Evidence-Based Practices for Children Exposed to Violence:

A Selection from Federal Databases

U.S. Department of Justice
U.S. Department of Health and Human Services

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

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

Understanding and Integrating Evidence

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

Sources of Evidence

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

Using Evidence-Based Practices

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

Some argue against anything short of full replication of evidence-based programs. But there are many challenges to full replication, not the least of which is that many programs that have documented results do not have extensive implementation manuals. As a practical matter, users are encouraged to become familiar with the full range of evidence-based programs in this package and consider which provide the best fit for their needs. Users should seek opportunities for replicating or adapting them in ways that are consistent with local circumstances, culture, and resources while still remaining faithful to the program content. For example, the form of the program might be changed (the type of setting in which the intervention is implemented, introduction of meals or transportation, adding cultural activities), while still maintaining the function of the program (e.g., the number of sessions, session content, how often the sessions occur, etc.).

Children Exposed to Violence Program Matrix: Effective Programs

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Continuum			Program Name	Age Range	Outcome Indicator	Evidence Standard (Rating)	Increase Resilience	Reduce Trauma/ Trauma Symptoms	Reduce Incidence	Agency Providing	Source of Information (e.g., Model Programs Guide or NREPP)	Program Description
Prevention/Promotion	Intervention/ Treatment	Systems Response										
x	x		Alternative for Families-Cognitive Behavioral Therapy (AF-CBT) Formerly known as Abuse Focused-Cognitive Behavioral Therapy	4-16	Reduction in child/parent violence, abuse related fear, and depression/anxiety reduction in externalizing difficulties	Exemplary	x	x	x	OJJDP	OJJDP CEV EBG	AF-CBT is a goal-driven intervention designed to address multidimensional risks (parent practices, child aggression, family conflict, and consequences or physical abuse). Treatment is tailored over 16 weeks within a three-phase structure: (1) engagement and psychoeducation phase includes family needs assessment, increasing participant motivation, and understanding the CBT model; (2) individual skill building phase teaches parents alternatives to hostile, coercive, and physical punishment and teaches parents and children emotional regulation; (3) family application phase enhances peer and social supports and family communication. Each phase is compromises several sessions incorporating social learning, behavioral, family systems, and cognitive and developmental principles.
x			Al's Pals: Kids Making Healthy Choices	0-5 (young children) 6-12 (children)	Social competence and prosocial behaviors	2.9	x			SAMHSA	NREPP	School-based prevention program that develops social-emotional skills such as self-control, problem-solving, and healthy decisionmaking in children in preschool, kindergarten, and first grade. Through fun lessons, engaging puppets, original music and materials, and appropriate teaching approaches, the curriculum helps young children regulate their feelings and behavior; creates and maintains a classroom environment of caring, cooperation, respect, and responsibility; teaches conflict resolution and peaceful problem-solving; promotes appreciation of differences and positive social relationships; prevents and addresses bullying behavior; conveys clear messages about the harms of alcohol, tobacco, and other substances; and builds children's abilities to make healthy choices and cope with life's difficulties. The program consists of a year-long, 46-session interactive curriculum delivered by trained classroom teachers. Ongoing communication with parents is also part of the program.
x			Behavioral Couples Therapy for Alcoholism and Drug Abuse	18-25 (young adults) 26-55 (adults)	1) Quality of relationship with intimate partner 2) Children's psychosocial functioning 3) Intimate partner violence 4) Treatment compliance	1) 3.5 2) 3.7 3) 3.7 4) 3.4	x		x	SAMHSA	NREPP	Substance abuse treatment approach based on the assumptions that (1) intimate partners can reward abstinence and (2) reducing relationship distress lessens risk for relapse. The therapist works with both the person who is abusing substances and his or her partner to build a relationship that supports abstinence. Program components include a recovery or sobriety contract between the partners and therapist; activities and assignments designed to increase positive feelings, shared activities, and constructive communication; and relapse prevention planning. Partners generally attend 15-20 hour-long sessions over 5-6 months.
x	x		Big Brothers Big Sisters (BBBS) School Based-Mentoring (SBM) Community Based Mentoring (CBM)	SBM: 9-16 CBM: 5-18	SBM: Improved academic performance, behaviors, and attitudes. More classroom effort and positive social behaviors CBM: Academic problems Aggression/violence Alcohol, tobacco, and other substance use Delinquency Family functioning Academic failure	SBM: Effective CBM: Exemplary	x		x	OJJDP	MPG OJJDP CEV EBG	Mentors in SBM programs spend more time than CBM mentors working on academics, have more contact with teachers, and, unlike CBM mentors, are often supervised by school staff. Common activities include academic activities such as tutoring and talking about school-related topics and nonacademic activities such as sports, creative activities, indoor games, and talking about a range of topics such as friends, family, the future, and the mentee's behavior. Mentors in SBM programs consist of older students and adults. CBM program is a one-to-one mentoring program that takes place in a community setting and provides local agencies with guidelines about screening, matching, training, supervising, and monitoring. Mentors in CBM programs usually consist of adults ages 22-49. SBM and CBM programs vary in duration and intensity.
x			Brief Strategic Family Therapy (BSFT)	6-12 (children) 13-17 (adolescents)	1) Family functioning 2) Socialized aggression (delinquency in the company of peers)	1) 3.2 2) 3.4	x		x	SAMHSA	NREPP	BSFT is a family-based intervention designed to prevent and treat child and adolescent behavior problems. BSFT targets children and adolescents who display—or are at risk for developing—behavior problems, including substance abuse. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems. BSFT is a short-term, problem-oriented intervention. A typical session lasts 60 to 90 minutes. The average length of treatment is 12 to 15 sessions over more than 3 months.
x			CARE (Care, Assess, Respond, Empower)	13-17 (adolescent) 18-25 (young adults)	1) Sense of personal control 2) Anger management	1) 3.6 2) 3.5	x			SAMHSA	NREPP	This high school-based suicide prevention program targets high-risk youth. CARE includes a 2-hour, one-on-one computer-assisted suicide assessment interview followed by a 2-hour motivational counseling and social support intervention. The counseling session is delivers empathy and support, provides a safe context for sharing personal information, and reinforces positive coping skills and help-seeking behaviors. CARE expedites access to help by connecting each high-risk youth to a school-based caseworker or a favorite teacher and establishing contact with a parent or guardian chosen by the youth. The program also includes a follow-up reassessment of broad suicide risk and protective factors and a booster motivational counseling session 9 weeks after the initial counseling session. The goals of CARE are threefold: to decrease suicidal behaviors, to decrease related risk factors, and to increase personal and social assets.
x		x	CASASTART (Striving Together to Achieve Rewarding Tomorrows, formerly known as Children at Risk)	6-12 (children) 13-17 (adolescents)	Violence	3.0			x	SAMHSA	NREPP	CASASTART is a community-based, school-centered substance abuse and violence prevention program. Youth participants may remain in the program up to 2 years. Specific program objectives of CASASTART include reducing drug and alcohol use, reducing involvement in drug trafficking, decreasing associations with delinquent peers, improving school performance, and reducing violent offenses. CASASTART's intervention model is informed by the research literature on social learning theory, social strain theory, social control theory, and positive youth development. Its eight fundamental components are community-enhanced policing, intensive case management, juvenile justice intervention, family services, after-school and summer activities, education services, mentoring, and the use of incentives to encourage youth development activities. Each site brings together key stakeholders in schools, law enforcement agencies, and social services and health agencies to develop tailored approaches to the delivery of the core service components consistent with local culture and practice.
x	x		Child Parent Psychotherapy	0-6, plus parent(s)	Improvements in children's behavior problems Improvement in representations of self and caregivers	Effective	x	x	x	OJJDP/ACYF	OJJDP CEV EBG	Child Parent Psychotherapy is a dyadic, relationship-based treatment for parents and young children that helps restore normal developmental functioning in the wake of violence and trauma by focusing on restoring the attachment relationships that are negatively affected by violence, establishing a sense of safety and trust within the parent-child relationship, and addressing the co-constructed meaning of the event or trauma shared by parent and child. Sessions focus on parent-child interactions to support and foster health coping, affect regulation, and increased appropriate reciprocity between parent and child. Parent guidance on development, behavioral management, crisis intervention, and case management are provided as needed in an unstructured way. Recommended intervention is 50 weekly session of 1-1.5 hours.

