so that left out a lot of community-based organizations. Some of those agencies that could not participate in the services felt, from a management perspective, that it was not worth their time to continue on the collaborative.

In the implementation phase, the role of the collaborative body has decreased. The Core Management Team and members of the Governing Board will present to the collaborative on the status of the initiative and plans for moving forward.

Subcommittees

At the start of the initiative, there were six subcommittees, which were comprised of collaborative members. In the planning phase of the initiative, the subcommittees were responsible for developing detailed goals, strategies, and budgets for the strategic plan, which they presented back to the larger collaborative body for approval. During the implementation phase, the subcommittees met on more of an ad hoc basis, when an issue related to their subcommittee's focus arose. As implementation matured, they met very rarely. The following table summarizes the different subcommittees and their goals.

Subcommittee	**Purpose**
Services	Create an effective system of care that: • Works to integrate and enhance current prevention, intervention, and treatment services; • Offers access to and utilization of quality programs with a preference for evidence-based services; • Addresses service gaps in areas with a high incidence of violence and limited service provision.
Policies & Procedures	Create system-wide policies & procedures that: • Identify key identification/response points for children exposed to or at risk of exposure to violence and develop screening, assessment, and referral protocols; • Prevent re-traumatizing; • Address safety planning for service recipients and staff; • Promote communication and collaboration among service providers; • Support responses to compassion fatigue.
Training	Create a training plan that: • Defines core competency domains (i.e., knowledge, attitudes/values, communication, practice, communities, and organizations/systems); • Identifies agencies and staff that require training, proficiency levels, and general schedule for trainings; • Recommends existing curricula and trainers.
Data & Evaluation	Create a data collection and evaluation plan that: • Establishes baseline data to assess and measure prevalence over time; • Identifies areas (defined by geography or agencies) that have significant numbers of children exposed to violence and limited service provision; • Incorporates a logic model for the initiative;

Subcommittee	Purpose
	• Itemizes steps to establish an integrated data system; • Defines the evaluation design for the initiative.
Community Engagement, Awareness, & Prevention	Provide advice on and assistance in: • Key components of a community awareness campaign on the effects of exposure to violence and appropriate response to prevent or intervene when violence occurs; • Engaging children, adults, agencies, and neighborhoods in implementing activities that spread the community awareness campaign messages; • Implementing targeted evidence-based violence prevention services; • Defining the objectives, audience, topics, and potential speakers for a September 2013 community forum/conference on Defending Childhood.
Funding & Sustainability	Create a funding and sustainability plan that: • Defines a three-year budget for the initiative based on input from the other subcommittees; • Identifies in-kind/existing funding and new funding to support the initiative for three years; • Incorporates a sustainability plan; • Recommends an ongoing governing structure for the initiative.

At the start of the CCDCI implementation, the subcommittees met every other month. However, once the initiative was in a secure place, the subcommittees began to meet only when needed for a specific purpose. For instance, the Training Subcommittee put most of its work in prior to a July 2012 all-day training on the new service system. After that, this subcommittee has not met much.

The one exception to the ad hoc status of meetings during the implementation phase has been the Services Subcommittee, which became the Cuyahoga County Child Trauma Services Network. Because services have been the primary focus of CCDCI's strategic plan (as will be discussed in depth in Chapter 3), many of the implementation challenges are addressed through this subcommittee, so it meets more often and consistently has the largest attendance. Early on, prior to rolling out the streamlined service system that would become the core of the CCDCI, the subcommittee held an all-day meeting, working through 25 questions related to the system. These questions included topics such as setting realistic target screening numbers, what a central intake and assessment office would look like, and Medicaid billing.

The Community Engagement, Awareness, & Prevention Subcommittee has had youth from different socioeconomic backgrounds on the committee almost from the beginning. Members restructured the subcommittee in order to be youth friendly. For example, while many subcommittees meet early in the day, this one holds meetings at times when youth can attend because they are out of school. Decisions are made by consensus, and youth are equal members. Youth help to test new messaging ideas, and their artwork is used throughout the campaigns.

The Policies and Procedures subcommittee became inactive early on, after their main task—developing a policies and procedures manual—was accomplished.

The Governing Board

The Governing Board consists of key community players, including the U.S. Attorney General for the Northern District of Ohio, who serves as the chair, and the Cleveland Chief of Police. Board members were responsible for approving the final strategic plan in Phase I of the initiative, but they also communicate with and engage their professional networks to support the Defending Childhood Initiative and contribute organizational resources during the implementation phase, as appropriate. Now that the project is in a "maintenance phase"—meaning that it has been up and running smoothly for a while—the governing board meets four times a year.

Project Staffing

Because the Witness/Victim Service Center is the agency administering the grant, the two project staff who oversee the daily administration of initiative are from that county office. With the exception of one Witness/Victim Service Center staff member, no personnel are 100% full-time equivalent (or even 50%) on CCDCI; all salaries are in-kind to CCDCI, so none of the grant funding is used for that purpose. Looking back, the Core Management Team wishes that more money had been allotted to the Witness/Victim Service Center staff, as one member expressed:

> *At times there's just no more work you can do. In hindsight, if any of us understood what this project was going to be, we would've built in a little more capacity from Witness/ Victim Services Center. We all rely on each other a lot, and are giving way more than the time we're allotted for.*

In June 2012, the Director of the Witness/Victim Service Center and leader of the CCDCI passed away. In June 2013, the contract dollars ran out for the consultant who had been brought on to lead the planning phase, as well as the beginning of implementation. It was deemed that once the initiative was mature enough, the consultant's services were no longer necessary, so a new contract was not given.

The original implementation grant was $2 million for two years. This table below shows how original grant monies were allocated. These allocation decisions reflected a consensus among the collaborative body after a community assessment conducted during Phase I revealed the need for more evidence-based treatment and intervention services for children who had been exposed to violence[11]. Because the original grant was for two years, the collaborative body felt that the funding should go towards creating a streamlined service system that could be sustainable past the two-year grant period.

[11] A copy of this community assessment report can be found at http://ja.cuyahogacounty.us/pdf_ja/en-US/DefendingChildhood/StrategicPlan/I_ComAssessment.pdf.

Category	Year 1	Year 2	Total
Services	$448,300	$924,958	**$1,373,258**
Awareness	$120,000	$95,000	**$215,000**
Evaluation	$83,808	$69,184	**$152,992**
Administration	$89,725	$64,025	**$153,750**
Training	$65,000	$40,000	**$105,000**
Total	**$806,833**	**$1,193,167**	**$2,000,000**

The Phase III award was a one-year grant for $610,000, which CCDCI mostly allocated to maintenance of the streamlined service system, and an additional $612,260 was awarded as a Phase IV two-year grant to support sustainability of the initiative.

CCDCI awarded contracts to multiple agencies to administer treatment, healing, and prevention services. The majority of these funds under services were allocated for treatment and healing direct intervention programs for children who have been exposed to violence, and for creating a Central Intake & Assessment office that administers assessments for children who may have been exposed to violence or trauma. These funds for contract agencies totaled well over half of the grant money received. CCDCI contracted with seven agencies to do five different evidence-based treatments ($800,000 of the original budget went to these treatment agencies). There has been some staff turnover among these agencies (discussed later in Chapter 3). Additionally, the contracts for some of these service providers were not extended because the therapies they were contracted for were not ones that were recommended by Central Intake. These agencies also did not accept cases with high frequency, even when the therapy recommended was one that they were contracted to provide. Because these contracts were service-based, there was money left over when their contracts expired. These dollars were reallocated to service providers that were providing more common therapies (e.g., trauma-focused cognitive behavioral therapy) and that extended their capacity to accept referrals from CCDCI. The Central Intake grant is not service-based, so it supports about six full-time staff members.

Chapter 3
The Cuyahoga County Defending Childhood Initiative Program Model

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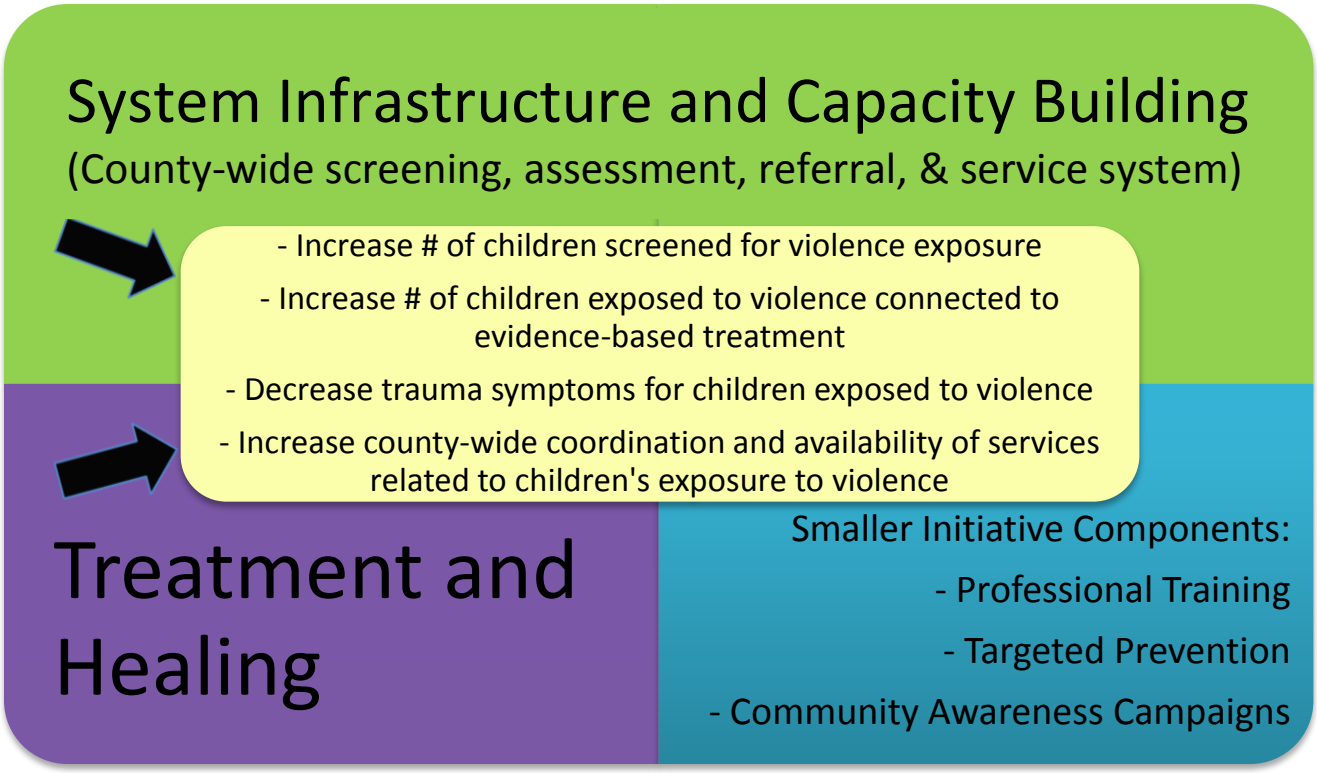
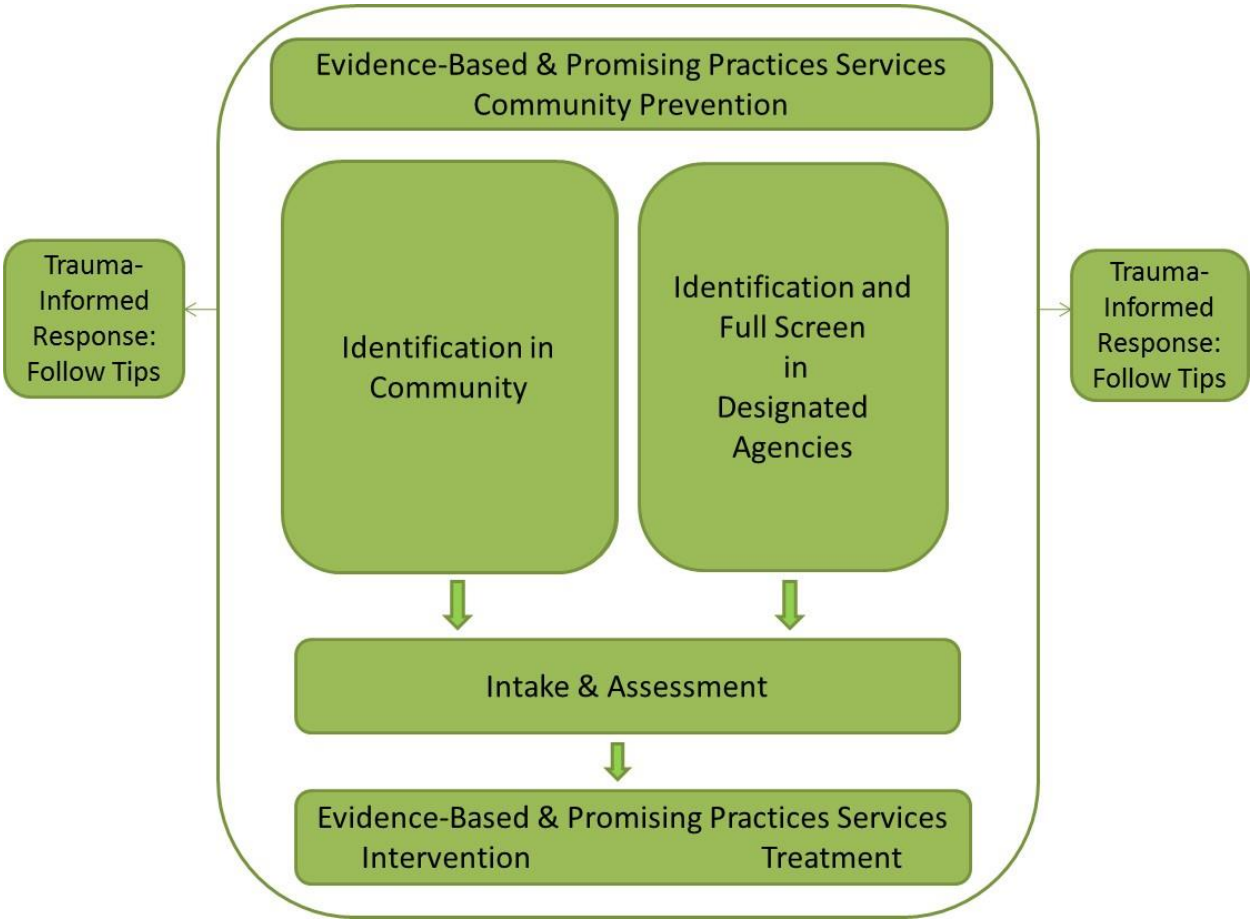
In this chapter, program activities are described in each of the key areas that comprise the Cuyahoga County Defending Childhood Initiative (CCDCI): screening, assessment, treatment and healing (direct intervention services), prevention programming, community awareness and education, and professional training. In each of these key areas, challenges to implementation will also be discussed. The figure below shows the different program model components of the CCDCI, and the goals it hoped to achieve through these activities:



Targeting all of Cuyahoga County, the majority of the CCDCI resources have been devoted to creating a streamlined service system that moves children ages 0-18 who have been exposed to violence and are experiencing trauma symptoms from identification/screening to assessment to treatment. This system as a whole has created a countywide infrastructure and capacity for systematically addressing children's exposure to violence. The following figure, affectionately called by the Core Management Team as "the robot" or "Frankenstein," illustrates this system.



Each component represented in the above figures will be discussed in depth below. In brief, multiple agencies screen for exposure to violence and trauma and, when appropriate, refer to a Central Intake and Assessment office that CCDCI funded as a centralized assessment agency. This agency (administered by FrontLine Service[12], who was awarded the CCDCI contract to play this role) then conducts a full assessment of the child and makes referrals for evidenced-based treatment to one of the agencies CCDCI contracted to provide such services.