*Although MST has been rates as exemplary with different populations the evidence standard when used with families with at least one parent charged with child abuse and neglect is promising at the moment.

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Prevention/Promotion	Intervention/ Treatment	Systems Response										
	x		Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	6-12/10-15	PTSD symptoms, depression symptoms, psychosocial dysfunction	Effective		x		OJJDP	NREPP, MPG/OJJDP CEV EBG	CBITS is a structured, school-based, group intervention designed to address PTSD, depression, and behavior problems related to community and family violence. Groups (5-8 students/group) incorporate cognitive-behavioral skills (e.g., relaxation training, changing disruptive/unhelpful thoughts, improving problem-solving) with exposure activities aimed at processing traumatic events, working through traumatic grief, or addressing traumatic memories through the use of age-appropriate didactic instruction, games, role-plays, worksheets, and homework assignments. Individuals are supported with supplemental individual sessions to help reduce posttraumatic stress. Parents are invited to attend two educational sessions and teachers are invited to one educational session to help foster resilience through establishing support for students.
x		x	Early Risers "Skills for Success"	6-12 (children) 26-55 (adults)	1) Academic competence and achievement 2) Behavioral self-regulation 3) Social competence 4) Parental investment in the child	1) 3.4 2) 3.5 3) 3.4 4) 3.2	x			SAMHSA	NREPP	The program targets elementary school children (ages 6 to 10) who are at high risk for early development of conduct problems, including substance use (i.e., who display early aggressive, disruptive, or nonconformist behaviors). It focuses on improving social relations (including family and school relations) for aggressive children and preventing/mitigating aggressive behavior.
x			Familias Unidas	6-12 (children) 13-17 (adolescents) 26-55 (adults)	1) Family functioning 2) Behavior problems 3) Externalizing disorders	1) 3.9 2) 3.9 3) 3.8	x		x	SAMHSA	NREPP	This family-based intervention is for Hispanic families with children ages 12-17. The program is designed to prevent conduct disorders; use of illicit drugs, alcohol, and cigarettes; and risky sexual behaviors by improving family functioning. Familias Unidas is guided by ecodevelopmental theory, which proposes that adolescent behavior is affected by a multiplicity of risk and protective processes operating at different levels (i.e., within family, within peer network, and beyond), often with compounding effects. The program is also influenced by culturally specific models developed for Hispanic populations in the United States. The intervention is delivered primarily through multiparent groups, which aim to develop effective parenting skills, and family visits, during which parents are encouraged to apply those skills while interacting with their adolescent. The multiparent groups, led by a trained facilitator, meet in weekly 2-hour sessions for the duration of the intervention.
x		x	Families and Schools Together (FAST)	0-5 (young children) 6-12 (children)	1) Child problem behaviors 2) Child social skills and academic competencies	1) 3.7 2) 3.7	x		x	SAMHSA	NREPP	FAST is a multifamily group intervention designed to build relationships between families, schools, and communities to increase well-being among elementary school children. The program's objectives are to enhance family functioning, prevent school failure, prevent substance misuse by children and other family members, and reduce the stress that children and parents experience in daily situations. Participants in the multifamily group work together to enhance protective factors for children, including parent-child bonding, parent involvement in schools, parent networks, family communication, parental authority, and social capital, with the aim of reducing the children's anxiety and aggression and increasing their social skills and attention spans.
	x	x	Functional Family Therapy (FFT)	6-12/13-21	Reduction in families' hostile interactions, reductions in new offending and entry for younger siblings of targeted youth, treatment costs, foster care, and residential placement	Exemplary	x		x	OJJDP	MPG/OJJDP CEV EBG	FFT is a family-based prevention and intervention program for dysfunctional youth that has been applied successfully in a variety of multiethnic, multicultural contexts to treat a range of high-risk youth and their families. It integrates several elements (established clinical theory, empirically supported principles, and extensive clinical experience) into a clear and comprehensive clinical model. The FFT model allows for successful intervention in complex and multidimensional problems through clinical practice that is flexibly structured and culturally sensitive. The model includes specific phases: engagement/motivation, behavior change, and generalization. Engagement and motivation are achieved through decreasing the intense negativity often characteristic of high-risk families. The behavior change phase aims to reduce and eliminate the problem behaviors and accompanying family relational patterns through individualized behavior change interventions (skill training in family communication, parenting, problem-solving, and conflict management). The goal of the generalization phase is to increase the family's capacity to adequately use multisystemic community resources and to engage in relapse prevention. FFT ranges from an average of 8 to 12 1-hour sessions for mild cases and incorporates up to 30 sessions of direct service for families in more difficult situations. Sessions are generally spread over a 3-month period and can be conducted in clinical settings, as an outpatient therapy, and as a home-based model.
x			Good Behavior Game (GBG)	6-10	Improvement in early risk behaviors of attention/concentration problems and shy and aggressive behavior, and academic functioning	Exemplary	x		x	OJJDP	MPG/OJJDP CEV EBG	This classroom management strategy is designed to improve aggressive/disruptive classroom behavior and prevent later criminality. The program is universal and can be applied to general populations of early elementary school children, although the most significant results have been found for children demonstrating early high-risk behavior. It is implemented when children are in early elementary grades to provide them with the skills they need to respond to later, possibly negative, life experiences and societal influences. GBG improves teachers' ability to define tasks, set rules, and discipline students and allows students to work in teams in which each individual is responsible to the rest of the group. Before the game begins, teachers clearly specify those disruptive behaviors (e.g., verbal and physical disruptions, noncompliance) that, if displayed, will result in a team's receiving a checkmark on the board. By the end of the game, teams that have not exceeded the maximum number of marks are rewarded, whereas teams that exceed this standard receive no rewards.
x			Healthy Families America (HFA)	0-2/3-5	Exposure to violence and effects of exposure to violence (e.g., PTSD symptoms)	Effective	x		x	OJJDP	MPG/OJJDP CEV EBG	HFA seeks to prevent child maltreatment, thereby limiting the amount of violence children are exposed to in the home and community. After screening a community population, at-risk families are provided home visitation services. Services include both prenatal and postnatal components. Approved prenatal curriculum typically focuses on developing healthy maternal behaviors, avoiding risky health behaviors, and supporting healthy fetal development. Postnatal home visits highlight child development, promote parental well-being and development, and support parent-child interaction through the use of instruction, modeling, and activities. Amount of services vary by family; home visits start on a weekly basis but are modified based on degree of risk and progress.

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Prevention/Promotion	Intervention/ Treatment	Systems Response										
x	x	x	Homebuilders	0-18	Children reunified with their family in a shorter amount of time either by spending more time with them or moving home 70% of children who were in the program remained home, compared with 47% of children in the control group	Effective	x	x	x	OJJDP	OJJDP CEV EBG	Homebuilders is a home and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. Goals are to reduce child abuse and neglect, family conflict, and child behavior problems and to teach families the skills they need to prevent placement or successfully reunify with their children. Program model engages families by delivering services in their natural environment, at times when they are most receptive to learning and by enlisting them as partners in assessment, goal setting, and treatment planning. Reunification cases often require case activities related to reintegrating the child into the home and community. Examples include helping the parent find childcare, enrolling the child in school, refurbishing the child's bedroom, and helping the child connect with clubs, sports, or other community groups. Duration of 6 weeks with 3-5 2-hour sessions per week is recommended.
x			Incredible Years	0-5 (young children) 6-12 (children) 26-55 (adults)	1) Positive and nurturing parenting 2) Harsh or negative parenting 3) Child behavior problems 4) Child positive behaviors, social competence, and school readiness skills 5) Parent bonding and involvement with teacher and school	1) 3.7 2) 3.7 3) 3.7 4) 3.7 5) 3.6	x			SAMHSA/OJJDP	NREPP, MPG/OJJDP CEV EBG	Program contains curricula for parents, teachers, and children and emphasizes the importance of the family as well as teacher socialization processes, especially those affecting young children. The parents' or teachers' behaviors must be changed, so the children's social interactions can be altered. The goal is to promote healthy parenting practices and avoid aversive parenting practices to prevent misconduct and promote resilience for at-risk children. There are many studies on this program. Some material on the application of this program to children in the welfare system is available.
	x		Kids Club and Moms Empowerment	3-5, 6-12, 13-21	Child/family well-being; child attitudes about violence; externalizing behavior	Effective	x	x	x	ACYF/OJJDP	OJJDP CEV EBG	The Kids Club is most effective when offered with the Moms Empowerment. The Kids Club is a small group intervention in which children share their experiences and learn they are not alone. Activities focus on displacement of emotions through stories, films, and plays to affect changes in knowledge, beliefs, and attitudes about family violence and emotional adjustment in the face of violence and social behavior within the small group. Moms Empowerment offers a small group parenting component focused on parenting and discipline and parental social and emotional adjustment in the face of family violence.
x			Life Skills Training (LST)	13-17 (adolescents)	Universal violence and delinquency prevention	4			x	SAMHSA	NREPP	This school-based program aims to prevent alcohol, tobacco, and marijuana use as well as violence by targeting major social and psychological factors that promote the initiation of substance use and other risky behaviors. LST is based on both the social influence and competence enhancement models of prevention. Consistent with this theoretical framework, LST addresses multiple risk and protective factors and teaches personal and social skills that build resilience and help youth navigate developmental tasks, including the skills necessary to understand and resist pro-drug influences. LST provides information relevant to the important life transitions that adolescents and young teens face, using culturally sensitive and developmentally and age-appropriate language and content.
x			Linking the Interests of Families and Teachers (LIFT)	6-11	Effective parenting in the home, decrease in aggressive behaviors with peers at school and on the playground, increase in teachers' positive impressions of child social skills	Exemplary	x		x	OJJDP	MPG/OJJDP CEV EBG	LIFT is a research-based intervention program designed to prevent the development of aggressive and antisocial behaviors in children in the elementary school setting (particularly first graders and fifth graders). Child social skills training sessions are held during the regular school day and are broken into distinct segments. The first segment includes classroom instruction and discussion about specific social and problem-solving skills, skills practice in small and large groups, free play in the context of a group cooperation game, and review and presentation of daily rewards. The second segment includes a formal class problem-solving session and free play and rewards.
	x		Motivational Interviewing (MI)	18-25 26-55 55+	1) Alcohol use 2) Negative consequences/problems associated with alcohol use 3) Drinking and driving 4) Alcohol-related injuries 5) Drug use 6) Retention in treatment	1) 3.4 2) 3.5 3) 3.5 4) 3.4 5) 3.3 6) 3.9	x		x	SAMHSA	NREPP	This program uses a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so the examination and resolution of ambivalence becomes its key goal. MI has been applied to a wide range of problem behaviors related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues.
	x	x	Multidimensional Treatment Foster Care (MTFC)	3-18	Decreased homicide rate, decreased rate of nonlethal crime	Exemplary 1) 2.8 2) 3.1	x		x	MPG/OJJDP CEV EBG	MPG/OJJDP CEV EBG	MTFC works with youth exposed to violence, including maltreatment that is prominent among youth especially female juvenile offenders and children receiving child welfare services. MTFC serves as an alternative to residential care or a group setting, where youth are placed with trained foster families who receive ongoing support through weekly group meetings and daily check-ins. Typically no more than two youth are placed in a home at a time, and placements are typically 6-9 months. Youth receive individual therapy and ongoing behavioral coaching. Biological parents or other after-placement caregivers are simultaneously provided training and support to prepare for the youth's transition back into the home. MTFC incorporates basic components of the Oregon Parent Training Model, and foster families and parents learn how to encourage new behaviors and develop positive relationships, set appropriate limits using timeouts and fair discipline, engage in effective problem-solving, and consistently monitor their youth's behavior and social interactions.