Screening

Screening for children's exposure to violence is an important first step in the CCDCI's service system; screening refers to how children are identified for potential intervention, treatment, and healing programs. The CCDCI research team piloted and developed a short, one-page screener that asks questions related to violence exposure and trauma. There are separate screeners for children seven years of age and younger (completed by the caregiver) and for children eight years of age and older (completed by the child). The screeners were based on existing violence exposure and trauma instruments (e.g., Juvenile Victimization Questionnaire, Trauma Symptom

[12] When the contract was first awarded, FrontLine Service was called Mental Health Services. The organization recently changed its name.

Checklist for Children, Violent Behavior Questionnaire, Child Behavior Checklist), and shortened to be appropriate for a screener. A copy of the screener is attached as Appendix A.[13]

If a child screens as having been exposed to violence or trauma, this facilitates a referral to a Central Intake and Assessment ("Central Intake") office for a full assessment. If the child screens positive on the full assessment, the child is then referred to appropriate treatment services. The threshold score that a child must meet or exceed in order to be referred was set by the CCDCI research team, with input from the treatment service providers. The person administering the screener has discretion to "override" the threshold if s/he feels that the child needs to be referred for a full assessment, even though the child does not meet the requirement on the screener. Some staff make overrides because they believe the older children may be trying to protect their mom or dad or that the parents of the younger children are lying. If a child answers yes to any of the suicide ideation questions, the child is automatically referred as well. The original threshold level was set high, taking into account the volume of screeners that would be completed and the capacity for the Central Intake office and service providers to meet the needs.

At the start of the initiative, the core management team identified a number of relevant government and non-profit agencies and invited them to be screening agencies. The management team asked these organizations to choose a logical point in their system/agency to implement screening consistently. All screening agencies participated in a training done by project staff. The two primary screening agencies have been the Cuyahoga County's Division of Children & Family Services (DCFS) and the Cuyahoga County Juvenile Court. Thirteen additional screening agencies include the service providers who received CCDCI contracts for evidence-based intervention and treatment and other local treatment agencies. Caregiver consent is received before any information is shared.

In the beginning months of screening, the screener was completed in hard copy with pen and paper. However, the consensus of the Research & Evaluation Subcommittee was that the screener needed to be electronic for four primary reasons. First, papers can get lost or misplaced. Second, if completed screeners were then faxed to Central Intake, confidentiality could be compromised if a copy was left on the fax machine. Third, computerization would decrease workload, because staff members would not have to fill out the form twice (once in person, then once data entering it into an electronic system). Fourth, an electronic system allows for real time information, generating a quicker response. Though the CCDCI did not have the money to develop the online screener system, the Begun Center for Violence Prevention Research at Case Western University paid for its development, with feedback from the Research & Evaluation Subcommittee, the Services Committee, and the Core Management Team. The online "home" for the screener is with Cuyahoga County, and the county is responsible for maintaining it on a secure, password-protected server. The online screener reads just like the paper copy.

In theory, development of the electronic system means that the worker who is administering the assessment is doing so on a tablet computer or smartphone.[14] The information is automatically

[13] Though copies of the screeners are included in this report, its authors do not want additional external agencies to use them until they have been validated. The CCDCI researchers are currently seeking external funding to conduct a validation study.

entered into a database. The electronic system calculates the screener score for the worker, and lets he or she know whether or not the child should be referred to Central Intake. It also says, "Notice the response" to the three critical items (about feeling of suicide and sexual abuse). If the screened child meets or exceeds the threshold level, or has been overridden, the worker will ask the parent or caregiver if a referral can be made. If the parent or caregiver does not consent to the referral, the child's data stays deidentified in the data set, and no referral is made. If they agree, the worker will click a button and the system automatically generates an email to Central Intake and sends a link that Central Intake staff click, directing them to the screener of the child who was just screened.[15] Central Intake can then reach out to the family to set up a time for a full assessment. The CCDCI research team can export all of the electronic data with no identifiers in order to run monthly quantitative reports for relevant stakeholders. The biggest referral source is DCFS, and about 50% of their referrals to Central Intake are because of exposure to domestic violence, and 25% due to exposure to sexual violence.

It is important to note that screening professionals are instructed to follow their agency protocol if they have a child who reports suicidal ideation or attempt; it does not just go to Central, it can also require an immediate response/crisis protocol based on the regulations of the screening agency.

From when screening started on July 23, 2012 through September 30, 2014, CCDCI has screened 16,219 children. Approximately 10 percent of those screened went on to be referred to Central Intake,[16] with over half of that number not due to meeting the threshold level but due to overrides. When overrides were given, sometimes it was because the person administering the screener felt that though the child did not necessarily need services addressing trauma, the child needed other services and felt sending them for a full assessment was maybe a way to connect them with those services. Other times the person administering the screener felt that the parent may not be entirely truthful about the child's trauma symptoms, especially when the administrator was from DCFS and the parent was concerned about their child being removed from the home.

Challenges Related to Screening

There have been some challenges related to administering the screener. Some were related to start-up. As one DCFS employee stated, "DCFS has over 600 employees, so in order to implement something new it takes time—time to get everyone the proper training and time to change past ways of doing things." For DCFS, intake is the point of screening. Early on when paper copies were used, some intake workers were not using the screener, because only a portion of staff had been at the initial training in July 2012, and not all intake workers were able to attend. Even after all workers were trained, there was staff turnover, and for staff that remained

[14] Some agencies do not use the online screener because they either do not have a computer, smartphone, or tablet with them when they screen (so will data enter it at a later time), or have rules about bringing technology into homes because of security issues.

[15] A crisis response can be requested in consideration of response to critical items. If crisis response is warranted, the screener is faxed to Central Intake, which has 24/7 capabilities and is also the agency home of mobile crisis services for suicide prevention. Thankfully, this does not come up often and the majority of outreach is done the following day.

[16] Not all who are referred to Central Intake follow through and complete an assessment.

and for new staff, screening has been inconsistent, indicating that follow-up "booster" trainings may be necessary.

After the agency had some time to adapt to the new screening requirement, other challenges arose. Some intake workers did not like having to administer the screener multiple times for one family: if a parent has seven children, and four of them are under eight, the one parent needs to answer the same questions for those four children, then do three additional screeners with the older children. Additionally, staff from DCFS are concerned that intake may not be the best time to do the screening, because the parent may have a child welfare case and at that point may not be fully honest on the screener, for fear of how it may affect their case. As one stakeholder summarized:

> *Families are nervous because they don't know what the outcome will be, and are worried about losing their kid, so sometimes parents aren't being honest, or refuse to sign the consent. At the beginning they're not feeling supported by DCFS and they're feeling accused, so they don't want anything associated with us.*

Some partner agencies also expressed worry that the threshold was set too high and that there were children who needed to be referred but who were not flagging as such on the screener. This has created a Catch-22: if the threshold set on the screening tool is too high, some children who may need services will get missed. However, if the threshold is lowered, kids may be identified but not receive services due to lack of capacity on behalf of treatment providers. The hope was that the override system would help alleviate some of this worry.

Additionally, for those that do meet the threshold, screening agents were concerned that introducing another organization (Central Intake) may unnecessarily complicate access to services. As one screening agency explained:

> *The new system is a little awkward—we used to just refer to some of our partner agencies before DCI, we have contracts with them, or we'd do it ourselves. We'd just do [multi-systemic therapy]. So now there's an extra layer. Staff have asked, "If I have a kid and mom in front of me, and they're ready for services, can't I just refer them to services?" Intake staff do not want to wait. And what if they're already involved in services now?*

DCFS staff often felt that put them in a predicament in terms of service planning, because they could get them into services immediately at DCFS, but the assessment process delays things.

On the other side, staff from Central Intake have expressed challenges as well. (The Central Intake process is described below.) Intake staff often receive hard copy screeners that are not fully completed, or where the address or phone numbers are inaccurate or illegible. For agencies that may use hard copies instead of the electronic system, there are data entry delays, and Central Intake may need receive the information until weeks after the screener was completed.

Central Intake and Assessment

Central Intake & Assessment—run by FrontLine Service, a non-profit agency that responded to CCDCI's request for proposals for a Central Intake administrator and that was awarded the contract—is the "hub" where all screening agencies send their screeners. Central Intake also receives referrals from 211, the United Way's "first call for help" free service line, which serves Cuyahoga County.[17]

Central Intake—available 24 hours a day, seven days a week, 365 days a year—is the site for all diagnostic assessments and crisis response in the county's service system, created under the Defending Childhood Initiative. Once Central Intake receives a screener, staff have 24 hours to reach out to the family. While most attempts are made by phone, the internal protocol is that after a few failed attempts, a staff member will go to the home. When the screener indicates crisis (i.e., imminent threat to self or others), Central Intake staff are required to reach the family within six hours.

After initial contact with the family, Intake staff then have 30 days to complete an assessment. If the family is not in crisis, the assessment focuses on gauging trauma symptoms to determine what services are appropriate. The assessment instrument used is one that was developed under a Substance Abuse and Mental Health Services Administration (SAMHSA) grant for a similar program in the county. The diagnostic assessment is comprehensive, with core components from valid and reliable instruments such as the Juvenile Victimization Questionnaire[18], Trauma Symptom Checklist for Children[19], Trauma Symptom Checklist for Young Children[20], and the Child Behavior Checklist[21]. The assessment takes anywhere from two to four hours to complete and is usually spread over two separate sessions. Most are completed in the families' homes,

[17] Further discussion of 211 and its relationship to the Defending Childhood Initiative will be discussed later on in this chapter under the subheading "Community Awareness and Education." Not many referrals have come to Central Intake through 211.

[18] For more information about the Juvenile Victimization Questionnaire, see Finkelhor D, Hamby SL, Ormrod R, and Turner H. (2005) "The Juvenile Victimization Questionnaire: Reliability, validity, and national norms." *Child Abuse and Neglect*, 29(2005):383-412; http://www.unh.edu/ccrc/juvenile_victimization_questionnaire.html.

[19] For more information about the Trauma Symptom Checklist for Children, see Briere J. (1996) Trauma Symptom Checklist for Children: Professional manual. Florida: Psychological Assessment Resources Inc.; Nader KO. (2004) "Assessing traumatic experiences in children and adolescents: Self-reports of DSM PTSD Criteria B-D symptoms." In J. Wilson & T. Keane (Eds.), *Assessing psychological trauma and PTSD, 2nd ed.* (pp. 513-537). New York: Guilford Press; Ohan JL, Myers K, and Collett BR. (2002) "Ten-year review of rating scales. IV: Scales assessing trauma and its effects." *Journal of the American Academy of Child and Adolescent Psychiatry, 41:*1401-1422.

[20] For more information about the Trauma Symptom Checklist for Young Children, see Briere, J. (2005) *Trauma Symptom Checklist for Young Children: Professional manual.* Florida: Psychological Assessment Resources Inc.; Briere J, Johnson K, Bissada A, Damon L, Crouch J, Gil E, Hanson R, and Ernst V. (2001) "The Trauma Symptom Checklist for Young Children (TSCYC): Reliability and association with abuse exposure in a multi-site study." *Child Abuse & Neglect*, 25:1001-1014.

[21] For more information on the Child Behavior Checklist, see Achenbach TM and Rescorla LA. (2000) *Manual for the ASEBA Preschool forms and Profiles.* Burlington, VT: University of Vermont Department of Psychiatry; Achenbach TM and Rescorla LA. (2001) *Manual for the ASEBA School-Age Forms and Profiles.* Burlington, VT: University of Vermont, Research Center for Children, Youth, and Families; Nakamura BJ, Ebesutani C, Bernstein A, and Chorpita BF. (2009) "A Psychometric Analysis of the Child Behavior Checklist DSM-Oriented Scales." *Journal of Psychopathology and Behavioral Assessment*, 31:178–189.

though some are also administered at FrontLine Service's office located in Cleveland. All staff[22] doing assessments have master's degrees in social work or counseling and are licensed social workers or counselors in the state of Ohio.

Once an assessment is complete, staff make a diagnosis and recommendation for treatment and then link families to a Defending Childhood contract agency that can provide the child with the most appropriate trauma-informed intervention, driven by the results of the assessment. Some children do not need to be referred, as the person doing the original screener had made an override, but after the assessment, the therapist did not think that therapeutic services were needed. A therapist may also deem a referral unnecessary for children who met the screener threshold but, on comprehensive assessment, did not seem to display trauma symptoms that required services.

All trauma treatment services that Central Intake refers to are evidence-based, and all are voluntary, except when ordered by the Juvenile Court. These treatments include: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (PCIT), Multi-Systemic Family Therapy (MST), Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT), and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS). (Different agencies are contracted for different treatments.) TF-CBT is the most needed, according to FrontLine staff, and SPARCS and AF-CBT are the least. (See below for more information on this.) Once an organization receives a referral, they have 48 hours to reach out and make an appointment and confirm it with Central Intake.

Logistically, every Monday and Thursday a staff member at FrontLine Service emails a chart to the treatment provider agencies asking them to fill out how many openings they have for the different treatments they provide, indicating how many new clients they would be able to serve. This helps inform the decision of which agency to refer to. There is often a waitlist for certain treatments because contract agencies are at their service capacity. The first child on the waitlist is the first child off.

According to FrontLine staff, everyone who starts an assessment finishes it, but not everyone who screens starts the assessment. While Central Intake reaches out to everyone who is referred to them, only about 50 percent agree to do an assessment. Given that a large percentage of these are DCFS families that are extremely leery of service providers for fear of losing their children, and that services are voluntary, the 50% response rate is high.

About 75 percent of the families completing an assessment are Medicaid-eligible, and FrontLine Service can get reimbursed through Medicaid for the assessment time, though they cannot get reimbursed for time spent on outreach.

Since Central Intake began on July 23, 2012 through September 30, 2014, they have done 726 assessments.

[22] The CCDCI grant to Central Intake is not service-based, so it supports about six staff members.

Challenges Related to Central Intake and Assessment

Though setting up the Central Intake system and doing the assessments has been extremely successful, it has not been without challenges. First, the biggest challenge might also be the biggest success: bringing together many different agencies from across the county and figuring out what a streamlined service system would look like in theory and how it would function in practice. Much of this was worked out in the Phase I planning year of the Defending Childhood Initiative. According to one stakeholder, "We had a year to figure it out and we needed every minute of it." Different agencies had to sacrifice different components of the process that they were used to having control over. For instance, some of the treatment agencies were used to doing their own assessments as well, and the assessment agency was used to doing their own treatments. That organizations were willing to sacrifice some of their own work for the sake of the larger system is a big success. As one treatment agency put it: "We're trying to change the way services are accessed in this county by creating this huge system, and it's working, and all major players are on board."

Some other challenges, however, have not been resolved. According to one stakeholder, the biggest challenge is lack of treatment availability, leading children to be put on a waitlist. Some are on for a short time period (e.g., one week), whereas others have been waitlisted for months. The lack of capacity of the treatment service providers is due to multiple reasons, including the high need generated by increased screening and identification and also the lack of dedicated staff at these agencies devoted to serving clients coming through the Defending Childhood network. Because the contracts are fee-for-service, where the agency only gets paid through DCI if they serve a client, agencies sometimes will take clients from elsewhere to fill their caseload and generate work and income for the agency. Then, for example, when a child gets referred to them from Central Intake, they often do not have capacity to take that child.

Knowing this, a Core Management Team member indicated one way Central Intake is trying to overcome this challenge:

> *We know we're going to have capacity issues. We've been trying to build in additional capacities. If you're a Medicaid agency and you are trained and can do fidelity to model, if that's you and you're interested, you can say that you want to be involved and be added to the [referral] list. Central Intake will refer to the contracted agencies first, but then they can go to another agency on the list.*

(A copy of the programmatic expectations for those agencies providing Defending Childhood treatment services outside of a formal contract is attached as Appendix B.)

A staff member at FrontLine Service suggested that in the future, it might be more effective to make contracts not service-based but guaranteed money, where agencies could hire someone dedicated solely to serving Defending Childhood referrals.