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Prevention/Promotion	Intervention/ Treatment	Systems Response										
	x		Multisystemic Therapy (MST) Note: Has been adapted with evidence of effectiveness for juvenile offenders, child abuse and neglect, and youth with problem sexual behaviors	12-17	By population of focus: *Juvenile offenders-* 1) Perceived family functioning-cohesion 2) Post-treatment arrest rates 3) Long-term arrest rates 4) Long-term incarceration rates 5) Self-reported criminal activity *Child abuse and neglect—* Parents more likely to demonstrate more adaptive parental control strategies, improved observed parent-child interaction, and positively reorganizing family behavior patterns *Youth with problem sexual behaviors—* Decreased recidivism for violent and sexual offenses among offending youth; improved parent-child interaction; reduction in parents' psychiatric symptomology; gains in family relations, peer relations, and individual psychiatric symptoms among youth 1) Incarceration and other out-of-home placement 2) Family and peer relations 3) Delinquent activities other than problem sexual behaviors	By population of focus: Juvenile offenders- 1) 3.0 2) 2.9 3) 3.0 4) 3.1 5) 3.2 *Child abuse and neglect- Promising Youth with problem sexual behaviors- Exemplary/ 1) 3.8 2) 3.6 3) 3.9	X		X	SAMHSA OJJDP	NREPP, MPG/OJJDP CEV EBG	MST, originally developed to treat serious juvenile offenders (sexual and violent offenses), is an intensive family- and community-based program intended to provide a multifaceted approach to treatment. It was developed from social-ecological and family systems theories, purports that youth antisocial behavior results from disconnects within or across overlapping systems in which families live. Acknowledging that problems arise from multiple influences (e.g., family conflict, poor school relations), the MST therapist bases his/her work on nine core principles, seeking to identify current patterns contributing to the issue, emphasize family strengths and resources, and empower caregivers and families to effectively function across all systems in which they interact.
x			Nurse-Family Partnership	0-5 (young children) 13-17 (adolescents) 18-25 (young adults) 26-55 (adults)	1) Child injuries and maltreatment Fewer child injuries, harmful ingestions, days of hospitalizations due to injuries; lower rates of CAN, fewer criminal behaviors and substance use problems among mothers	1) 3.5 Exemplary	x		x	SAMHSA, MPG/OJJDP CEV EBG	MPG, NREPP	Nurse-Family Partnership targets low-income, first-time mothers. Visiting nurses provide services in-home, beginning during pregnancy and lasting until the child is 2 years old. The overall goals of the program are to improve the prenatal health of the mother, and therefore of the baby; improve the early care of the infant/toddler, and therefore improve his/her health and development; and work with the mother on her own personal development with special attention to the areas of work, school, and family planning. Although this program was designed to target broad health outcomes for low-income families, some of the findings show significant positive effects on reducing child abuse and neglect, as well as other negative outcomes most highly associated with child abuse and neglect (e.g., parent and child rates of arrest and delinquency).
x			Nurturing Parenting Programs (NPP)	6-12 (children) 26-55 (adults)	1) Family interaction 2) Recidivism of child abuse and neglect 3) Children's behavior and attitudes toward parenting	1) 3.2 2) 2.9 3) 3.0	x		x	SAMHSA, OJJDP	NREPP, OJJDP CEV EBG	The goals of NPP are to: Increase parents' sense of self-worth, personal empowerment, empathy, bonding, and attachment. Increase the use of alternative strategies to harsh and abusive disciplinary practices. Increase parents' knowledge of age-appropriate developmental expectations. Reduce abuse and neglect rates. NPP instruction is based on psychoeducational and cognitive-behavioral approaches to learning and focuses on "re-parenting" or helping parents learn new patterns of parenting to replace their existing, learned, abusive patterns. Group sessions combine concurrent separate experiences for parents and children with shared "family nurturing time." In home-based sessions, parents and children meet separately and jointly during a 90-minute lesson once per week for 15 weeks.
x			Olweus Bullying Prevention Program	6-14	Decrease in perpetration and victimization; decrease in fighting and vandalism; increase in positive social climate in school, order, and discipline in school; and better social relationships and attitudes toward school	Effective	x			CDC/OJJDP	MPG/OJJDP CEV EBG	This program was developed to promote the reduction and prevention of bullying behavior and victimization problems. The program is based on an ecological model, intervening with a child's environment on many levels: the individual children who are bullying and being bullied, the families, the teachers and students within the classroom, the school as a whole, and the community. The main arena for the program is the school, and school staff has the primary responsibility for introducing and implementing the program. Schools are provided ongoing support by project staff. Adult behavior is crucial to the success of the Olweus Bullying Prevention Program. To achieve the program's goals, two conditions must be met: adults at school and, to some degree, at home must become aware of the extent of bully–victim problems; adults must engage themselves in changing the situation.
	x		Parent-Child Interaction Therapy (PCIT)	0-5 (young children) 6-12 (children) 26-55 (adults)	1) Parent-child interaction 2) Recurrence of physical abuse	1) 3.2 2) 3.9	x		x	SAMHSA	NREPP	This treatment program for young children with conduct disorders places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. PCIT was developed for children ages 2-7 with externalizing behavior disorders. In PCIT, parents are taught specific skills to establish or strengthen a nurturing and secure relationship with their child while encouraging prosocial behavior and discouraging negative behavior. This treatment has two phases, each focusing on a different parent-child interaction: child-directed interaction and parent-directed interaction. In each phase, parents attend one didactic session to learn interaction skills and then attend a series of coaching sessions with the child in which they apply these skills.

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Prevention/Promotion	Intervention/ Treatment	Systems Response										
x			Parenting Through Change (PTC)	6-12 (children) 18-25 (young adults) 26-55 (adults)	1) Academic functioning 2) Delinquency	1) 3.8 2) 3.6	X		x	SAMHSA	NREPP	PTC is a theory-based intervention to prevent internalizing and externalizing conduct behaviors and associated problems and promote healthy child adjustment. Based on the Parent Management Training--Oregon Model, PTC provides recently separated single mothers with 14 weekly group sessions to learn effective parenting practices including skill encouragement, limit-setting, problem-solving, monitoring, and positive involvement. PTC also includes strategies to help parents decrease coercive exchanges with their children and use contingent positive reinforcements (e.g., praise, incentives) to promote prosocial behavior.
x	x		Parenting Wisely	3-18	1) Child problem behaviors 2) Parental knowledge, beliefs, and behaviors 3) Parental sense of competence	1) 2.7 2) 2.7 3) 2.8	x	x		SAMHSA	NREPP	Parenting Wisely is a set of interactive, computer-based training programs for parents of children. Based on social learning, cognitive behavioral, and family systems theories, the programs aim to increase parental communication and disciplinary skills. The original Parenting Wisely program, American Teens, is designed for parents whose preteens and teens are at risk for or are exhibiting behavior problems such as substance abuse, delinquency, and school dropout. Parents use a self-instructional program on an agency's personal computer, either on site or at home, using the CD-ROM or online format. During each of nine sessions, users view a video enactment of a typical family struggle and then choose from a list of solutions representing different levels of effectiveness, each of which is portrayed and critiqued through interactive questions and answers. Each session ends with a quiz. All nine sessions can be completed in 2 to 3 hours. Parents also receive workbooks containing program content and exercises to promote skill building and practice.
x			Perry Preschool Project (High Scope Curriculum)	3-4	Less antisocial behavior and misconduct Delinquency and crime rates for the children in the program were significantly lower than for those in the control group	Exemplary	x		x	OJJDP	MPG/OJJDP CEV EBG	This high-quality education is for disadvantaged children ages 3 to 4 to improve their capacity for future success in school and in life. The intervention breaks the link between childhood poverty and school failure by promoting young children's intellectual, social, and physical development. By increasing academic success, the Perry Preschool Project is able to improve employment opportunities and wages and to decrease crime, teenage pregnancy, and welfare use. The program consists of a 30-week school year. During that year there is a daily 2½-hour classroom session and a weekly 1½-hour home visit. The home visits are a way to involve the mother in the educational process and enable her to provide her child with support. They also serve to extend what the child has learned in school to the home. Teachers organize group meetings of mothers and fathers with children in the program.
x			Primary Project	0-5 (young children) 6-12 (children)	1) Peer sociability 2) Behavior control 3) Adaptive assertiveness	1) 3.2 2) 3.3 3) 3.3	x		x	SAMHSA	NREPP	This school-based program provides early detection and prevention of school adjustment difficulties in children ages 4-9. The program begins with screening to identify children with early school adjustment difficulties (e.g., mild aggression, withdrawal, and learning difficulties) that interfere with learning. Following identification, children are referred to a series of one-on-one sessions with a trained paraprofessional who uses developmentally appropriate child-led play and relationship techniques to help adjustment to the school environment. Children generally are seen weekly for 30-40 minutes for 10-14 weeks. Targeted outcomes for children in Primary Project include increased task orientation, behavior control, assertiveness, and peer social skills.
x	x		Project Support	3-5, 6-12	Child/family well-being; safety	Effective	x	x		OJJDP/ACYF	OJJDP CEV EBG	Project Support is designed to be implemented in-home within the initial stages of transition out of a domestic abuse shelter. It was developed to target child conduct problems that often accompany exposure to domestic violence and to assist maternal self-efficacy in dealing with these difficulties. The main goals of the intervention are to provide direct support to mothers and children as they make the transition from shelter to independent living and to teach mothers effective strategies to manage a child's conduct difficulties when there is evidence of clinically significant conduct problems with at least one child between the ages 4 and 9.
	x		Prolonged Exposure Therapy	15-21	PTSD symptoms, depression symptoms, social functioning	Exemplary	x	x		OJJDP	MPG/OJJDP CEV EBG	Prolonged exposure therapy has been shown to be highly effective for reducing the symptoms of PTSD associated with sexual and nonsexual assault, including avoidance, intrusion, and arousal. Moreover, for most clients, gains in symptom reduction during treatment are maintained at 12 months following treatment.
x			Promoting Alternative Thinking Strategies (PATHS), PATHS Preschool	0-5 (young children) 6-12 (children)	1) Emotional knowledge 2) Internalizing behaviors 3) Externalizing behaviors 4) Depression 5) Neurocognitive capacity 6) Learning environment 7) Social-emotional competence	1) 2.5 2) 2.5 3) 2.9 4) 3.2 5) 2.8 6) 2.6 7) 2.8	X		X	SAMHSA	NREPP	PATHS and PATHS Preschool are school-based preventive interventions for children in elementary school or preschool. The interventions are designed to enhance areas of social-emotional development such as self-control, self-esteem, emotional awareness, social skills, friendships, and interpersonal problem-solving skills while reducing aggression and other behavior problems. Skill concepts are presented through direct instruction, discussion, modeling, storytelling, role-playing activities, and video presentations. The elementary school PATHS curriculum is available in two units: the PATHS Turtle Unit for kindergarten and the PATHS Basic Kit for grades 1-6. The curriculum includes 131 20- to 30-minute lessons designed to be taught by regular classroom teachers approximately 3 times per week over the course of a school year. PATHS Preschool, an adaptation of PATHS for children ages 3 to 5, is designed to be implemented over a 2-year period. Its lessons and activities highlight writing, reading, storytelling, singing, drawing, science, and math concepts and help students build the critical cognitive skills necessary for school readiness and academic success. The PATHS Preschool program can be integrated into existing learning environments and adapted to suit individual classroom needs.
x			Reconnecting Youth: A Peer Group Approach to Building Life Skills (RY)	13-17 (adolescents) 18-25 (young adults)	1) School performance 2) Mental health risk and protective factors	1) 3.3 2) 3.3	x			SAMHSA	NREPP	This school-based prevention program for students teaches skills to build resilience against risk factors and control early signs of substance abuse and emotional distress. Eligible students must have either fewer than the average number of credits earned for all students in their grade level at their school, high absenteeism, and a significant drop in grades during the prior semester or a record of dropping out of school. Eligible students may show signs of multiple problem behaviors, such as substance abuse, aggression, depression, or suicidal ideation. The program incorporates several social support mechanisms for participating youth: social and school bonding activities to improve teens' relationships and increase their repertoire of safe, healthy activities; development of a crisis response plan detailing the school system's suicide prevention approaches; and parent involvement, including active parental consent for their teen's participation and ongoing support of their teen's RY goals.