The capacity issue, however, underscores another challenge, discussed above under Screening as well, as it relates to the threshold set on the screener as to who goes on to be referred to Central Intake. Some stakeholders believe the threshold may be too high and therefore some children

who may need trauma services are missed and therefore never get assessed. However, if the threshold is lowered, there would be even more people on the waitlist if the lowering is not coupled with expanded treatment capacity (which would require more funding).

On the other hand, many of the referrals that Central Intake receives—approximately 60%—do not meet the screening threshold, but instead are overrides from the person administering the screener. As a FrontLine staff member stated:

> *From our perspective, they're not all appropriate for us in the spirit of what the program is. The kid should have experienced some kind of trauma. They need services, but not ours. For example, they need non-trauma services because they're not doing well in their family so they need family preservation services. I understand why DCFS is doing the override; the kids need services.*

Another challenge that was identified during stakeholder interviews was the linkage between Central Intake and the treatment agencies. In the current system, once a treatment agency receives a referral and schedules an appointment with the family, it is supposed to let Central Intake know that a connection has been made; sometimes the treatment workers do not communicate that information back to Central Intake.

A final challenge is that, oftentimes, after originally scheduling an assessment, families cancel altogether.

Treatment and Healing

For this report, therapeutic programs designed to treat the psychological effects in children who have been exposed to violence are categorized as "treatment and healing." In CCCDCI's service system, after Central Intake completes an assessment and a preferred treatment is identified, the child is referred to one of the CCDCI contracted treatment agencies[23] for an evidence-based intervention. 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.[24] CCDCI only contracted for therapies that research has shown to be at least promising. The table below shows the specific therapies that are offered and the agencies that have been contracted[25] for them over the course of the implementation of the initiative, or were contracted for one therapy but had the capacity for another. It also briefly describes each treatment.

[23] As discussed in the previous Assessment section, because some of the contracted treatment agencies are at capacity, and to avoid a child being on a waitlist for an extended period of time, sometimes Central Intake will refer to a non-contracted DCI partner where they do evidence-based therapy. One such example is Murtis Taylor Human Services, which is able to provide TF-CBT and PCIT.

[24] 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.

[25] The contracts for Beech Brook and Bellfaire/JCB were eventually terminated.

Treatment	Description	Contracted Agencies
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)[26]	TF-CBT is a treatment designed to help children, adolescents, and their parents to overcome the negative effects of trauma. 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.	- Applewood - Beech Brook - Bellfaire/JCB - Catholic Charities - FrontLine Service
Alternatives for Families: Cognitive Behavioral Therapy (AF-CBT)[27]	AF-CBT is designed to assist children and teens with behavioral health problems associated with growing up in families in which parents have a history of resorting to coercive discipline, if not outright physical abuse. Children and families for which the model is intended often are known to experience chronic conflict within their homes. AF-CBT addresses both the key risk factors for and clinical consequences of exposure to family aggression.	- Applewood - Beech Brook - Bellfaire/JCB
Multisystemic Therapy (MST)[28]	MST is an intensive family- and community-based treatment that addresses the multiple determinants of anti-social behavior in adolescents. As such, MST treats the factors (e.g., family, school, peer group, community, etc.) that contribute to behavior problems. On a highly individualized level, treatment goals are developed in collaboration with the family, and family strengths are used as levers for family change.[29]	- Cuyahoga County DCFS - Applewood
Parent-Child Interaction Therapy (PCIT)[30]	PCIT provides coaching to parents and other caregivers who want to help their children to learn	- Beech Brook - The Cleveland

[26] 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.

[27] AF-CBT is considered promising. See Kolko, David J. 1996a. "Individual Cognitive Behavioral Treatment and Family Therapy for Physically Abused Children and their Offending Parents: A Comparison of Clinical Outcomes." *Child Maltreatment*, 1:322-342; and Kolko DJ, Iselin AM, & Gully K. (2011) "Evaluation of the sustainability and clinical outcome of Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT) in a child protection center." *Child Abuse & Neglect*, 35(2):105-116.

[28] MST is considered evidence-based. Studies that demonstrate its effectiveness include: *Timmons-Mitchell* J, Bender MB, Kishna MA, and Mitchell CC. (2006) "An Independent Effectiveness Trial of Multisystemic Therapy with Juvenile Justice Youth." *Journal of Clinical Child and Adolescent Psychology*, 35(2):227-236; and Borduin C, Mann BJ, Cone LT, Henggeler SW, Fucci BR, Blaske DM, and Williams RA.(1995) "Multisystemic Treatment of Serious Juvenile Offenders: Long-Term Prevention of Criminality and Violence." *Journal of Consulting and Clinical Psychology*, 63(4):569-578.

[29] Though designed to directly address trauma, MST was chosen because, for some individuals, before trauma can be addressed, the family and home environment needs to be stabilized. For these individuals, MST may be an important first intervention to reduce out-of-home placements such as incarceration, residential treatment, and hospitalization. Staff members understand that after a young person completed MST, he or she may need to be referred to a second intervention to address trauma symptoms.

[30] PCIT is considered evidence-based. Studies that demonstrate its effectiveness include: Chaffin M, Silovsky J, Funderburk B, Valle LA, Brestan EV, Balachova T, et al. (2004) "Parent-Child Interaction Therapy with physically abusive parents: Efficacy for reducing future abuse reports." *Journal of Consulting and Clinical Psychology*,

Treatment	Description	Contracted Agencies
	how to relate and behave better. Discipline skill building and coached parent/caregiver-directed play occur with the assistance of a PCIT therapist. Parent/caregivers are also given a homework assignment after each session to practice PRIDE skills (praise, reflect, imitate, describe, enthusiasm) with children every day for 5-10 minutes.	Christian Home
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)[31]	SPARCS is a group intervention specifically designed to address the needs of chronically traumatized adolescents who may still be living with ongoing stress and experiencing problems in their adjustment. Goals of the program often focus on affect regulation, self-perception, coping and relationship building while also reducing somatization, dissociation, avoidance, and hopelessness. SPARCS draws heavily from cognitive-behavioral and dialectical behavior therapy concepts and techniques.	- Bellfaire/JCB

Each agency signed a Pledge of Participation, indicating that they were uphold the Defending Childhood mission to work with the CCDCI to forge an effective response to children's exposure to violence. A copy of this pledge, along with a trauma-informed checklist that each pledgee was given to assist them in becoming more trauma-informed, is in Appendix C. 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. Program fidelity is most accurately measured across five areas: program adherence, quality of delivery, program exposure, participant responsiveness, and program differentiation.[32] In the pledge, agencies agree to implement the treatments with fidelity.

The next table, put together by CCDCI, summarizes each treatment in terms of age range, parental involvement, relevant diagnosis, primary focus of treatment, frequency and duration of services, and location of services.

72(3):500-510; and Schuhmann EM, Foote RC, Eyberg SM, Boggs SR, and Algina J. (1998) "Efficacy of Parent-Child Interaction Therapy: Interim report of a randomized trial with short-term maintenance." *Journal of Child Clinical Psychology*, 27(1):34-45.

[31] SPARCS is considered promising. See, for example: Weiner D, Schneider A, and Lyons J. (2009) "Evidence-based treatments for trauma among culturally diverse foster care youth: Treatment retention and outcomes." *Children and Youth Services Review*, 31:1199-1205; Habib M, Labruna V, and Newman J. (2013) "Complex histories and complex presentations: Implementation of a manually-guided group treatment for traumatized adolescents." *Journal of Family Violence*, 28:717-728.

[32] For more information on evaluating fidelity, please see: A) Mowbray CT, Holter MC, Teague GB, and Bydee D. (2003) "Fidelity Criteria: Development, Measurement, and Validation." *American Journal of Evaluation*, 24:315-340; B) Durlak JA and DuPre EP. (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 AA, Hanson K, Hawkins JD, and Arthur MW. (2008) "Bridging Science to Practice: Achieving Prevention Program Implementation Fidelity in the Community Youth Development Study." *American Journal of Community Psychology*, 41:235-249.

After some of the original contracts were up, CCDCI did not extend the contracts of some of the service providers who were contracted for specific therapies that were not often recommended by Central Intake (e.g., SPARCS and AF-CBT[33]). This decision allowed CCDCI to reallocate resources to agencies doing TF-CBT, the most common treatment Central Intake has referred for. All staff members who are doing the evidence-based treatments have been trained in those treatments, and, at a minimum, have master's degrees and are licensed social workers or licensed professional counselors. In Ohio, in order to do TF-CBT, one has to have a license and attend a two-day training. Those trained on TF-CBT also attend follow-up consultation calls.

Description	**TF-CBT**	**AF-CBT**	**MST**	**PCIT**	**SPARCS**
Age Range	3-17 years	5-18 years	12-17 years	2.5-7 years	12-19 years
Parental Involvement	Yes	Yes	Yes	Yes	No
Relevant Diagnosis	Trauma-related diagnoses	Trauma-related diagnoses	Disruptive behavior disorders	Disruptive behavior disorders	Trauma-related diagnoses
Primary Focus of Treatment	Treatment of trauma	Treatment of trauma when there is parental aggression/coercion, if not physical abuse, or aggressive family interactions	Treatment addresses chronic and severe delinquent, violent, and other anti-social behaviors, especially when youth is at risk of out-of-home placement or returning from out-of-home placement	Treatment of oppositional, defiant, and other externalizing behaviors	Treatment of adolescents exposed to chronic interpersonal trauma and other traumas
Frequency of Services	~12-16 weekly sessions for children and parents, and several conjoint parent-child sessions, as needed	~12-18 hours of therapy	Therapists work with family members at least weekly, if not daily, throughout services provision	~ 12-14 sessions	16 one hour sessions
Duration of Services	~3-6 months	~3-6 months	~4 months	12-20 weeks, and may include booster sessions 1 month, 3	6-12 months

[33] One reason AF-CBT has not been used much is because it is an intense therapy that is highly parent-driven, which reduces parents' willingness to engage.

Description	TF-CBT	AF-CBT	MST	PCIT	SPARCS
				months, 6 months, and 1 year post-discharge	
Location of Services	Office- or home-based	Office- or home-based	Home- and community-based	Office-based	Office- and school-based

The acronym PRACTICE reflects the components of the TF-CBT treatment model: Psychoeducation and parenting skills, Relaxation skills, Affect expression and regulation skills, Cognitive coping skills and processing (learning to understand the relationships between thoughts, feelings and behaviors and think in new and healthier ways), Trauma narrative, In vivo exposure (when needed), Conjoint parent-child sessions, and Enhancing safety and future development. The trauma narrative includes verbal, written, and/or symbolic recounting of traumatic events so the child learns to be able to discuss the events they choose in ways that do not produce overwhelming emotions. There is lots of room for creativity during the trauma narrative – a child can write it out, act it out, use puppets, etc. Because this is the most emotionally trying component of TF-CBT, some clients drop off at this point.

While research has shown TF-CBT to be effective if a child completes the full length of services, according to one therapist at Catholic Charities, maybe only 25% of those who start TF-CBT at their organization complete. As she stated, "Some drop off the face of the earth – their phone number changes, they've moved – but most of it is when they get to the hard part they don't want to do it anymore. This isn't evidence-based if the people don't finish it. We have very few successful completions so our impact isn't as big as we'd like." Other agencies have had higher retention rates. FrontLine Service is also a CCDCI contract agency for TF-CBT and has reported a higher retention rate. The greater retention seen at FrontLine Service may be in part due to the fact that it is the original assessor agency, so it had developed a previous relationship with the family and child. DCFS, a CCDCI contract agency for MST, reported having a high retention rate as well: "If people start, they usually complete. However, MST requires a tremendous amount of time from the family and it's a very specific target, which is why we don't get many cases."

Illustrating the Process: The Example of Catholic Charities

It is helpful to look at one provider in order to illustrate the case flow from Central Intake to treatment. Catholic Charities is one of the TF-CBT CCDCI contract agencies. (Seven of their staff of 15 have been trained in TF-CBT.) Two times each week, Central Intake sends out an email to all treatment providers outlining the new cases and treatment needs. If Catholic Charities does not have any openings, they will email back that they are not able to take on any new clients. If they can, they respond that they can take a TF-CBT case. Central Intake will then fax over the full assessment (approximately 30 pages long) for the child being referred. Next, a linkage appointment is scheduled, where the Central Intake worker who did the assessment meets with the assigned Catholic Charities therapist and the referred family together. This completes the referral and ends the involvement of Central Intake with the family. Catholic Charities then schedules the first TF-CBT session with the family. All of their therapy sessions are at the home, which helps to decrease issues around transportation. Because they have a CCDCI contract, if the child is not covered by Medicaid, they can bill the sessions to the contract; most, however, are Medicaid clients, and the same is reported by the other contract agencies.

Challenges Related to Treatment & Healing

As the above paragraph highlights, retention in treatment and healing services is a challenge. Additionally, there is a drop-off in numbers from screening to assessment, then from assessment to treatment, then in treatment, meaning many who need services are not receiving them. As one stakeholder explained, "Families just spent a month with FrontLine getting assessed, then have to go somewhere else for services. Sometimes we lose them." A representative from DCFS echoed this sentiment: "If the goal is screening, great, we're meeting that. If the goal is service provision and completion, we're falling short."

In interviews with the evaluation team, providers identified some reasons for families dropping out or refusing services. First, some believed that the family is not fully informed about what they are getting into; once they see how long the treatment will take, and how much time needs to be devoted to it, some of those interviewed reported that families are taken aback and feel like they cannot commit to or continue with the therapy. As one treatment provider stated: "Our services have a heavy parent component and when they see how involved they have to be, they say, 'no thanks.'" Second, some families feel like they already have therapeutic services so they do not feel like they need to attend more, even though the ones they are currently receiving may not be trauma-informed or evidence-based. One provider stated that they try to think of ways to keep clients involved. For example, some therapists will stop halfway through a session to play cards for 10 minutes in order to make the time feel less intense. One provider suggested that going to the schools to do the therapy might be helpful, but it is hard to do because the Cleveland Metropolitan School District has a contract with a treatment agency and they do not want other agencies to come in.

Other identified challenges related to staff burnout and training. All treatment agencies stated that they were facing the issue of staff burnout. Although encouraged to take time off, therapists still reported feeling vicarious trauma and exhaustion.

Regarding training, it is expensive to train staff, so agencies do not have enough staff trained in the evidence-based therapies to meet the needs of Central Intake. Additionally, once staff are trained, they sometimes leave the agency, leaving a gap that needs to be filled by training another staff member, which costs money. And while the CCDCI continues to pay for consultation calls, some of those they originally trained are no longer providers.

One contact from a non-contract agency providing treatment to CCDCI clients suggested:

> *I'd recommend a small financial award to non-contract providers to help us maintain services. The buy-in is there, but there is still a lot of cost. Many of the clients are Medicaid eligible – 90%. But it's the training costs where we need help.*

Other discussed challenges were agencies not receiving as many referrals as they thought they would receive. Sometimes after completing a treatment with a client, they still need to refer on for additional treatment because they are not addressing the trauma as the primary issue. For example, with multisystemic therapy, treatment is focused on decreasing anti-social behavior and helping to address a family/home situation so that a young person does not end up in out-of-home placement.

Prevention

While the majority of the services funding went to assessment, treatment, and healing programs, a small portion of the budget ($150,000) did go to prevention programming—efforts designed to prevent initial or subsequent exposure to violence. CCDCI contracted with West Side Community House ("West Side"), a non-profit organization located in Cleveland that has been working with children and families since 1890, to run the Adults and Children Together (ACT) program. CCDCI also provided funding to the Family & Children First Council ("FCFC"), a county agency that had already been administering the Families and Schools Together (FAST) program. The money allowed FCFC to add a partner school that West Side could work with to implement FAST.