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Prevention/Promotion	Intervention/ Treatment	Systems Response										
		x	Richmond Comprehensive Homicide Initiative	12-30	Decreased homicide rate, decreased rate of nonlethal crime	Effective			x	OJJDP	MPG	The Richmond (Calif.) Comprehensive Homicide Initiative is a problem-oriented policing program composed of a broad collection of enforcement and nonenforcement strategies designed to reduce homicide. The initiative departed from the traditional police definition of homicide as a unique offense in which the appropriate police role is largely limited to after-the-fact investigation, instead recognizing that homicide prevention is a critical police responsibility that can best be accomplished by identifying the paths that frequently lead to homicide and closing them by intervening early. With this new definition in mind, the initiative members developed a plan concentrated on specific problem areas, including targeting domestic violence, enhancing investigative capabilities, intervening in the lives of at-risk youth, and targeting outdoor- gun-, drug-, and gang-related violence. Examples of the nonenforcement strategies, which emphasize youth and prevention, include collaborating with the community and public agencies in crime-reduction planning and collaborating with the Battered Women's Alternatives and the Rape Crisis Coalition to support programs and practices to reduce domestic violence and examples of traditional investigative and enforcement functions including obtaining the assistance of the Drug Enforcement Administration, the FBI, and the California Bureau of Narcotics Enforcement in targeting violence-prone members of the drug culture.
x			SAFEChildren	6-12 (children) 26-55 (adults)	1) Child problem behaviors 2) Parental involvement in child's education	1) 3.6 2) 3.6	x		x	SAMHSA	NREPP	This family-focused preventive intervention is designed to increase academic achievement and decrease risk for later drug abuse and associated problems such as aggression, school failure, and low social competence. It targets first-grade children and their families living in inner-city neighborhoods. The intervention has two components. The first is a multiple-family group approach that focuses on parenting skills, family relationships, understanding and managing developmental and situational challenges, increasing parental support, skills and issues in engaging as a parent with the school, and managing issues such as neighborhood problems (e.g., violence) as well as family participation in 20 weekly sessions (2 to 2.5 hours each) led by a trained, professional family group leader. The second component is a reading tutoring program for the child.
x			Safe Dates	12-14 (8th and 9th graders)	Sexual violence perpetration; findings consistent at 4-year follow-up	Exemplary			x	CDC/OJJDP	MPG/OJJDP CEV EBG	This is a school-based program to stop or prevent the initiation of psychological, physical, and sexual abuse on dates or between individuals involved in a dating relationship. Its goals are to change adolescent dating violence norms and gender-role norms, improve conflict resolution skills for dating relationships, promote victims' and perpetrators' beliefs in the need for help and awareness of community resources for dating violence, promote help-seeking by victims and perpetrators, and improve peer help-giving skills.
x		x	San Diego Breaking Cycles (SDBC)	13-21	Children's peer relationships, school attendance and performance, decreased delinquent behavior, reduced likelihood of drug use over 18 months	Effective			x	OJJDP	MPG/OJJDP CEV EBG	SDBC comprises two components: prevention and graduated sanctions. Each component includes services relevant for children exposed to violence and focuses on the early identification of youth at risk for delinquency; the provision of graduated family-centered, community-based treatments; and the termination of the cyclic substance abuse and violence among juveniles. The prevention component includes a comprehensive assessment conducted by a multiagency community assessment team that identifies strengths and risks of the youth and family and links them with community social supports. The graduated sanctions component is accessed via court orders and provided to youth at-risk for out-of-home placement. It includes the provision of psychoeducational groups for youth and families, individual and family therapy and substance abuse counseling, and other community supports.
x			Strengthening Families Program (SFP) Note: Has also been adapted with evidence of effectiveness for parents and youth ages 10-14	6-12 (children) 13-17 (adolescents) 26-55 (adults)	1) Children's internalizing and externalizing behaviors 2) Parenting practices/parenting efficacy 3) Family relationships Adaptation for parents and youth age 10-14 1) School success 2) Aggression	1) 3.1 2) 3.1 3) 3.1 Adaptation for parents and youth ages 10-14 1) 2.9 2) 3.0	x		x	SAMHSA	NREPP	This family skills training program is designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children. SFP comprises three life-skills courses delivered in 14 weekly, 2-hour sessions. Parenting skills sessions are help parents learn to increase desired behaviors in children by using attention and rewards, clear communication, effective discipline, substance use education, problem solving, and limit setting. Children's life skills sessions help children learn effective communication, understand their feelings, improve social and problem-solving skills, resist peer pressure, understand the consequences of substance use, and comply with parental rules. Family life skills sessions help families engage in structured family activities, practice therapeutic child play, conduct family meetings, learn communication skills, practice effective discipline, reinforce positive behaviors in each other, and plan family activities together.
	x		Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)	3 to 21	1) Child behavior problems 2) Child symptoms of PTSD 3) Child depression 4) Child feelings of shame 5) Parental emotional reaction to child's experience of sexual abuse 6) Personal and prosocial behaviors	1) 3.8 2) 3.6 3) 3.8 4) 3.7 5) 3.7 6) 2.9 Exemplary	x	x		SAMHSA/OJJDP	NREPP, OJJDP CEV EBG	TF-CBT is a structured, weekly conjoint child and parent psychosocial therapy for children and youth with emotional/behavioral difficulties associated with violence exposure and trauma. It focuses on providing a safe, trusting environment where children and parents build skills in coping, stress reduction, and management of overwhelming emotions and traumatic grief. The core components (PRACTICE) include psychoeducation about childhood trauma, relevant violence, PTSD, and parent guidance; relaxation skills individualized to the child and parent; affective modulation skills adapted to the child, family, and culture; cognitive coping including connecting thoughts, feelings, and behaviors related to the trauma; completing a trauma narrative; in-vivo exposure to reduce anxiety; conjoint parent-child sessions to practice skills and enhance trauma-related discussions; and enhancing personal safety and optimal development through providing safety and social skills training as needed.
x			Triple P (Positive Parenting Program)	0-8 (young children)	1) Negative and disruptive child behaviors 2) Negative parenting practices as a risk factor for later child behavior problems 3) Positive parenting practices as a protective factor for later child behavior problems	1) 2.9 2) 2.9 3) 3.0	X		X	SAMHSA, CDC, OJJDP	NREPP	The program is aimed at reducing coercive parenting, including maltreatment. A recent randomized population trial of Triple P in 18 counties in South Carolina showed significant reductions in substantiated child maltreatment, child maltreatment injuries, and out-of-home placements for those in the Triple P counties. Within the Triple P system, the Pathways Triple P adjunctive intervention provides a four-session adjunct to standard or enhanced group or individual Triple P for parents who have abused or are at risk of maltreating their children.