ACT, which was developed by the American Psychological Association's Violence Prevention Office, is a promising program[34] that teaches positive parenting skills to parents and caregivers of children from birth to age eight. West Side's ACT program is delivered in two-hour sessions once a week over the course of nine weeks. Facilitators attended a two-day training in Toledo, Ohio. Parent participants are usually caregivers of children who attend West Side programming. The set curriculum, which teaches parents different methods of child rearing and discipline, includes the following topic modules:

- Understanding Children's Behaviors
- Young Children's Exposure to Violence
- Understanding and Controlling Parents' Anger
- Understanding and Helping Angry Children

[34] ACT is considered a promising program. See Portwood S G, Lambert RG, Abrams LP, and Nelson EB. (2011) "An Evaluation of the Adults and Children Together (ACT) Against Violence Parents Raising Safe Kids Program." *Journal of Primary Prevention*, 32:147-160.

- Children and Electronic Media
- Discipline and Parenting Styles
- Discipline for Positive Behaviors
- Take ACT to Your Home and Community

The ACT program was chosen because staff at West Side found that parents, especially those referred by DCFS, had too little information about parenting, and when they were given information, it was too much too fast. According to a West Side staff member, "Parents still didn't understand why they had come to DCFS." ACT allowed for time for staff to build relationships with parents to help them understand the reality of why they were there.

There are about 16 parents per group, with the average age of parents about 20 years. For each session, transportation, daycare, and dinner is provided free of charge. Parents receive a certificate if they complete the course. They need to attend all sessions in order to obtain a certificate. If they miss a class, they must attend a make-up session. According to project staff, there is a 99% attendance rate. After the nine weeks is complete, there are ongoing support groups, as the parents have bonded and want to continue seeing each other. West Side received a grant from the St. Luke's Foundation, which helped support their ACT programming by allowing them to provide these post-sessions in order to promote group cohesion (as well as a pre-session). Through September 2014, 35 families participated in ACT, 26 of whom (74%) successfully completed.

FAST is an evidence-based prevention program[35] that SAMHSA has stated is an exemplary model program for prevention and early intervention of juvenile substance abuse, and the U.S. Department of Justice has rated as an "exemplary" program for preventing juvenile delinquency. As part of the Defending Childhood Initiative, West Side runs the FAST program at Almira Elementary School on West 98th Street in Cleveland. The program consists of 8 weekly sessions of structured interactive activities between children and parents. It focuses on strengthening the family and promoting parent involvement by building relationships between parents and schools, improving the parent-child bond, and imparting values and norms around personal accountability and family relationships management. After the weekly sessions are completed, there is a potluck celebration. Former FAST parents refer other parents of at-risk children, and receive a stipend for assisting with recruitment.

The West Side FAST program targets parents of young children from kindergarten through fourth grade, and teachers from Almira also attend. According to a West Side staff member, the parents like that some teachers attend, because it gives them an opportunity to hear about their child's classroom behavior, and it leads to decreased problem behaviors in school because of the positive communication between teachers and parents.

[35] FAST is considered evidence-based. See, for example: McDonald L, Moberg DP, Brown R, Rodriguez–Espiricueta I, Flores NI, Burke MP, and Coover G. (2006). "Afterschool Multifamily Groups: A Randomized Controlled Trial Involving Low-Income, Urban, Latino Children." *Children and Schools*, 28(1):25–34; and Kratchowill TR, McDonald L, Levin JR, Scalia PA, and Coover G. (2009) "Families and Schools Together: An Experimental Study of Multifamily Support Groups for Children at Risk." *Journal of School Psychology* 47:245–65.

Through September 2014, eight families were enrolled in FAST, with six (75%) successfully completing.

West Side staff outlined some of the challenges to doing their work, including maintaining connections to parents when phone numbers change, participants move, or have completed their DCFS requirements. Additionally, one staff member stated that the reading materials might be above the parents' education level.

The decision not to focus too much on prevention programming was made in the Phase I planning process. A change in administration in the Cleveland Metropolitan School District (CMSD) made it difficult to gain early involvement and commitment from schools, the most logical setting for large-scale prevention programming, and the collaborative had to move forward with the strategic plan with programming that was feasible. Additionally, because the target of the initiative was the full county, it would require getting school districts other than the CMSD to agree to administer prevention programming. This is a daunting task for any large city or county.

Community Awareness and Education

Community awareness and education refers to efforts to increase knowledge of children's exposure to violence and available resources and services, including media campaigns, community outreach. For the CCDCI, the community awareness and education campaigns were frontloaded at the start of the initiative. These included two main community awareness strategies: 1) a general awareness campaign, and 2) a neighborhood-based "We Have the Power to Stop the Violence!" contest. While these are discussed in detail below, Appendix D provides a list of all CCDCI community events held, including presentations made to local groups or politicians that helped to generate awareness about the Defending Childhood Initiative.

General Awareness Campaign

The primary focus of the broad campaign was to let the county know that they could call 211 (First Call for Help, run by the United Way) to get help for children who have been exposed to violence. 211 is a 24-hours a day, seven days a week information referral agency that provides health and human services information. 211 workers provide free links to services throughout the area using electronic databases of information, which includes approximately 10,000 agencies. 211 representatives can answer information about where to find, for example, Earned Income Tax Credit support, foreclosure prevention services, senior care, and emergency daycare. As a 211 representative stated, "There are families in the area going from crisis to crisis—they have basic needs and don't know where to find things. 211 can answer their questions." The partnership between CCDCI and 211 seemed like a logical way to create one location with an easy, familiar, and memorable phone number for people to call for issues related to children's exposure to violence. All 211 staff know to refer to Central Intake if a full assessment is appropriate, adhering to the following Community Access Procedure, an exact quote of the protocol developed by CCDCI:

1. *The general community is invited to call 211 and speak to a trained, professional operator to learn more about Defending Childhood and to determine whether or not Defending Childhood services may be appropriate for themselves or for a child about whom they are concerned.*
2. *Individuals may not remember or know to say that they are calling about Defending Childhood. In that case, operators may determine that the Defending Childhood protocol is appropriate based on a conversation with the caller in which the caller reveals that he or she is calling due to a situation that deals with violence and behaviors that have become troubling since exposure to violence. Conversational triggers may include domestic violence, child abuse, sexual assault, teen dating violence, fights at school or in the community, gang violence, or other related incidents.*
3. *Before proceeding with Defending Childhood protocols, the operator will make sure that the caller or the person the caller is concerned about is safe and is not in any danger, or is not a danger to him or herself or others.*
4. *The operator will determine whether the caller is calling about him or herself (and is under 18 years old), or if the caller is calling about someone else. The questions will be asked accordingly.*
5. *The operator will begin a basic screening questionnaire. The basic screening questions are progressive, meaning that subsequent questions should be asked and answered only when indicated based on the answers to the previous question.*
6. *Callers that respond affirmatively to each question will be referred to the Defending Childhood Central Intake and Assessment Agency, FrontLine Service. Referrals are made through email. The email sent to FrontLine Service will include contact information of the caller. FrontLine Service is then responsible for contacting the caller within twenty-four hours. A full screen will be completed then.*
7. *In certain situations or if a crisis arises, operators have the option of calling FrontLine Service directly and connecting the caller immediately. This is called a warm transfer. Situations in which a warm transfer may be appropriate are those in which there is a more immediate mental health concern, or situations in which the operator feels that connection with the caller will be lost if not made immediately.*
8. *FrontLine Service will then follow their standard protocol of screening and assessing children.*

A copy of the 211 DCI protocol and screener is attached as Appendix E.

On September 28, 2012, CCDCI held a press conference at a local school announcing that you can call 211 for CEV. The U.S. Attorney General Eric Holder was at the press conference, along with U.S. Attorney for the Northern District of Ohio, Steve Dettelbach, and then Cuyahoga County Executive Ed FitzGerald. The press conference was on multiple radio stations, television stations, and websites. Steve Dettelbach kicked off the conference, discussing the Defending Childhood Initiative and introducing Attorney General Holder, who came up and talked about issues of children's exposure to violence from a national perspective. Then Ed FitzGerald talked about CEV from the county perspective and the partnership with United Way 211. He stated that you can call 211 for CEV, and what you can expect when you call. United Way paid for the event and all the promotion materials, so there was no cost to CCDCI.

Two other locations that the community can go for general information about the Cuyahoga County Defending Childhood Initiative are the CCDCI website (http://defendingchildhood.com/) and the CCDCI Facebook page (https://www.facebook.com/DefendingChildhood), although the latter is not updated very often.

"We Have the Power to Stop the Violence"

At the start of the initiative, an "I Have the Power to Stop the Violence!" contest was held,[36] where youth crafted drawings, poetry, music, and videos that adapt the wider community awareness campaign messages to their specific neighborhoods. Young people from different school districts around the county, from detention centers, and those connected to local community-based organizations submitted artwork in the form of poems, drawings, and videos for the contest. (A flyer for this contest can be found in Appendix F.) One young female interpreted the "I Have the Power to Stop the Violence" theme in the following poem:

> *A fight breaks out and shots are fired*
> *Screams are heard and a mother cries*
> *Another Life lost another child dies*
> *Why can't we put our weapons down*
> *And turn the way we treat others around?*
> *Treat others with respect*
> *And realize with life you can't renege with like a bet*
> *Lets end the cycle we have set in motion*
> *Lets make the street safer and stop the commotion*
> *Hold hands and stand strong together*
> *Bury the hatred and hatchets forever*
> *We all have the power to stop the violence*
> *But nothing will be accomplished if we remain silent*

A total of 54 entries were received, and entries were divided into the age categories 10-13 and 14-18. There was one entry that was a composite of paintings done by even younger children from the Domestic Violence & Child Advocacy Center's shelter-based program, though it did not fit into any of the age categories for which there were prizes. The entries were narrowed down into six finalists in each age category, and were judged by communities leaders. The contest entries, especially the first, second, and third place winners, were announced during a two-day conference (discussed below) and have been placed into the community awareness campaign whenever possible. After this first contest, CCDCI changed their motto from "I have the power to stop the violence" to "We have the power to stop the violence" in order to highlight the collective nature of the efforts needed to address violence in the community.

On April 20, 2013, CCDCI held a "We Have the Power to Stop the Violence" Youth Summit for 25 high school students from throughout the county, providing them with an explanation of the Defending Childhood Initiative and what constitutes violence. The organizers received feedback

[36] This event was held in August 2011, prior to the official start of the Defending Childhood Demonstration Program implementation, but after Cuyahoga County knew they were going to be awarded the initial $2 million.

from the youth about what violence means to them and facilitated a discussion on appropriate ways to respond to violence. A copy of the agenda from this event is found in Appendix G.

On June 20, 2013, CCDCI held an "Action Challenge" community meeting, inviting youth and families to conduct an event or activity in their neighborhood that promotes the "We have the power to stop the violence" message. Twenty-seven people attended this event. A copy of the flyer for this meeting is attached as Appendix H.

Challenges to Community Awareness & Education

While there was a feeling of excitement surrounding the press conference, over time 211 did not generate the number of CEV calls that was expected—less than 100 when CCDCI staff had expected nearly 20,000. This shortcoming may have resulted for multiple reasons, including the fact that there was limited money allocated to public relations, potentially leading to a lack of target population reach and dosage/saturation. One treatment provider stated that, "We ask families if they've called 211, and they'll say, 'What's that?' People haven't necessarily heard about DCI, especially in the suburbs."

Another challenge has been learning how to be succinct in message while not having people misinterpret the message. For example, after the 211 press conference, a local newspaper ran the headline "Abuse hotline hits Cleveland."

The CCDCI hired a public relations firm to help design messages about the effects of violence on children, how to help a child exposed to violence, alternatives to violence, and who to call for assistance (211). The hiring process was a challenge. When CCDCI first issued the request for proposals (RFP), there was only one response, and it was not what the CCDCI was looking for. The one proposal kept highlighting, "If we had more money, here's what we could also do." It also did not want to target young people, and CCDCI did. They reissued the RFP with slight changes to encourage partnerships to carry out certain aspects of the campaign, but the content was mostly the same. After the reissue, they received two good proposals, and they went with one they described as a young, tech-savvy "hipster" firm that would use a combination of traditional marketing and social media. However, the whole process delayed various components of the campaign (e.g., website launch). Additionally, the Cuyahoga County leadership was hesitant to approve some of the firm's preferred methods for getting the CCDCI message out. For example, the firm wanted to create a twitter handle and generate tweets for CCDCI; however, the county would not agree to allow a third party to do this type of work. In the end, much of the firm's proposed work was never fully implemented.

Because the money from the CCDCI budget dedicated to community awareness and education was much smaller than other components of the program model, and because much of the work happened at the start of the initiative, there was not much focus on community awareness in the third year of the initiative.

Professional Training

Like with the community awareness and education campaigns, much of the training of professionals occurred early on in the implementation of the initiative, with the major trainings held more towards the beginning of service provision (July 2012 – 2013). Prior to the official October 1, 2011 start of the implementation phase, on September 22-23, 2011, CCDCI held a two-day training conference. The conference was geared toward staff of organizations involved in Cuyahoga County's Defending Childhood Initiative, social workers, law enforcement, attorneys, educators, court personnel, faith and community based organizations, and health care workers. The first part of day one was for network providers to get TF-CBT training, followed by plenary sessions led by recognized experts and breakout sessions. In the evening, finalist presentations and awards for "I Have the Power to Stop Violence!" contest were presented. The second training day consisted of plenaries and concurrent breakout sessions. A copy of the registration form and full agenda is attached as Appendix I.

On July 18, 2012, CCDCI held a full-day service system training, right before the roll-out of the screener. The target audience was workers from the various screening agencies. It covered the following topics:

- What is Defending Childhood?
- What is my role in the Defending Childhood service system?
- About the five evidence-based treatment modalities (TF-CBT, AF-CBT, MST PCIT, SPARCS).
- Compassion fatigue - what it means and how to overcome it.
- How to administer and score the screener.

Kristine Buffington, a nationally recognized expert on childhood exposure to violence and traumatic stress, discussed the nature of exposure to violence, its effects on children, and strategies to address the negative consequences to build resiliency and prevent future violence.

Additionally, at this event, Karamu, a local theater group, staged an original play called *Sometimes Hope Is Enough*. It tells the moving and emotional journey of three siblings who come together to say their final goodbyes to their brother who has died from gun violence. After years of separation, the brothers push through the issues of their past to find the strength of family and discover that, with help, "sometimes hope is enough." The author of the play wrote it based on interviews with young people in foster care and young people who had recently "aged out" of foster care. After the play, members of the Cuyahoga County DCFS Teen Advisory Group who have "aged out" of foster care held a panel discussion.

The training was well attended, with 175 people participating. CCDCI staff distributed short evaluation forms afterwards and the training received high ratings, though some thought it could be a two-day training. Many mentioned how much they enjoyed the play. While all the screening agencies were present, not all of the workers who administer the screener could be there, as agencies would be not be able to do their work that day if everyone was at the training. Additional requests for training, particularly on the screener, were responded to by two members

of the core management team going out and doing a short training, which was attended by new staff or previously untrained staff.

As mentioned in above sections, one of the challenges around training is staff-turnover: one trains workers on things such as administering the screener, or on certain evidence-based treatments, and then they leave their agencies and no longer work with Defending Childhood, thereby creating a need for training protocols when new staff come on board.

A list of all training dates, topics, and number of attendees is included as Appendix J.

Chapter 4
Implementation Barriers, Facilitators, and Sustainability

General Barriers and Challenges

Apart from the barriers and challenges described in Chapter 3 in relation to specific elements of the Cuyahoga County Defending Childhood Initiative (CCDCI), several smaller challenges cut across multiple aspects of the initiative.

Anchoring the Initiative within the County

CCDCI is run out of Cuyahoga County's Department of Public Safety & Justice Services. As with any county-run program, it has to abide by county spending and contract guidelines. Early on, this requirement led to implementation delays, especially in relation to professional training. As one Core Management Team (CMT) member stated, "It's county government and it's hard to get anything done. You spend $500 on a trainer and you have to get approval from 95 people." Another noted the frustration felt with the county rule that you must get a certain number of bids before choosing a contractor:

> *It's not just the processing. We need training in evidence-based practices and need to ensure fidelity to the model. You have to have training from authorized people. So that makes it hard because you can't just put out a general RFP.*

The external public relations firm that was contracted felt frustrated with the bureaucracy of county government processes, especially as it related to restrictions on Twitter and Facebook usage.

However, the accountability and transparency required for county programs is not unusual or undesirable, given recent local county politics. In July 2008, federal agents conducted a massive raid of county offices, which led to more than 30 county officials and contractors pleading guilty to a variety of corruption charges. As one CMT member stated, "Procurement is a disaster, and it's a disaster [in order] to protect the integrity of spending public funds. This county has had issues with that."

Because the CCDCI leadership recognized these challenges early on, they were able to overcome some of them by leveraging existing relationships with well-respected organizations in the community. For instance, they contracted with the Alcohol, Drug Addiction, and Mental Health Services (ADAHMS) Board to procure contracting through their existing training institute.

Turnover in county leadership, particularly within Public Safety and Justice Services, also presented a challenge. Part of the decision to embed the CCDCI within the county was for sustainability purposes, but with turnover of directors, the original leaders who had children's exposure to violence (CEV) constantly on their radar left, and the Core Management Team had to start over with new executives, advocating for the importance of thinking about CEV in all

aspects of the department's work. While the new leadership has been supportive, it has been time-consuming to bring new leaders up to speed and get them to believe in the work. In addition to the leadership turnover, over the course of the initiative the form of county government changed as well. In the Phase I planning phase, there was one type of county government, but during the Phase II implementation phase, the county government changed from being a three-person county commission to one elected county executive and an 11-member council. With the installment of the new government came a new departmental structure and new leadership.

Time and Money Constraints

Because CCDCI contracted most of the grant money away to contracted agencies, this put a strain on the Core Management Team, who did not budget enough money for themselves in comparison to the amount of work they have put into the project. As one CMT member stated, "I don't know that anybody around the table can work harder than they're working. The "to do" list seems overwhelming. People work beyond their time. If we held people to the ten percent time they're paid for, we'd be even further behind."

Additionally, when you envision a large-scale initiative with many moving parts and many different stakeholders, sometimes one part of the system is ready to move forward when another is not. A CMT member explained: "How long it takes to process things, and the scale of which we vision this … when you do a system change approach, you need many parts to move in concert. Sometimes the other groups and parts can't prioritize when you're ready to go." Building in more administrative resources and planning for a longer start-up implementation time may have addressed some of these issues, though when the initiative first began, it was only supposed to be for two years, so pushing to start programming as soon as possible made sense.

Facilitators

While there were challenges, they were not considered major barriers to implementation. Conversely, there were some mechanisms in place that helped facilitate the successful implementation of the CCDCI.

Prior County Investment

Although, as noted above, anchoring the initiative within Cuyahoga County government was a challenge, it was also deemed by the CMT to be overall a good decision. As one member stated:

> *If you really want system change you have to come from within. There are a lot of resources you can share, and we can work our way into other things (for example, child training), working from the inside.*

The County has had a significant previous investment in services to children, big systems, trauma-informed care, and exposure to violence. Therefore, the CCDCI had a strong base of operations from which to expand. As one CMT member pointed out, "If this had started without that base, it would've been harder." Because county government is also considered as more trustworthy (despite prior corruption scandals) because it is more known than smaller local non-

profit agencies, and because of its infrastructure, it is easier to get contracts and grants, making the initiative more sustainable. One member summed up the county's role as both barrier and facilitator: "Bad for implementation, good for sustainability."

Local Research Capacity and Partnerships

The presence and active involvement from the beginning of the initiative of a local research team has been an integral part of the Cuyahoga County Defending Childhood Initiative. Research team members are national experts and leaders in the field of violence and trauma research, especially as it relates to children. For many years, the three researchers—Jeff Kretschmar, Daniel Flannery, and Mark Singer, all of Case Western Reserve University—have been integrated into and played a role in program development and evaluation related to violence prevention and intervention programming in Cuyahoga County. As a result, they have long had access to multiple databases (e.g., adult and juvenile crime data from the Cleveland Police Department, data from the Cuyahoga County Juvenile Court, child maltreatment data from the Department of Children and Family Services), and organizations are comfortable working with and providing data to them. For the Cuyahoga County DCI, the researchers conducted the original community needs assessment[37] that helped inform the program model design. Additionally, one of the primary components of the model was the screening of children throughout the county for children's exposure to violence. The researchers developed the short screener that was used, as well as built the online database for electronically connecting the screeners to Central Intake and Assessment. They worked closely with the screening, assessment, and treatment staff to determine the appropriate screening threshold, and advise on the use of evidence-based assessments and interventions.

In addition to strong relationships between local researchers and service providers, Cleveland has a history of good public/private partnerships as well. The Children Who Witness Violence program was the predecessor to Defending Childhood, so buy-in from all the key players, including law enforcement, was easy to achieve. (This program still exists, and largely funnels law enforcement referrals into Defending Childhood.) Moreover, from the start there has been recognition by major players (e.g., the Attorney General, Cleveland Foundation, head of probation, political actors) who believe children's exposure to violence is an important issue that needed to be addressed countywide, and many of their decisions are informed by their knowledge of CEV.

Finally, as one CMT member highlighted, "One of our strengths is that Clevelanders generally don't leave. We take our relationships with us throughout our careers, we reinvent ourselves in other parts of service in Cleveland." Many of the relationships between the major players around issues of children, violence, and trauma are longstanding, spanning initiatives and decades.

Technical Assistance

The Cuyahoga County DCI team has asked for limited technical assistance (TA) from Futures Without Violence, the designated technical assistance provider for the *Defending Childhood*

[37] A copy of this assessment can be found at http://ja.cuyahogacounty.us/pdf_ja/en-US/DefendingChildhood/StrategicPlan/I_ComAssessment.pdf, last accessed 3/31/15.

Demonstration Program during the implementation years. Cuyahoga DCI staff reached out for help brainstorming around their community awareness and media campaign, particularly on how to adapt messages to reach suburban communities and how best to use social media to share their messages. They also reached out to OJJDP and Futures Without Violence for assistance finding money to do a validation study of the one-page screener they created, although they were not able to obtain any funding.

Although representatives from CCDCI participate in the monthly TA calls and attend all-sites meetings, members of the core management team felt that they had chosen their plan and allocated their money before Futures Without Violence came on as the TA provider, so many of the meeting topics or the webinars offered, though topical, were not relevant to the work they had chosen to do for their local initiative and took away time from other tasks. Additionally, because during the planning phase there was a different technical assistance provider, JBS International, Inc., when the new TA provider came on for the implementation years, the TA representatives needed to spend time developing new relationships at a critical point in implementation for the site. As one core management team member stated:

> *The first TA provider we had a relationship with. The new group comes in and is like, 'Let's get to know each other' as we're trying to hold our head above water trying to implement our system. We were at different places. Now we're coming closer together but during that transition, we were on different tracks. We've already done that. We went through a long community process, made our decisions; we can't go back and change things.*

This sentiment is not at all a reflection on Futures Without Violence, whom CCDCI staff have identified as helpful whenever they have reached out, but more speaks to the difficulty in changing TA providers at a critical juncture of the initiative.

Sustainability

With the initiative now in a "maintenance" phase, focus has been on sustainability. Though the county was given additional funding by OJJDP to extend through June 30, 2017, staff are still actively seeking to bring in more money. While early on in the project there was discussion of moving CCDCI under the Health and Human Services branch of the county so that it could receive levy funds, and meetings were held with county executives about this possibility, in the end it was decided to keep the initiative under Public Safety and Justice Services. The county did contribute an additional $100,000 for continued administration of the initiative. In order to keep CCDCI on the radar of private foundations, members of the Funding & Sustainability Committee have met with various local funders, including The Gund Foundation, Sisters of Charity Foundation, St. Luke's Foundation, and the Mt. Sinai Healthcare Foundation, as well as with the Foundation Management Services Cleveland, a consultant group that works with medium-size foundations. A representative from The Cleveland Foundation is also on the collaborative body and a part of the Funding & Sustainability Committee.

The biggest strategy for sustainability, however, has been was built into the initiative's design from the start. The streamlined service system—from screening to assessment to treatment—is

designed to be sustainable, in part due to Medicaid reimbursements for assessment and treatment, as well as an electronic screening system that remains in place after the Defending Childhood grant ends. And where additional costs are incurred, major players have pledged to continue the work because of their commitment to the cause.

Conclusion

The work of the Cuyahoga County Defending Childhood Initiative is extraordinarily impressive. There have been some big challenges, to be sure, yet perhaps they are the natural product of the level of system transformation that the county has attempted. The CCDCI can be potentially viewed as national model for a streamlined service system to address children's exposure to violence. There are many large cities around the country with similar demographics that are stricken by high levels of community violence (e.g., Baltimore, MD; Kansas City, MO; Oakland, CA). Cuyahoga County's strategies may be able to be replicated in those places. The high level of detail and sophistication in many of their strategies could provide other cities with a particularly clear roadmap and guidance for replicating their model. However, it is unknown whether or not Cuyahoga County's strong preexisting service infrastructure, interdisciplinary collaboration, and local research capacity may be found in comparable cities.

Appendix A
Screeners

DEFENDING CHILDHOOD SCREENING INSTRUMENT: 7 & YOUNGER

SECTION ONE: TO BE COMPLETED BY AGENCY WORKER. PLEASE PRINT!				
Child's Name				
Child's Gender		Male	Female	
Child's Race (Circle One)	Asian White	Black Other: _____		Multi-Racial
Child's DOB				
Caregiver Name				
Caregiver Phone #				
Caregiver Second Phone #				
Caregiver Address (Including City, State, Zip)				
Agency Submitting Form				
Agency Worker Name				
Agency Worker Phone Number				
Is Child Involved w/Other Agencies?	List:		Yes	No
Questions answered with assistance from (circle):		Child	Caregiver	Other:_____

SECTION TWO: TO BE COMPLETED IN INTERVIEW WITH CAREGIVER		
Now we will ask you about some things that might have happened in your child's life. Please answer YES or NO.	YES	NO
1. Sometimes people are attacked WITH sticks, rocks, knives, or other things that would hurt. At any time in your child's life, did anyone hit or attack your child on purpose WITH an object or weapon? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?	1	0
2. At any time in your child's life, did anyone hit or attack your child WITHOUT using an object or weapon?	1	0
3. Not including spanking on your child's bottom, at any time in your child's life, did a grown-up (parents, babysitters, adults who live with your child, or others who watch your child) in your child's life hit, beat, kick, or physically hurt your child in any way?	1	0
4. At any time in your child's life, did your child SEE or HEAR any family member (including parents, relatives, siblings) get pushed, slapped, hit, punched, beat up, or attacked with a weapon in the home by any other family member?	1	0
5. At any time in your child's life, did your child SEE or HEAR any adult get pushed, slapped, hit, punched, beat up, or attacked with a weapon at home by another adult?	1	0
6. At any time in your child's life, in real life, did your child SEE or HEAR anyone get attacked on purpose with or without a weapon? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?	1	0

SECTION TWO CONTINUED: TO BE COMPLETED IN INTERVIEW WITH CAREGIVER		
	YES	NO
7. At any time in your child's life, did a GROWN-UP OR OLDER CHILD touch your child's private parts when they shouldn't have, or make your child touch their private parts? Or did a GROWN-UP or OLDER CHILD force your child to have sex?	1	0
Question 7 has been identified as a CRITICAL ITEM. See Scoring Key for additional information **Add all Yes responses in Section 2 and place the total here _____.** **According to the scoring key, this child scored (Circle) :** **Low Moderate High**		

SECTION THREE: TO BE COMPLETED IN INTERVIEW WITH CAREGIVER
When you think about the violence your child has experienced, has it happened MOSTLY (check one): ___At Home ___In the Neighborhood ___At School ___In many places
This item is not scored.

SECTION FOUR: TO BE COMPLETED IN INTERVIEW WITH CAREGIVER				
Please tell me how often your child behaved in the following ways in the last month	Never	Sometimes	Often	Almost Always
1. Didn't want to play or be active?	0	1	2	3
2. Had trouble going to sleep?	0	1	2	3
3. Had difficulty concentrating or focusing?	0	1	2	3
4. Got startled or spooked easily?	0	1	2	3
5. Was aggressive to people or animals?	0	1	2	3
6. Seemed afraid of the dark?	0	1	2	3
7. Refused to eat?	0	1	2	3
8. Cried or had a tantrum until he or she was exhausted?	0	1	2	3
Add the item scores in Section 4 and record the total here _____. **According to the scoring key, this child scored (Circle) :** **Low Moderate High**				

SECTION FIVE: TO BE COMPLETED BY AGENCY WORKER. PLEASE PRINT!		
If a child has been identified as HIGH on either scales, they should be referred to Central Intake & Assessment unless caregiver refuses assessment/services. Are you referring this child to Central Intake & Assessment?	YES	NO
Is this child at imminent risk or a danger to others?	YES	NO
Reason for current referral to Defending Childhood:		

FAX ALL REFERRALS TO MHS, INC. 216.861.7671
FOR QUESTIONS, CALL MHS, INC at 216.361.8640

Additional Information: (Attach pages if needed)

DEFENDING CHILDHOOD SCREENING INSTRUMENT: 8 & OLDER

SECTION ONE: TO BE COMPLETED BY AGENCY WORKER. PLEASE PRINT!	
Child's Name	
Child's Gender	Male Female
Child's Race (Circle One)	Asian Black Multi-Racial White Other: _____
Child's DOB	
Caregiver Name	
Caregiver Phone #	
Caregiver Second Phone #	
Caregiver Address (Including City, State, Zip)	
Agency Submitting Form	
Agency Worker Name	
Agency Worker Phone Number	
Is Child Involved w/Other Agencies?	Yes No List:
Questions answered with assistance from (circle):	Child Caregiver Other:_____

SECTION TWO: TO BE COMPLETED IN INTERVIEW WITH YOUTH				
How often has any of the following happened to you over the past year?	Never	Sometimes	Often	Very Often
1. You being slapped, punched or hit?	0	1	2	3
2. Seeing someone else being slapped, punched, or hit?	0	1	2	3
3. You being threatened?	0	1	2	3
4. Seeing someone else being threatened?	0	1	2	3
5. You being beaten up?	0	1	2	3
6. Seeing someone else being beaten up?	0	1	2	3
7. You being touched in a private place on your body where you didn't want to be touched?	0	1	2	3
Item #7 has been identified as a critical item. See scoring key for additional information. **Add the item scores for Section 2 and record the total here _____. According to the scoring key, this child scored (Circle) :** **Low Moderate High**				

SECTION THREE: TO BE COMPLETED IN INTERVIEW WITH YOUTH				
How often in the past year have you:	Never	Sometimes	Often	Very Often
8. Told others that you would hurt them?	0	1	2	3
9. Slapped, punched, or hit someone before they hit you?	0	1	2	3

SECTION THREE CONTINUED: TO BE COMPLETED IN INTERVIEW WITH YOUTH				
	Never	Sometimes	Often	Very Often
10. Slapped, punched, or hit someone after they hit you?	0	1	2	3
Add the item scores for Section 3 and record the total here _____. According to the scoring key, this child scored (Circle) : **Low Moderate High**				

SECTION FOUR: TO BE COMPELTED IN INTERVIEW WITH YOUTH
When you think about the violence you have experienced, has it happened MOSTLY (check one): ___At Home ___In the Neighborhood ___At School ___In many places
This item is not scored.