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Prevention/ Promotion	Intervention/ Treatment	Systems Response										
	x		Child and Family Traumatic Stress Intervention (CFTSI)	7-18	Prevent the development of Chronic PTSD in children	Promising		x		ACYF	NCTSN	Four-session caregiver-child early intervention for children with recent exposure (30 days) to a potentially traumatic event. Sessions involve assessment for trauma and PTSD for caregiver and child, using information from the assessments to identify key issues, improve caregiver-child communication, select and practice behavioral skill modules as homework, other supportive measures and determine next steps at final session.
x	x		Combined Parent Child CBT	4-17	CEV relevant; Limited Data	Promising	x		x	OJJDP	NCTSN	Consists of 16 sessions that aim to empower parents to effectively parent in a non-coercive manner, improve parent-child relationships, assist children in healing from their abusive experiences, and enhance the safety of family members. The treatment consists of 3 components: (1) Parent Interventions, (2) Child Interventions, and (3) Parent-Child.
	x	x	DV Home Visitation	0-18	Trauma-related symptoms	Promising		x	x	ACYF	OJJDP CEV EBG	A joint project of the Yale Child Study Center and the New Haven Police Department that provides enhanced law enforcement, community-based advocacy, and mental health services to families affected by domestic violence, in an effort to increase children's safety and decrease negative psychological effects of exposure to domestic violence. The project conducts outreach home visits by teams of advocates and patrol officers. At the initial home visit, the team and non-offending parent identify issues affecting family safety.
	x		Eye Movement Desensitization and Reprocessing (EMDR)	2-17	Reduce reactivity to traumatic memories, reduce trauma symptoms	Promising		x		SAMHSA	OJJDP CEV EBG	An 8-phase psychotherapy treatment originally designed to alleviate the symptoms of trauma. During the EMDR trauma processing phases, the client attends to emotionally disturbing material in brief sequential doses that include the client's beliefs, emotions, and body sensations associated with the traumatic event while simultaneously focusing on an external stimulus.
x	x		Family Centered Treatement (FCT)	5-21	Lower residential placements and decrease in duration of placement in first year	Promising	x		x	OJJDP	MPG / OJJDP CEV EBG	Intensive in-home service treatment especially well suited for high-risk juveniles not responding to typical community-based services or found to need institutional placement, as well as those returning from incarceration or institutional placement. A primary goal is to keep youth in the community and divert them from further penetration into the juvenile justice system. FCT is different from other traditional in-home family therapy or counseling programs in that it is family focused rather than client focused. Treatment services concentrate on providing a foundation that maintains family integrity, capitalizes on the youth's and family's inherent resources (i.e., skills, values, and communication patterns), develops resiliency, and demands responsibility and accountability.
x			Multimodality Trauma Treatment Trauma-Focused Coping (MMTT)	18-Sep	Beneficial effects of treatment for reducing PTSD, depression, anxiety, and anger	Promising	x	x		OJJDP	NCTSN	A skills-oriented, cognitive behavioral treatment (CBT) approach for children exposed to single incident trauma and targets posttraumatic stress disorder (PTSD) and collateral symptoms of depression, anxiety, anger, and external locus of control. It was designed as a peermediating group intervention in schools. It has been shown to be easily adaptable for use as group or individual treatment in clinic populations as well.
	x		Partners with Families and Children: Spokane	0-5 (Early childhood) 26-55 (Adult)	1: Interpersonal violence within families 2: Parenting stress 3: Child behavior problems 4: Caregiver-child attachment 5: Service access	Promising	x			SAMHSA	NREPP	Families with children under 30 months referred by child protective services, law enforcement, or other public health agencies due to chronic child neglect or risk of child maltreatment. A multidisciplinary intervention based on wraparound service principles and attachment theory. Its characteristic features are intensive case management using an integrated system of care approach; on-site resources for gender-specific, integrated parental substance abuse and mental health services; parental coaching to improve parent-child interactions and relationships; and a commitment to provide services as long as the family wants and benefits from services

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Prevention/ Promotion	Intervention/ Treatment	Systems Response										
	x		Real Life Heroes	6-12 (Childhood) 13-17 (Adolescent)	1) Feelings of security with primary caregiver 2) Problem behaviors	Promising	x		x	SAMHSA	NREPP	Based on cognitive behavioral therapy models for treating posttraumatic stress disorder (PTSD) in school-aged youth. Focuses on rebuilding attachments, building the skills and interpersonal resources needed to reintegrate painful memories, fostering healing, and restoring hope. The protocol components include safety planning, trauma psychoeducation, skill building in affect regulation and problem solving, cognitive restructuring of beliefs, nonverbal processing of events, and enhanced social support.
x			Second Step	6-12 (Childhood)	1) Social competence and prosocial behavior 2) Incidence of negative, aggressive, or antisocial behaviors	1) 2.4 2) 2.4	x		x	SAMHSA	NREPP, OJJDP CEV EBG	Classroom-based social-skills program that teaches socioemotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. Builds on cognitive behavioral intervention models integrated with social learning theory, empathy research, and social information-processing theories. Consists of in-school curricula, parent training, and skill development.
	x		Seeking Safety for Adolescents	Adolescents	Child/family well-being; substance use, trauma-related symptoms, psychopathology	Promising		x		ACYF	NREPP	The program is a present-focused coping skills therapy designed for use with adolescents with PTSD and substance abuse disorders. The program consists of 25 topics that address cognitive, behavioral and interpersonal domains. Each offers a safe coping skill for topics including asking for help, coping with triggers, detaching from emotional pain, etc.
	x		Sexual Abuse, Family Education & Treatment (SAFE-T)	6-12 / 13-21	Reduced recidivism for sexual assualt charges; reduced criminal behavior; reduced exposure and ameliorated effects of exposure	Promising	x		x	OJJDP	MPG / OJJDP CEV EBG	SAFE-T is a sexual offender specific treatment program, therefore, its primary outcomes are reported recidivism rates. From quasiexperimental studies of adolescent sexual offenders (with mostly child or peer victims), SAFE-T has been effective in reducing long-term recidivism rates of sexual, violent, property, and "other" offenses, thereby reducing rates of sexual and non-sexual violence in the community through prevention. Further, almost half of sexual offenders (43%) receiving SAFE-T treatment have reported a history of sexual victimization.
	x		Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	12-19	Overall functioning, conduct-related problems, coping responses, PTSD symptoms	Promising	x	x	x	ACYF	NCTSN	Primarily a cognitive-beahavioral therapy and dialectical behavioral therapy; intervention delivered in a group setting to address the needs of chronically traumatized adolescents who may still be living with ongoing stress and experiencing problems with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance and struggles with their own purpose and meaning in life as well as worldviews that make it difficult for them to see a future for themselves. Delivered in 16-22 one hour sessions.
	x	x	Trauma Systems Therapy (TST)	6-19	Traumatic stress symptoms, family and school related problems	Promising		x		ACYF	NCTSN	Targeted at children and adolescents who are having difficulty regulating their emotions as a result of the interaction betweeen the traumaatic experience and stressors in the social environment, TST has up to five phases: Surviving, Stabilizing, Enduring, Understanding and Transcending. Treatment modules include: Home and Community-based Services, Services Advocacy, Emotional Regulation and Skills Training, Cognitive Processing and Psychopharmacology.