SECTION FIVE: TO BE COMPLETED IN INTERVIEW WITH YOUTH				
These items describe things that kids sometimes think, feel, or do. Listen to each item and say how often you currently…	Not at all	Once in a while	Often	Almost all the time
11. Feel mean?	0	1	2	3
12. Feel afraid?	0	1	2	3
13. Feel like nobody likes you?	0	1	2	3
14. Feel like things are not real?	0	1	2	3
15. Remember things you don't want to remember?	0	1	2	3
Add the item scores for Section 5 and record the total here _____. According to the scoring key, this child scored (Circle) : **Low Moderate High**				

SECTION SIX: TO BE COMPLETED IN INTERVIEW WITH YOUTH				
These items describe things that kids sometimes think, feel, or do. Listen to each item and say how often you currently…	Not at all	Once in a while	Often	Almost all the time
16. Think about hurting yourself?	0	1	2	3
17. Think about killing yourself?	0	1	2	3
These items are not scored, but are CRITICAL ITEMS. See scoring key for information.				

SECTION SEVEN: TO BE COMPLETED BY AGENCY WORKER. PLEASE PRINT!		
If a child has been identified as HIGH on any of the three scales, they should be referred to Central Intake & Assessment unless caregiver refuses assessment/services. Are you referring this child to Central Intake & Assessment?	YES	NO
Is this child at imminent risk or a danger to others?	YES	NO
Reason for current referral to Defending Childhood:		
FAX ALL REFERRALS TO MHS, INC. 216.861.7671 FOR QUESTIONS, CALL MHS, INC at 216.361.8640		

Additional Information: (Attach pages if needed)

Appendix B
Programmatic Expectations for Non-Contracted Agencies Providing Defending Childhood Treatment Services

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Programmatic Expectations

These expectations establish the basis upon which agencies and organizations may provide Defending Childhood treatment services, outside of a formal contract or agreement. The purpose of establishing such relationships is to increase overall treatment capacity through utilization of Medicaid and other funding sources that may be available to agencies.

A. Pre-Expectations

All agencies wishing to provide Defending Childhood Services must have accomplished these tasks prior to receiving any referrals:

1. The Pledge of Participation has been signed by the highest ranking official in the agency and such agency is in compliance with the terms of the DEFENDING CHILDHOOD Pledge of Participation.
2. The activities in the Trauma Informed Organization Checklist are being undertaken to assist the agency in becoming trauma informed and an annual self report will be submitted to DC to indicate progress in implementing the actions in the Checklist.
3. Staff providing the DC evidence-based treatment practices have the requisite staff credentials, training, and on-going supervision and oversight to maintain fidelity to the selected treatment practice(s).
4. An agency representative is participating in the Cuyahoga County Child Trauma Services Network.
5. Selected agency staff are participating in the DC screening function to identify children exposed to violence experiencing trauma symptoms.

B. Service Expectations

1. Any Evidence Based practices provided must be provided with fidelity to the model.
2. A designated person, with one back-up staff member, will accept and respond to all referrals from DC Central Intake and Assessment within 48 hours of receipt of referral.
3. The staff person providing services will utilize effective strategies to engage families.
4. Payment for these services will be through Medicaid or other funding sources that the agency has available, not through DC.

5. Assessment instruments will be completed and reporting requirements will be complied with.
6. Staff providing DC evidence-based treatment practices are permitted by their employer to participate in compassion fatigue groups and to attend trainings made available through the Defending Childhood Initiative.

Agencies Participating

All agencies that meet the programmatic expectations are encouraged to participate. Please provide the following information to Jakolya Gordon.

Agency Name: _____
CEO/Executive Director: _____
Primary Contact Person: _____
E-mail/Phone: _____
Date: _____

Current DEFENDING CHILDHOOD Treatment Models:

Treatment Type	Check Treatment(s) to be Provided	Funding Source(s)	# Staff Currently Providing Service	# Staff Requiring Training	Staff to Receive Referrals
AF-CBT					
MST					
PCIT					
SPARCS					
TF-CBT					

Other Evidence-Based Treatment for Children Exposed to Violence Experiencing Trauma Symptoms Currently Provided by Agency & Available to DEFENDING CHILDHOOD:

Treatment Type	Funding Source(s)	# Staff Currently Providing Service	Staff to Receive Referrals

Appendix C
Pledge of Participation and Trauma-Informed Checklist

DEFENDING CHILDHOOD
PROTECT HEAL THRIVE
CUYAHOGA COUNTY CHILDREN EXPOSED TO VIOLENCE INITIATIVE

Trauma-Informed Organization Process

1. Any organization may sign the Pledge of Participation whether or not they hold a contract to provide services through DEFENDING CHILDHOOD. The Pledge simply signifies a commitment to the initiative, and to participating wherever possible and appropriate. Examples of organizations include faith based institutions, community centers, governmental organizations at all levels, hospitals, schools, general nonprofits.

2. The Pledge of Participation should be signed by the highest ranking official of the organization, such as an Executive Director, Chief, or Chief Executive Officer. For participants representing larger organizations, it may be appropriate to sign the Pledge within single departments or divisions if it is unlikely that the top level official will sign the Pledge. To the extent possible, large organizations with multiple participants should work together to determine the best possible plan for obtaining appropriate signatures.

3. Organizations that sign the Pledge of Participation should be prepared to implement the Trauma Informed Organizational Checklist. DEFENDING CHILDHOOD's Core Management Team is available to assist organizations in this regard. Organizations should be prepared to report their progress in becoming trauma informed on an annual basis.

4. Please submit signed forms to Jakolya Gordon via email (jgordon@cuyahogacounty.us), or via U.S. Mail (310 West Lakeside Ave., Suite 300; Cleveland, Ohio 44113).

5. The Pledge will remain valid throughout the life of the DEFENDING CHILDHOOD Initiative unless individual agencies or organizations determine the need to opt out.

DEFENDING CHILDHOOD
PROTECT HEAL THRIVE
CUYAHOGA COUNTY CHILDREN EXPOSED TO VIOLENCE INITIATIVE

PLEDGE OF PARTICIPATION

(Name of Organization) Hereby Pledges its Support for and Participation in

DEFENDING CHILDHOOD

Success in transforming a community and forging an effective response to childhood exposure to violence requires support and a widespread commitment to trauma informed practices.

We pledge our participation in DEFENDING CHILDHOOD and will uphold its mission to empower the general public and child-serving agencies to prevent violence and to identify and intervene when children are exposed to violence in their homes, schools, and communities, relieving the child's trauma and ending the cycle of violence.

We pledge that we will work together with DEFENDING CHILDHOOD to minimize the negative social, emotional, and cognitive effects of exposure to violence, and to promote the resiliency and well being of all children.

To signify our commitment, we pledge that we will do the following, to the extent appropriate given our organizational mission and capacity:

1. Participate in an ongoing governance structure that will provide leadership and direction to the DEFENDING CHILDHOOD initiative, and lend expertise as needed through an engaged committee structure;
2. Participate in the DEFENDING CHILDHOOD training institute so that we may become more aware of the impact of exposure to violence and more trauma informed;
3. Participate in DEFENDING CHILDHOOD'S quality service system, which identifies and serves children in need of assistance as a result of their exposure to violence;
4. Assist with community engagement efforts by promoting the messages related to the campaign;
5. Participate in data collection and evaluation activities;
6. Support DEFENDING CHILDHOOD activities through in-kind or other resources; and
7. Explore ways to become a trauma informed organization through use of the DEFENDING CHILDHOOD Checklist.

_____ _____

Signature **Date**

DEFENDING CHILDHOOD

TRAUMA INFORMED ORGANIZATIONAL CHECKLIST

All agencies and organizations that sign the DEFENDING CHILDHOOD PLEDGE OF PARTICIPATION are encouraged to undertake the activities listed below, which will assist them in becoming more trauma informed. Agencies and organizations will be asked annually to submit a self reporting instrument that details their progress in completing the checklist.	
CHECK WHEN COMPLETE	*ACTION ITEM*
	1. Select a DEFENDING CHILDHOOD Champion within the organization. The champion should be someone who can recognize areas of administrative or operational policy that can be changed to be more sensitive to issues related to exposure to violence and trauma.
	2. Ensure a safe environment for all those involved with the organization in order to prevent re-traumatization in any way.
	3. Maintain a culturally competent and sensitive environment so that all people feel welcome to participate in services and activities, or to approach any representative of the organization.
	4. Commit to educating individuals at all levels of the organization via a variety of resources and approaches that spread the word about trauma and the effects that it can have on people. Post information on violence exposure and trauma, including relevant phone numbers and resources, in such a way that it can be viewed by employees or members, as well as children and their families.
	5. Participate in DEFENDING CHILDHOOD training to gain an understanding of exposure to violence and trauma symptoms, and how to properly respond/react to these symptoms and traumatic events.
	6. Provide information about DEFENDING CHILDHOOD services to all employees so that they are able to provide referrals to relevant agencies or departments in case of emergency or traumatic events.

Appendix D. Community Awareness Events, 10/1/11 – 9/30/14

Event Date	Event Time	# of Participants	Event Name/Topic
10/17/2011	2:00pm – 3:00pm	75	Press Conference DCI Awards & Plans
10/26/2011	9:30am – 12:00pm	26	Youth Talk on Adolescent Health: Cuyahoga County Presented on DCI
10/29/2011	11:00am – 12:00pm	11	Youth Summit: CEV Awareness & Youth Participation in DCI
12/15/2011	5:00pm – 6:30pm	37	Youth Meeting: CEV Awareness & Youth Participation in DCI Awareness & Youth
2/14/2012	10:00am – 11:30am	35	Informational session for agencies interested in screening for Defending Childhood
2/27/2012	9:00am – 10:30am	10	Informational session for agencies interested in screening for Defending Childhood
2/28/2012	1:30pm – 3:00pm	20	Informational session for agencies interested in screening for Defending Childhood
3/7/2012	9:00am – 10:00am	100-125	Diversity Center of Northeast Ohio SPRING YOUTH SERIES
4/19/2012	9:00am – 4:00pm	20-30	Defending Childhood RFP Technical Assistance Session
5/4/2012	10:00am – 11:30am	30-35	"I Have the Power Stop Violence!" Summit
5/18/2012	9:00am – 10:30am	20-30	"I Have the Power Stop Violence!" Summit
7/27/2012	9:30am – 11:00am	30	Trauma Collaborative Meeting
8/22/2012	9:30am – 10:00am	8	Community Awareness/Public Relations Vendors TA session
9/2/2012	11:15am – 11:30am	75	Community Access Launch
9/12/2012	10:00 a.m.	8	Coordination of Services
10/15/2012	2:30pm – 5:30pm	6	Engaging Community Partners – presentation to city council members
10/25/2012	8:30am – 4:30pm	5	DCI & Engaging the School District presentation to CMSD administrators
12/6/2012	1:00pm – 2:30pm	5	Presentation at Law Enforcement conference
2/7/2013	1:00pm – 1:30pm	30	Collaborative Meeting to let partners know how to engage in outreach and access 211
2/20/2013	10:00am – 12:00pm	12	Adults and Children Together (ACT)
2/21/2013	10:00am – 12:00pm	30	Collaborative Meeting to let partners know how to engage in outreach and access 211
3/28/2013	8:15am	30	Collaborative Meeting to let partners know how to engage in outreach and access 211
4/4/2013	7:30pm	100+	Cleveland International Film Festival
4/6/2013	4:00pm	100+	Cleveland International Film Festival
4/20/2013	11:00am	25	Youth Summit: DCI, We Have the Power to Stop the Violence
6/21/2013	5:30pm	27	Youth/families learning about how to get involved with DCI and conducting action event
7/1/2013			Launch of Community Awareness Campaign (e.g., website, billboards, etc.)
8/6/2013	1:00pm – 2:30pm	21	DCI presentation given to high school youth
9/17/2013	10:00am – 11:30am	13	DCI: Creating a service system for children exposed to violence presentation
4/27/14	11:00am – 3:00pm	125	Child Abuse & Maltreatment Prevention & Intervention Presentation to community
6/13/2014	8:00am – 3:30pm	500+	Distributed materials at 10th Annual Fatherhood Conference

Appendix E
211 Defending Childhood Initiative Screener

DEFENDING CHILDHOOD

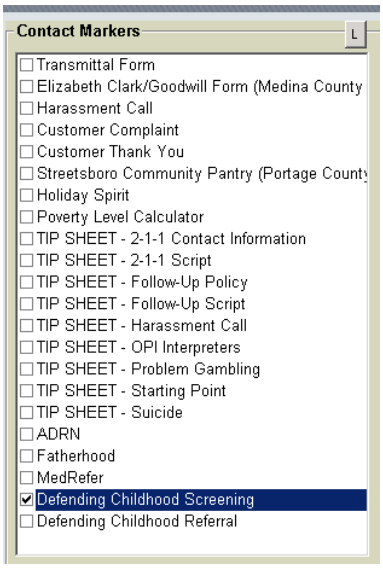
2-1-1 is the initial screening point for Defending Childhood. Some callers will ask for Defending Childhood by name, but many will call looking for other assistance and, in the course of the conversation, provide information about themselves or their situation that leads you to believe their child might be a good candidate for the program.

Here's a summary of Defending Childhood, as presented in Refer (where it's indexed as ***General Counseling Services***, ***General Counseling Services * Children Witnessing Violence***, ***Child Abuse Counseling***, ***Child Sexual Assault Counseling***):

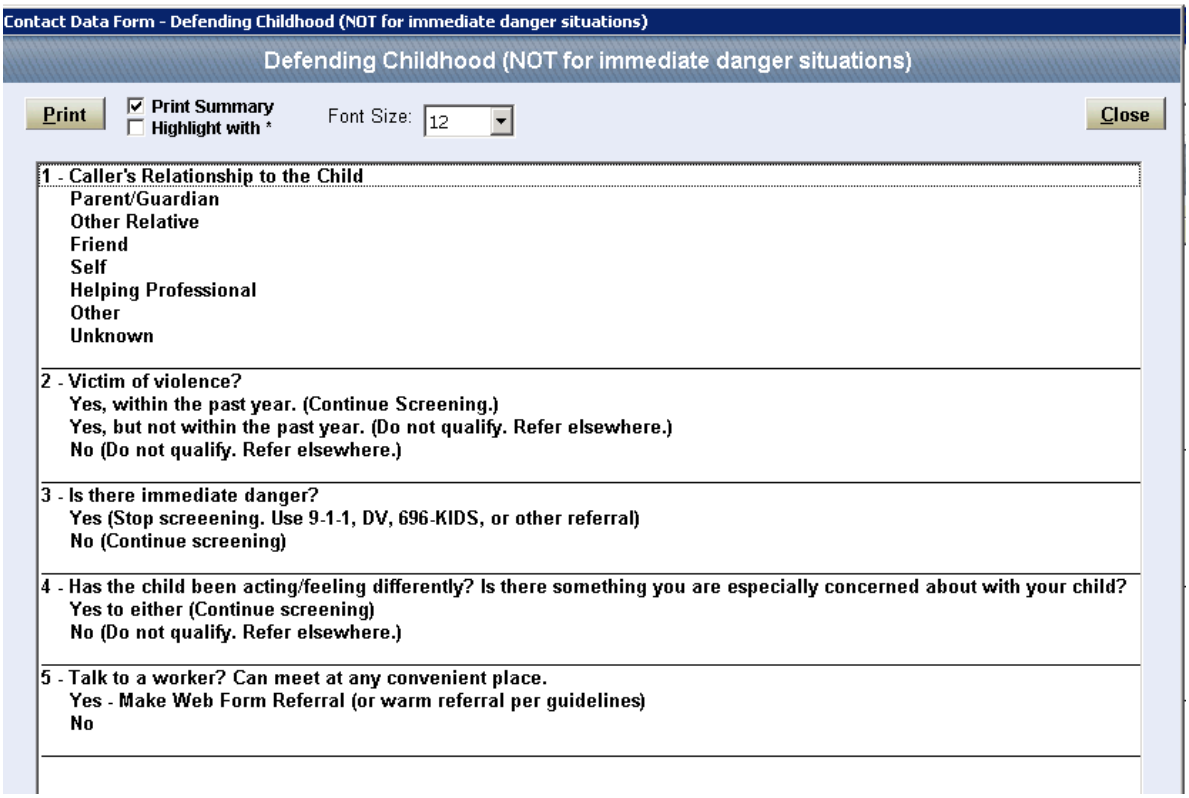
THE PROGRAM: *Provides a psychological evaluation and individualized counseling to children who have suffered psychological trauma as a result of witnessing or directly experiencing violence (including domestic violence, bullying, sexual assault, incest, etc.).*

THE ELIGIBILITY: *Cuyahoga county youth age birth through 17 who have been behaving differently than normal (sleep issues, bed wetting, fighting, etc.) or feeling upset after experiencing or witnessing violence sometime during the last year.*

THE SCREENING: This piece is extremely important. The tool to determine whether or not a caller should actually be referred to Defending Childhood is located with all the other checkboxes. (Even if callers ask for the program by name, the screening is still required.) Click CHECKBOX on your DATA page:



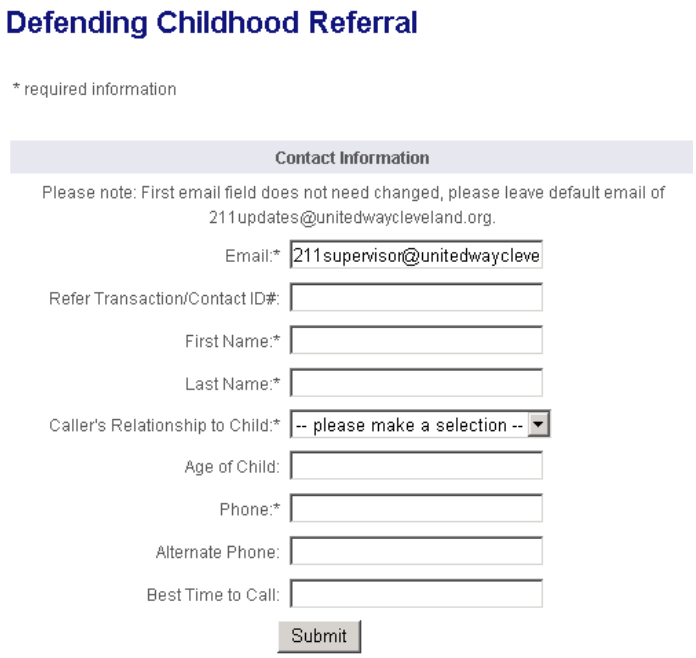
The Screening looks like this: (questions are progressive)



IF, AT ANY POINT IN THE SCREENING, A CALLER IS DISQUALIFIED refer them elsewhere as you would with any other call.

IF THE CALLER QUALIFIES proceed to the next checkbox:

And fill out this web form:



Make sure to also record the referral in Refer.

Curious about what happens after you send that referral along? Per Refer: *A licensed counselor will return the call within one business day. Counselor will set up an in-person assessment at a location convenient for the client.*

Is there ever an instance when one would need to actually transfer a call to the program?
A warm transfer may be appropriate in situations where it's uncertain whether a caller will be able to receive a call back from MHS. If you're unsure about whether a transfer is necessary, ask a supervisor.

Questions? Consult a supervisor.

Appendix F
"I Have the Power to Stop the Violence" Contest Flyer

2011 "I HAVE THE POWER TO STOP VIOLENCE CONTEST!"

WIN PRIZES!!!

WIN PRIZES!!!

Do you have a message that you want your community to receive about stopping the violence that happens in school, neighborhoods, and even at home? If so, here is your chance to make that happen. We want to hear your voices, see your videos, read your words and see your artwork!

This year, Cuyahoga County DEFENDING CHILDHOOD is excited to announce " I Have the Power to Stop Violence!" contest. We are looking for the best campaign ad created by you, the youth of Cuyahoga County that will educate, inspire and call viewers to action.

Please complete the registration/release form on the following page. Refer to the contest guidelines to ensure that your application is complete.

Please remember! You have to use the slogan, " I Have the Power to Stop Violence!" in your work.

All registration/release forms including your work must be received no later than
August 26, 2011

Send all required materials to:

Jakolya Gordon W/VSC, 310 W. Lakeside Ave, Suite 300, Cleveland, Ohio 44113
or
jgordon@cuyahogacounty.us
(216) 348.4398

Join Us on Facebook: www.facebook.com/Cuyahogacountydefendingchildhood

DEFENDING CHILDHOOD
PROTECT HEAL THRIVE
CUYAHOGA COUNTY CHILDREN EXPOSED TO VIOLENCE INITIATIVE

CONTEST!!!
WIN PRIZES!!!!

2011 "I Have the Power to Stop Violence!" Contest Information

WHAT IS IT?

Cuyahoga County has a new project called DEFENDING CHILDHOOD. It's about stopping the violence that happens in school, in neighborhoods, and even at home.
We're having a contest because we want YOU to be a part of the project!
We want to hear your voices, see your videos, read your words, and see your artwork!

We want to know what you think about when you hear the words, *"I Have the Power to Stop Violence!"* That's the slogan of the project, and we need help with it! What does the slogan mean to you? What can you do to stop violence in your neighborhood, school, or even at home?

WHO CAN ENTER?

The contest is open to anyone 10 through 18 years living in Cuyahoga County. Only one entry per person or group working together.

HOW DO I ENTER?

You can enter by:

- **Making a video**- Video submissions must be 30-90 seconds in length and must be submitted on a DVD, emailed as an electronic file or provide the YouTube link.
- **Writing and recording a song (words and music must be original) or a poem**- You should record yourself singing your song and send it to us on a CD, email it to us as an electronic file or provide the YouTube link. You should also type your lyrics and send them to us. If you write a poem, you can take a video of yourself saying it, or you can just send us the words. Anything written should be typed, but if you don't have a computer or a typewriter, you can print in your best handwriting and send that to us.
- **Making a collage or a poster, drawing a picture, or taking a photo** – All of your artwork should be two-dimensional. That means that we can't accept entries that are sculptures or figurines.

Remember! You have to use the slogan, "I Have the Power to Stop Violence!" in your entry.

Send all entries to: I Have The Power To Stop Violence Contest, c/o: Jakolya Gordon W/VSC, 310 W. Lakeside Ave, Suite 300, Cleveland, Ohio 44113. If you have any questions, please contact: Jakolya Gordon at 216.348.4398 or jgordon@cuyahogacounty.us

DEADLINE: August 26, 2011. Judging will be based on originality, creativity, and use of the theme "I Have The Power To Stop Violence!" Judging will be done by teams composed of youth and professionals. Final judging and presentation of awards will take place on Thursday, September 22, 2011.

WHAT DO WINNERS GET?

Prizes will be awarded by age group: 10-13 and 14-18. There will be 1st, 2nd, and 3rd place winners for each age group. In addition to fun prizes like gift cards, winning entries will be used in the DEFENDING CHILDHOOD project! That means that you get to help design our ad campaign and help us talk to other people about the project. Winners will be contacted by phone or mail.

OTHER DETAILS

1. All entries become the property of County of Cuyahoga, Ohio, and will not be returned.
2. Please include your first name and first initial of your last name on your work (e.g. Michael J). No other identifying information is needed but you must make sure to complete the registration/release form and return it to us with your work.
3. Do not use acts of violence as a way you would deal with your problems. We want to make sure you have non-hurtful ideas on how to stop violence.
4. Your work may be used in DEFENDING CHILDHOOD community awareness campaign.

" I Have the Power to Stop Violence!" Contest

Registration & Release Form

(Please type or print legibly)

Individual or Group Members Names*: _____

_____

Age: _____**Gender**: (circle one) **M /F**

Street Address: _____

City: _____**State**: _____**Zip Code**:_____

School Name: _____**School Address**: _____

Home Phone: _____**Cell Phone**: _____

Email Address: _____

In consideration of my performance, and for other good and valuable consideration, I hereby grant County of Cuyahoga, Ohio, the exclusive right, but not the obligation, to exhibit my performance, use my name, image, likeness, and voice to advertise, promote, publicize or use otherwise in connection with DEFENDING CHILDHOOD.I understand that I will have no right to review/approve such submissions and will not receive any compensation or credit for said uses. I also understand all rules relative to this contest.

For an Adult:
By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any claims, for compensation against any person or organization utilizing this material.

Signature_____Date_____

For a Minor:
If this release is obtained from an individual under the age of 18, then the signature of that individual's parent or legal guardian is also required. By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any claims, for compensation against any person or organization utilizing this material.

Parent/Guardian Signature_____ Date_____

***Please include this form with your work**

All entries must be received by **August 26, 2011**.

WITNESS/VICTIM SERVICE CENTER 310 WEST LAKESIDE-SUITE 300 CLEVELAND, OHIO 44113 216.443.7345

Appendix G
Youth Summit Agenda

CUYAHOGA COUNTY CHILDREN EXPOSED TO VIOLENCE INITIATIVE
Youth Summit Session: "We Have The Power To Stop Violence!"
April 20, 2013

Red: Favorite Color?

Orange: Favorite Movie?

Pink: Favorite Rapper/Singer/Group?

Yellow: Favorite Having Fun Activity?

1. INTRODUCTIONS (5-8 mins)

- Ice Breaker Activity
  - Each participant picks 2 different colors of starburst/candy
  - Each color represents a different question
  - Each participant must state their name before answering the question

2. PURPOSE OF SESSION (.30 secs)

- To obtain your views on violence
- To provide information on violence & DEFENDING CHILDHOOD
- To identify individuals who would like to participate in DEFENDING CHILDHOOD

3. ACTIVITY 1: What You Don't See Is……(15-20 mins)

- Divide into groups
- Look at the photo and draw & write about you think the rest of the photo shows
- Select a person from your group to briefly describe the group ideas

❖ **Give a copy of the complete photo to each group**

- Discussion:
  - What was your reaction when you saw the whole photo?
  - Do you think what is shown in the photo is violence?
  - What do you consider violence?
  - What do you think this child is feeling?
  - What kind of violence is "hidden" in the small photo? In the complete photo?
  - What other kinds of violence are "hidden"?

Moderator's Note: *Bring out the idea that violence may not be easy to see or may be ignored the adults who should stop it. The activities we'll be doing today will help us see the 'whole picture' of violence that happens to children and what we can do to eliminate or prevent this.*

4. ACTIVITY 2 True-False: (5 –8 min)- Use Signs

- ✓ In 2014, Cleveland had the seventh highest city crime rate in the country. **False-2010**
- ✓ Cleveland had 2 of the 25 most dangerous neighborhoods in the country, one of which ranked as the second most dangerous neighborhood in 2010 with a violent crime rate with a 1 in 6 chance of becoming a victim. **True**

- ✓ For the first time in 12 years, *playing sports* was the leading cause of death for children between 1-9 years of age. **False-HOMICIDE**
- ✓ According to the Youth Risk Behavior Survey administered to Cleveland Metropolitan School District, over 60% of middle school students and nearly 50% of high school students report having been in a physical fight in the past year. Nearly 16% of high school students reported having carried a weapon such as a knife or gun in the past 30 days. **True**
- ✓ Physical punishment (hitting/slapping) can be used if it helps children learn. **False**
- ✓ Verbal punishments (name-calling) don't hurt children as much as physical punishment. **False**
- ✓ Children who are bullied or teased deserve to be treated that way **False**

What do you think happens to youth exposed to this type of violence?

5. Closing Activity: "A Web Power To Stop Violence!"

- Each person stands in different/random place in the room.
- Each person answers the given questions below and pass the ball of string to the next person to answer the same questions

State your name again and answer the following questions:

1. What I learned today is……?
2. I have the power to stop violence by…..?

Example: My name is Jakolya. What I learned today is violence affects everybody and I Have The Power To Stop Violence by talking to a caring adult who can help me

Ask the group:
What does the image of the web mean to you?

DEFENDING CHILDHOOD

- Cuyahoga County is one of only eight communities selected nationally to participate in United States Attorney General Eric Holder's DEFENDING CHILDHOOD Demonstration Program.

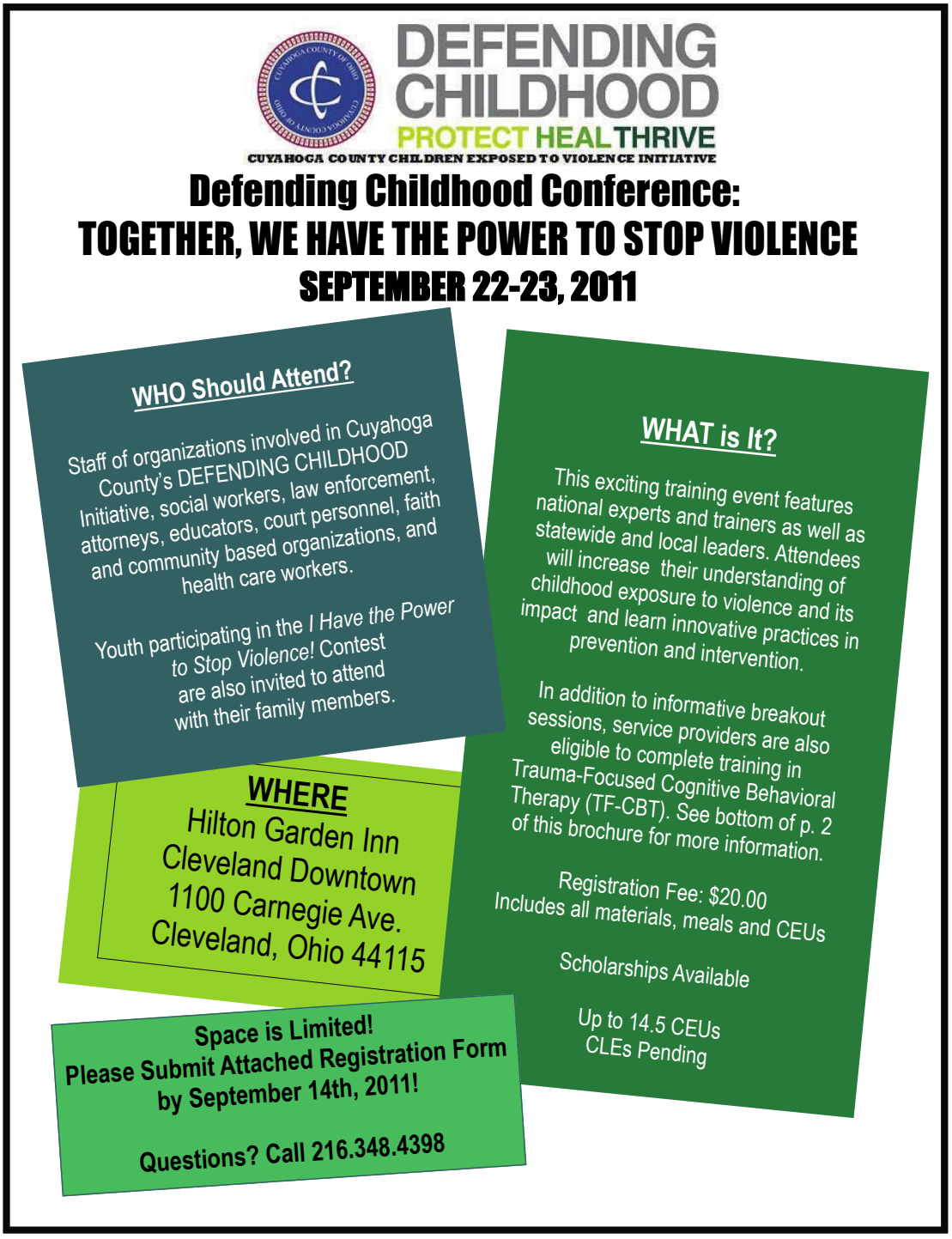
- DEFENDING CHILDHOOD is designed to prevent and reduce the impact of children's exposure to violence in their homes, schools, and communities.