Service Characteristics with Evidence-Based Support for Children Exposed to Violence

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

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

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

- **Combined Home and Center-based approaches**

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

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

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

- **Developmentally and culturally appropriate services**

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

- **Attrition and Retention** as a barrier to both practice and research: The difficulty of engaging and retaining families in services is a critical service barrier across all types of services. It is particularly challenging when children have been exposed to violence because families with co-occurring violence experiences have many safety concerns and pressing needs.

- **Mandated Reporting**: One critical service barrier in the area of CEV, particularly in the area of treatment, is the concern by providers that having to make a referral for child maltreatment will dissolve the treatment relationship between the provider and the caregiver and will result in attrition however some early evidence is emerging that demonstrates that with proper training on when and how to report with families in treatment, families can be effectively retained in services and reporting can be effectively managed without sacrificing treatment.

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

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

Common service and system gaps

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

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

- **Trauma-informed and trauma-specific care**: Children exposed to violence are often involved in service systems that serve populations with high rates of exposure to traumatic events. Children who have experienced a traumatic event or multiple events and are experiencing negative psychological symptoms may need trauma specific treatment such as Trauma Focused Cognitive Behavior Therapy or Exposure Therapy. At the same time,

services should be trauma-informed, with an appreciation for the high prevalence of traumatic experiences in persons receiving them, and a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on individuals. A trauma-informed approach can help staff reduce rates of re-traumatization and engage children and families that have experienced trauma.

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

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

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

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

Glossary of Terms

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

- **Assessment**

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

- **Child Maltreatment**

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

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

- **Children's Exposure to Violence (CEV)**

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

- **Complex Trauma**

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

- **Continuum of Care**

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

- **Crisis Response**

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

- **Domestic Violence**

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

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

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

- **Effective**

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

- **Evidence Based**

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

- **Exemplary**

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

- **Experimental Design**

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

- **Incidence**

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

- **Intervention***

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

- **Intimate Partner Violence (IPV)**

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

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

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

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

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

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

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

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

- **Observational Study**

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

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

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

- **Prevalence**

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

- **Prevention***

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

- **Promising Programs**

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

- **Promotion**

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

- **Protective Factors**

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

- **Public Health Approach**

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

- **Quasi-Experimental Design**

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

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

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

- **Research Design**

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

- **Resilience**

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

- **Reliability**

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

- **Risk Factors**

  Risk factors are conditions in the individual or environment that can predict an increased likelihood of developing a problem.

- **Stress to Trauma Continuum**

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

  - **Positive stress response** is a normal and essential part of healthy development, characterized by brief increases in heart rate and mild elevations in hormone levels. Situations that trigger a positive stress response are the first day with a new caregiver or receiving a vaccination.
  - **Tolerable stress response** activates the body's alert systems to a greater degree because of more severe, longer lasting difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury. If the activation is time limited and buffered by relationships with adults who help the child adapt, the brain and other organs recover from what might be damaging effects.
  - **Toxic stress response** can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems and increase the risk for stress-related disease and cognitive impairment well into adulthood.

- **System Response**

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

- **Trauma***

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

  - School shootings
  - Gang-related violence in the community
  - Terrorist attacks
  - Natural disasters (e.g., earthquakes, floods, hurricanes)
  - Serious accidents (e.g., car or motorcycle crashes)
  - Sudden or violent loss of a loved one
  - Physical or sexual assault (e.g., beatings, shootings, or rapes)

Exposure to trauma can occur repeatedly over long periods. These experiences call forth a range of responses, including intense feelings of fear, loss of trust in others, decreased sense of personal safety, guilt, and shame. These are ***chronic traumatic situations*** and include the following (http://www.nctsnet.org/nccts/nav.do?pid=faq_def):

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

- **Trauma-informed Care**

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

  Trauma-informed treatment programs generally recognize the following:

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

- **Trauma Symptoms**

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

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

- **Treatment***

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

- **Validity**

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

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

- **Primary Prevention**

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

- **Secondary Prevention**

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

- **Tertiary Prevention**

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

- **Universal Interventions**

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

- **Selected Interventions**

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

- **Indicated Interventions**

  Approaches that are aimed at helping those who have already perpetrated violence or have been victimized.

High Fidelity Implementation of Evidence-based Practices

Delivery of an evidence-based practice (EBP) with fidelity is correlated with intervention success. Hallmarks of high fidelity implementation of EBPs as identified in the *National Implementing Evidence-Based Practices Project*,[1] supported by SAMHSA, the John D. and Catherine T. MacArthur Foundation, the Robert Wood Johnson Foundation, and a variety of additional public and private funders include:

COORDINATED, MULTI-LEVEL SUPPORT

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

TOOLKITS

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

CONSULTATION & TRAINING

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

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[1] Bond et al. (2009) "Strategies for Improving Fidelity in the National Evidence-Based Practices Project." *Research on Social Work Practice*. 19: 569.
http://rsw.sagepub.com/content/19/5/569

FIDELITY MEASUREMENT

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

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

IMPLEMENTATION MONITORS

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