- Exposure to violence, particularly multiple exposures, interferes with children's emotional and social development and learning capability

Would you like to volunteer to help with DEFENDING CHILDHOOD?__

Appendix H
Action Challenge Flyer

Appendix I
Registration Form and Agenda for September 2011 Conference



Defending Childhood Conference:
TOGETHER, WE HAVE THE POWER TO STOP VIOLENCE

Schedule of Events

Thursday, September 22, 2011

8:00-12:00	Special Institute Pre-Conference (see below)
11:30-12:15	General Registration
12:15-12:45	Lunch, Welcoming Remarks
12:45-1:45	Plenary Session by David Wolfe, Ph.D., Centre for Addiction and Mental Health, University of Toronto: Childhood Exposure to Violence: Violence in Our Homes, Communities and Schools
1:45-2:45	Plenary Session by Charles R. Figley, Ph.D., Tulane University Traumatology Institute: Vicarious Trauma and Compassion Fatigue
2:45-3:00	Break
3:00-5:00	Breakout Sessions
5:00-5:15	Break ** Note * Contest participants should arrive for registration beginning at 4:30*
5:15– 5:45	Plenary Session: Childhood Exposure to Violence & What the Community Needs to Know
5:45-7:00	Dinner and "I Have the Power to Stop Violence!" Contest Finalist Presentations and Judging
7:00-7:30	Presentation of Awards
7:30	Adjourn

Friday, September 23, 2011

8:00	Special Institute Begins (see below)
9:00-10:05	Plenary Session by Benjamin E. Saunders, Ph.D., National Crime Victims Research & Treatment Center, Medical University of South Carolina: Children Exposed to Violence: Impact, Identification & Interventions
10:05-10:15	Break
10:15– 12:15	Breakout Sessions
12:15-1:30	Lunch and Plenary Session by Charles A. Wilson, MSSW, Chadwick Center for Children & Families, Children's Hospital of San Diego: Re-Traumatization of System Involved Children
1:30-1:40	Break
1:40-3:40	Breakout Sessions
3:40-3:50	Break
3:50-4:30	Closing Session: Collaborative Community Response through DEFENDING CHILDHOOD
4:30	Adjourn

****SPECIAL TF-CBT INSTITUTE FOR SERVICE PROVIDERS****

Clinicians and service providers may opt to attend a Special Institute to receive full, comprehensive training on Trauma Focused Cognitive Behavioral Therapy (TF-CBT).

Attendees registering for the Special Institute must attend each session on the therapy, beginning at 8:00 a.m. on both days, September 22 & 23.

The Special Institute will take place concurrently with the conference throughout the entire two day event. If you choose to participate in the Special Institute, you must arrive at 8:00 a.m. on September 22, stay at the training for the entire two day event, and attend each of the specially designated sessions.

Space is limited! Please be sure to indicate on your registration form if you will attend the Special Institute.

CEU Information: 14.5 CEUs are available for attendees of both days of the conference, including the Special Institute. 11.25 CEUs are available for attendees of both days without the Special Institute. In order to get CEUs, attendees must attend the entire conference, including the dinner and awards presentation on Thursday, September 22.

CLEs are pending.

Attendees wishing to receive information on scholarships should call Jakolya Gordon at 216.348.4398

Defending Childhood: Conference
TOGETHER, WE HAVE THE POWER TO STOP VIOLENCE
Registration Form

DEFENDING CHILDHOOD
PROTECT HEAL THRIVE
CUYAHOGA COUNTY CHILDREN EXPOSED TO VIOLENCE INITIATIVE

Register by: September 14, 2011

Please print or type information. One form per person. Photocopy as needed.

Section 1: Attendee Information

Name: _____

Title: _____

Agency/Organization: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Day Phone: ( ) _____ Fax: _____

E-mail Address: _____ Special Needs/Vegetarian: _____

Section 2: Registration Fee

☐ Registration Fee: $20.00 **Register by: September 14, 2011**
Includes meals and CLEs/CEUs

☐ I will be attending the TF-CBT Special Institute

Section 3: CLEs and/or CEUs

☐ I am requesting CLEs

_____

☐ I am requesting CEUs for: ☐ Social Work ☐ Marriage/Family Therapist
☐ Counselor ☐ Chemical Dependency Professionals

Section 4: Payment Information

Mail this completed registration form *(one for each person)*, along with your payment/purchase order to:

Jakolya Gordon
Witness Victim Service Center
310 West Lakeside Avenue, #300
Cleveland, Ohio 44113

I am enclosing my: ☐ Check ☐ Money Order ☐ Purchase Order

In the amount of: $ _____

Make checks or money orders payable to: ADAMHS Board ***Questions? Call (216) 348-4398***

Appendix J
List of All Professional Training Activities

Training Date	Training Name	Training Time	# of Participants	Audience	Training Topic	Description
3/29/2012	Orientation on Pilot Instruments	2:00pm - 4:00pm	61	Direct staff, clinicians, supervisors	Screening Instruments	Staff of agencies participating in screening for Defending Childhood were provided with training on screening instruments used in the pilot project.
7/18/2012	Service System Orientation & Training	8:30am - 4:30pm	170	Staff of Defending Childhood participating agencies	Defending Childhood	All day training geared towards staff who would be implementing the service system. Explained DC, compassion fatigue, children exposed to violence, traumatic stress, and brief overview of five evidence-based modalities.
8/14/2012	Service System Orientation & Training	12:30pm - 2:30pm	10	Staff of Beech Brook (treatment agency)	Defending Childhood	Training on DC service system.
8/28/2012	Service System Orientation & Training	2:00pm - 3:30pm	31	Staff of Defending Childhood participating agencies	Defending Childhood	Training on DC service system.
9/5/2012	Service System Orientation & Training	2:00pm	3	Administrative staff of 211	Defending Childhood	Training on DC service system.
10/22/2012	Service System Training	3:00pm - 4:00pm	8	Mental health providers	Cuyahoga County's screening	Staff were trained on how to use the screener with families.
10/31/2012	Assessment Instruments	9:30am	41	Mental health providers	Assessment instruments	Mental health providers were given an orientation on assessment instruments that will be used when working with families.
11/27-11/28/2012	TF-CBT Provider Training	8:30am - 4:30pm	36	Mental health providers	TF-CBT	Mental health care providers were trained in TFCBT techniques.
12/11-12/12/2012	AF-CBT Provider Training	8:30am-4:30pm	18	Mental health providers	AF-CBT	Mental health care providers were trained in AF-CBT techniques.

1/7-1/11/2013	Parent Child Interaction Therapy (PCIT)	9:00am - 5:00pm	12	Mental health providers	PCIT	Mental health care providers were trained in PCIT techniques.
1/9-1/10/2013	Structured Psychotherapy Adolescents Responding to Stress (SPARCS)	9:00am - 5:00pm	12	Mental health providers	SPARCS	Mental health providers were trained in SPARCS techniques.
1/24/2013	Adults and Children Together (ACT)	9:00am - 5:00pm	4	Community-Based Workers	ACT	Community based workers were trained in ACT techniques.
1/25/2013	DCI Web-Based Training	2:00pm - 3:30pm	7	Screening Agency: Child Welfare Workers	DCI web-based training	Workers were trained in entering screening data in the web-based system.
1/30/2013	DCI System Orientation & Training	1:00pm - 2:30pm	8	Mental health providers	Defending Childhood Initiative System orientation	Workers were provided with an overview on DC and policies & procedures for screening and providing direct service.
2/13/2013	TF-CBT Consultation Call	8:30am - 9:30am	14	Mental health providers trained in TF-CBT techniques	TF-CBT	Mental health providers trained in TF-CBT receive follow up training support through monthly calls.
2/27/2013	TF-CBT Consultation Call	9:00am - 10:00am	14	Mental health providers trained in TF-CBT techniques	TF-CBT	Mental health providers trained in TF-CBT received follow up training support through monthly calls.
2/27/2013	TF-CBT Consultation Call	10:00am - 11:00am	14	Mental health providers trained in TF-CBT techniques	TF-CBT	Mental health providers trained in TF-CBT received follow up training support through monthly calls.
3/13/2013	TF-CBT Consultation Call	8:30am - 9:30am	14	Mental health providers trained in TF-CBT techniques	TF-CBT	Mental health providers trained in TF-CBT received follow up training support through monthly calls.
3/27/2013	TF-CBT Consultation Call	9:00am - 10:00am	14	Mental health providers trained in TF-CBT techniques	TF-CBT	Mental health providers trained in TF-CBT received follow up training support through monthly calls.
3/27/2013	TF-CBT Consultation Call	10:00am - 11:00am	14	Mental health providers trained in TF-CBT techniques	TF-CBT	Mental health providers trained in TF-CBT received follow up training support through monthly calls.

7/10/2013	TF-CBT Consultation Call	8:30am - 9:30am	10	Mental health providers	TF-CBT	Mental health care providers were trained in TFCBT techniques participate in monthly support calls to strengthen learning modules of applied practice.
7/24/2013	TF-CBT Consultation Call	9:00am - 10:00am	10	Mental health providers	TF-CBT	Mental health care providers were trained in TFCBT techniques participate in monthly support calls to strengthen learning modules of applied practice.
7/24/2013	TF-CBT Consultation Call	10:00am - 11:00am	10	Mental health providers	TF-CBT	Mental health care providers were trained in TFCBT techniques participate in monthly support calls to strengthen learning modules of applied practice.
7/30/2013	AF-CBT	9:00am - 5:00pm	12	Mental health providers	AF-CBT	Mental health care providers were trained in AF-CBT techniques and were required to participate in a follow-up training to support their learning environment.
10/13/2013	TF-CBT Consultation Call	8:30am - 9:30am	12	Mental health providers	TF-CBT	Mental health care providers were trained in TFCBT techniques participate in monthly support calls to strengthen learning modules of applied practice.
10/16/2013	AF-CBT Consultation Call	11:00am - 12:00pm	16	Mental health providers	AF-CBT	Mental health care providers were trained in AF-CBT techniques participate in monthly TA calls to strengthen learning modules of applied practice.
10/21/2013	PCIT Consultation Call	9:00am - 10:00am	5	Mental health providers	PCIT	Mental health care providers were trained in PCIT techniques participate in monthly TA calls to strengthen learning modules of applied practice.
11/4/2013	AF-CBT Overview	9:00am - 10:30am	5	Staff of Central Intake & Assessment	AF-CBT	Staff assigned to Central & Intake were trained in basic concepts of AF-CBT to determine appropriate referrals.

11/13/2013	TF-CBT Consultation Call	8:30am - 9:30am	12	Mental health providers	TF-CBT	Mental health care providers were trained in TF-CBT techniques participate in monthly TA calls to strengthen learning modules of applied practice.
11/20/2013	PCIT Consultation Call	9:00am-10:00am	5	Mental health providers	PCIT	Mental health care providers were trained in PCIT techniques participate in monthly TA calls to strengthen learning modules of applied practice.
11/20/2013	AF-CBT Consultation Call	11:00am - 12:00pm	16	Mental health providers	AF-CBT	Mental health care providers were trained in AF-CBT techniques participate in monthly TA calls to strengthen learning modules of applied practice.
11/20/2013	TF-CBT Consultation Call	9:00am - 10:00am	12	Mental health providers	TF-CBT	Mental health care providers were trained in TF-CBT techniques participate in monthly TA calls to strengthen learning modules of applied practice.
11/20/2013	TF-CBT Consultation Call	10:00am - 11:00am	12	Mental health providers	TF-CBT	Mental health care providers were trained in TF-CBT techniques participate in monthly TA calls to strengthen learning modules of applied practice.
12/11/2013	TF-CBT Consultation Call	8:30am - 9:30am	2	Mental health providers	TF-CBT	Mental health care providers were trained in TF-CBT techniques participate in monthly TA calls to strengthen learning modules of applied practice.
12/18/2013	TF-CBT Consultation Call	9:00am - 10:00am	8	Mental health providers	TF-CBT	Mental health care providers were trained in TF-CBT techniques participate in monthly TA calls to strengthen learning modules of applied practice.
12/18/2013	TF-CBT Consultation Call	10:00am - 11:00am	8	Mental health providers	TF-CBT	Mental health care providers were trained in TF-CBT techniques participate in monthly TA calls to strengthen learning modules of applied practice.

12/18/2013	AF-CBT Consultation Call	11:00am - 12:00pm	16	Mental health providers	AF-CBT	Mental health care providers were trained in AF-CBT techniques participate in monthly TA calls to strengthen learning modules of applied practice.
1/7-1/11/2013	Parent Child Interaction Therapy (PCIT)	9:00am - 5:00pm	12	Mental health providers	PCIT	Mental health care providers were trained in PCIT techniques.
1/9-1/10/2013	Structured Psychotherapy Adolescents Responding to Stress (SPARCS)	9:00am - 5:00pm	12	Mental health providers	SPARCS	Mental health providers were trained in SPARCS techniques.
1/24/2013	Adults and Children Together (ACT)	9:00am - 5:00pm	4	Community-Based Workers	ACT	Community based workers were trained in ACT techniques.
1/25/2013	DCI Web-Based Training	2:00pm - 3:30pm	7	Screening Agency: Child Welfare Workers	DCI web-based training	Workers were trained in entering screening data in the web-based system.
1/30/2013	DCI System Orientation & Training	1:00pm - 2:30pm	8	Mental health providers	Defending Childhood Initiative system orientation	Workers were provided with an overview on DC and policies & procedures for screening and providing direct service.
2/13/2013	TF-CBT Consultation Call	8:30am - 9:30am	14	Mental health providers trained in TF-CBT techniques	TF-CBT	Mental health providers trained in TF-CBT receive follow up training support through monthly calls
2/27/2013	TF-CBT Consultation Call	9:00am - 10:00am	14	Mental health providers trained in TF-CBT techniques	TF-CBT	Mental health providers trained in TF-CBT received follow up training support through monthly calls.
2/27/2013	TF-CBT Consultation Call	10:00am - 11:00am	14	Mental health providers trained in TF-CBT techniques	TF-CBT	Mental health providers trained in TF-CBT received follow up training support through monthly calls.
3/13/2013	TF-CBT Consultation Call	8:30am - 9:30am	14	Mental health providers trained in TF-CBT techniques	TF-CBT	Mental health providers trained in TF-CBT received follow up training support through monthly calls.

3/27/2013	TF-CBT Consultation Call	9:00am - 10:00am	14	Mental health providers trained in TF-CBT techniques	TF-CBT	Mental health providers trained in TF-CBT received follow up training support through monthly calls.
3/27/2013	TF-CBT Consultation Call	10:00am - 11:00am	14	Mental health providers trained in TF-CBT techniques	TF-CBT	Mental health providers trained in TF-CBT received follow up training support through monthly calls.
6/3-6/4/2013	Defending Childhood & OVCTTAC Compassion Fatigue/Vicarious Trauma	8:30am - 5:00pm	43	Mental health providers	Compassion Fatigue, Vicarious Trauma	This training provided a comprehensive overview to staff working with victims of crime and abuse on how to build resiliency, coping strategies and self-care.
1/8/2014	TF-CBT Consultation Call	9:00am - 10:00am	12	Mental health providers	TF-CBT	Mental heath care providers were trained in TF-CBT techniques participate in monthly TA calls.
1/22/2014	PCIT Consultation Call	9:00am - 10:00am	5	Mental health providers	PCIT	Mental health care providers were trained in PCIT techniques participate in monthly support calls to strengthen learning modules of applied practice.
2/19/2014	PCIT Consultation Call	9:00am - 10:00am	5	Mental health providers	PCIT	Mental health care providers were trained in PCIT techniques participate in monthly TA calls to strengthen learning modules of applied practice.
3/19/2014	PCIT Consultation Call	9:00am - 10:00am	5	Mental health providers	PCIT	Mental health care providers were trained in PCIT techniques participate in monthly TA calls to strengthen learning modules of applied practice.
3/27-3/28/2014	TF-CBT Training	9:00am - 4:00pm	54	Mental health providers	TF-CBT	Mental health care providers were trained in TF-CBT techniques participate in monthly TA calls to strengthen learning modules of applied practice.